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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LZZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DOPNA, effective 05/25/2016, is rescinded effective 05/25/2016.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 — Date :
William Abderhalden, DSFM — 06/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/15/2016
(L33)

Posted 07/11/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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

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

MDH
Minnesota
Department
of Health

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

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.

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245298 Y1	A. Building B. Wing Y2	6/1/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 06/23/2016	SIGNATURE OF SURVEYOR 20794	DATE 06/01/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245298 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/16/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	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 101	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 101	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 101	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 101	Completed	Reg. #	Completed
LSC K0144	04/05/2016	LSC K0147	04/05/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	06/23/2016	20794	06/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

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 FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00866		6/1/2016

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 report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 05/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 06/23/2016	SIGNATURE OF SURVEYOR 20794	DATE 06/01/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: LZZ913

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LZZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Facility's request for a continuing waiver involving F354 and F458 is recommended,

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II — 05/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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: 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 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 all 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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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 **all** 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 no later than 60 days 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 Services Office of Ombudsman for Older Minnesotans

Stratis Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A post-certification (PCR) survey was conducted on May 2 through May 3, 2016 and complaint investigation(s) were also completed at the time of the PCR, Federal deficiencies were cited at this time. Investigation of complaints H5298056 and H5298057 were completed and found not to be substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	{F 441}	5/24/16 A accepted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Interim Executive Director 5/23/16

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

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(F 441)	Continued From page 1 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on 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	(F 441)	**F 441** It is the policy of Golden Living Center Twin Rivers that the facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction for identified incidents: Residents identified remain free from infection due to nurse not wearing personal protective equipment (gloves). Further education has been completed with nurse involved in incidents noted during survey. Nursing staff were educated in regards to the Infection Control Policy and the need to wear protective personal equipment when there is possible contact with blood or body fluids. DNS or designee will complete weekly audits of medication administration competency including administration of insulin, eye drops, and blood sugar checks to assure ongoing compliance with Infection Control policy. QAPI Committee will provide direction or change when necessary based on the compliance noted. Date of Completion: 5/24/16 DNS or designee is responsible for monitoring compliance.	

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{F 441}	Continued From page 2	{F 441}		

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.

R18's diagnoses, as indicated on quarterly MDS dated 4/18/16, included type 2 diabetes mellitus. Review of the physician Order Summary Report dated 4/5/16 identified R40 received 3 units Humalog insulin with 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 the insulin. LPN-A did not wash hands before or following R18's injectable medication, and again, wore no gloves.

R40's diagnoses, as indicated on the quarterly MDS dated 1/21/16, included type 2 diabetes mellitus. Review of the physician Order Summary Report dated 4/5/16 identified R40 received Novolog insulin on a sliding scale, before meals.

During observation of medication administration on 5/2/16, at 4:50 p.m. LPN-A attached a needle to R40's Novolog insulin pen, primed the pen, and

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{F 441}	Continued From page 3	{F 441}		

dialed a dose of 1 unit. LPN-A cleansed R40's skin with an alcohol pad and injected medication into R40's abdomen. LPN-A did not wash hands or wear gloves before or after R40's insulin administration.

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."

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.

A facility policy titled Blood Sugar Monitoring dated 1/13/16, directed: "1. Check physician order for blood sugar testing frequency 2. Put on gloves 3. Follow manufacturer's directions for use and care of the equipment used in your facility 4. Discard used lancet in sharps container 5. Check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 4 puncture site to be sure bleeding has stopped. Apply Band-Aid as needed."	{F 441}		
{F 458} SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Provider requesting a wavier for this federal deficiency	{F 458}	F 458 Bedrooms measure at least 80 sq ft/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 residing in the aforementioned rooms. The residents' health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. The Director of Maintenance is responsible for the monitoring of this waivered requirement.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245298 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	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	Correction	ID Prefix F0354	Correction	ID Prefix F0465	Correction
Reg. # 483.25(m)(2)	Completed	Reg. # 483.30(b)	Completed	Reg. # 483.70(h)	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/16/2016	SIGNATURE OF SURVEYOR 32613	DATE 05/03/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245298 Y1	A. Building 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).

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LSC	04/14/2016	LSC	04/14/2016	LSC	04/14/2016
ID Prefix F0242	Correction	ID Prefix F0246	Correction	ID Prefix F0248	Correction
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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/16/2016	SIGNATURE OF SURVEYOR 32613	DATE 05/03/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 2-3, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Licensing order 1375 has been not been corrected. The orginal licensing order issued on February 25, 2016, will remain in effect. Penalty assessment is recommended.	{2 000}	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 of correction that you have reviewed these orders, and identify the date when they will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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{2 000}	Continued From page 1 In addition, a complaint investigation(s) were also completed at the time of the state licensing revisit survey, and an investigation of complaint/s H5298056 and H5298057 were completed and found not to be substantiated.	{2 000}	be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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{21375}	Continued From page 2 sanitary environment. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on February 25, 2016, will remain in effect. Penalty assessment issued. 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. R18's diagnoses, as indicated on quarterly MDS dated 4/18/16, included type 2 diabetes mellitus.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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{21375}	Continued From page 3 Review of the physician Order Summary Report dated 4/5/16 identified R40 received 3 units Humalog insulin with 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 the insulin. LPN-A did not wash hands before or following R18's injectable medication, and again, wore no gloves. R40's diagnoses, as indicated on the quarterly MDS dated 1/21/16, included type 2 diabetes mellitus. Review of the physician Order Summary Report dated 4/5/16 identified R40 received Novolog insulin on a sliding scale, before meals. During observation of medication administration on 5/2/16, at 4:50 p.m. LPN-A attached a needle to R40's Novolog insulin pen, primed the pen, and dialed a dose of 1 unit. LPN-A cleansed R40's skin with an alcohol pad and injected medication into R40's abdomen. LPN-A did not wash hands or wear gloves before or after R40's insulin administration. 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.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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{21375}	Continued From page 4 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." 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. A facility policy titled Blood Sugar Monitoring dated 1/13/16, directed: "1. Check physician order for blood sugar testing frequency 2. Put on gloves 3. Follow manufacturer's directions for use and care of the equipment used in your facility 4. Discard used lancet in sharps container 5. Check puncture site to be sure bleeding has stopped. Apply Band-Aid as needed."	{21375}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00866 Y1	A. Building 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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20900	Correction	ID Prefix 20920	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 6 B	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 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.0900 Subp. 1	Completed	Reg. # MN Rule 4658.1320 A.B.C	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 4658.1400	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed	Reg. # MN St. Statute 144.651 Subd. 10	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 144.651 Subd. 15	Completed	Reg. # MN St. Statute 626.557 Subd. 3	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/16/2016	SIGNATURE OF SURVEYOR 32613	DATE 05/03/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LZZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Michelle Thompson, HFE NE II — 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 04/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 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 all 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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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 **all** 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 no later than 60 days 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 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.

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

305 Fremont St. • Anoka, MN 55303
763-421-5660 • Fax: 763-421-6581 • www.GoldenLivingCenters.com

4/1/16

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
Lynby A Y	Interim Executive Director	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____ RECEIVED MAR 22 2016	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET MN Dept of Health St.Cloud ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint investigations H5298053, H5298054 and H5298055 were completed at the time of the standard survey, and were not substantiated during this survey.	F 000	Twin Rivers objects to the allegations of non-compliance in this Statement of Deficiency and deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the administrator of any employees, agents or other individuals who draft or may be discussed in this Response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the facility.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	**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:	4/4/16

4/1/16 del addendum to POC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim Executive Director — (X6) DATE: 3/18/16

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

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	245298	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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F 164	Continued From page 1 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to ensure personal visual privacy for 1 of 1 residents (R8) during random observations. Findings include: R8's admission Minimum Data Set (MDS) assessment, dated 1/27/16, identified R8 was cognitively intact and required extensive assistance with bed mobility, personal hygiene and dressing. 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.	F 164	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. 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. QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/4/16 The DNS or designee is responsible for monitoring compliance.	

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F 164	Continued From page 2 R23 was observed on 2/23/16 at 2:00 p.m. lying in his bed with just a sheet covering his lower body, with his bare chest exposed. The residents room door was open, and could be seen by other residents, visitors and staff who were walking by R8's room from the hallway. During a follow up interview on 2/23/26, at 3:58 p.m., R8 was lying in bed with the door fully open, exposing his unclothed chest and abdomen. Residents, staff and visitor were walking by R8 room with the door open and could be seem from the hallway. R8 stated he had not been offered a different room location or bed that would provide more visual privacy. During an interview on 2/24/16, at 2:20 p.m., family member (FM)-A stated she was "Uncomfortable," to see R8 partially unclothed 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	F 164		

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F 164	Continued From page 3 Residents' Rights, dated 2/26/15, included the facility would implement and monitor the residents' right to privacy and confidentiality.	F 164		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225	**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 the State agency however reports were noted not to filed 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. 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. Executive Director will monitor 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.	4/4/16

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F 225	Continued From page 4 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to 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	F 225	Date of Completion: 4/4/16 The Executive Director or designee is responsible for monitoring compliance.	

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F 225	Continued From page 5 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	F 225		

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F 225	Continued From page 6 pouch locked up. The report indicated the ED was not notified until 6/9/15, seven day after the incident. A facility Verification of Investigation dated 6/9/15, indicated the report was submitted to the state agency seven days later. During interview 2/24/16, at 3:33 p.m. SW stated she was waiting to see if the money came back from laundry and stated "I know this incident should have been reported immediately to the state agency." During interview 2/25/16, at 12:00 p.m. the ED-A stated she does not know why this was reported late to ED-B and state agency, the previous ED-B was no longer at the facility at this time and it should have been reported immediately. Additional review of the facility's Verification of Investigation reports indicated there were seven additional reports of residnets missing money which identified the following: R101's Verification of Investigation indicated that on 6/8/15," resident told the business office manger that he was missing $20. Social worker followed up with resident and he then stated it was $10 or $15. He stated he had in his green zipper pouch that was tied to the back of his wheelchair and he also stated the lost the key to his drawer." The ED and state agency were immediately notified. R100's Verification of Investigation indicated that on 7/09/15, "Reported to nurse that [sic] (staff member) ,nursing assistant registered (NAR) had posted personal note/check on her Facebook	F 225		

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F 225	Continued From page 7	F 225		

page about resident [R101] had passed away." Resident Interview Summary on the Investigation further indicated: "Resident had expired. Social Worker spoke with daughter, [sic] , who stated she had given the check with sentiments written on it for her [sic] (staff member) to have. She had no concerns." The report did indicate the ED and state agency were immediately informed.

R44's Verification of Investigation dated 7/22/15, indicated R44 "had coins in a pouch in his room. Spouse [sic] alleges that approximately $13 in quarters were taken from the pouch in residents room." The report did indicate the ED and state agency were immediately informed.

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 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

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F 225	Continued From page 8 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. 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 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 discharged in late December early January. Although the former resident R68 had been discharged the faciltiy had two additional allegations of missing money on February 8, and 12, 2016. Although the facility had nine incidents of misappropriation of resident property from June 2015 through February 2016, there was no indication the facility completed a thorough investigation of the missing resident money.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 9 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 REQUIREMENTS 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 226	**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 the State agency however reports were noted not to filed 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. 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. Executive Director will monitor 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.	4/4/16

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F 226	Continued From page 10 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 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.	F 226		

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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 pouch locked up. The report indicated the ED was not notified until 6/9/15, seven day after the incident.

A facility Verification of Investigation dated 6/9/15, indicated the report was submitted to the state agency seven days later.

During interview 2/24/16, at 3:33 p.m. SW stated she was waiting to see if the money came back from laundry and stated "I know this incident should have been reported immediately to the state agency."

During interview 2/25/16, at 12:00 p.m. the ED-A stated she does not know why this was reported late to ED-B and state agency, the previous ED-B

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F 226	Continued From page 12 was no longer at the facility at this time and it should have been reported immediately. Additional review of the facility's Verification of Investigation reports indicated there were seven additional reports of residnets missing money which identified the following: R101's Verification of Investigation indicated that on 6/8/15," resident told the business office manger that he was missing $20. Social worker followed up with resident and he then stated it was $10 or $15. He stated he had in his green zipper pouch that was tied to the back of his wheelchair and he also stated the lost the key to his drawer." The ED and state agency were immediately notified. R100's Verification of Investigation indicated that on 7/09/15, "Reported to nurse that [sic] (staff member) ,nursing assistant registered (NAR) had posted personal note/check on her Facebook page about resident [R101] had passed away." Resident Interview Summary on the Investigation further indicated: "Resident had expired. Social Worker spoke with daughter, [sic] , who stated she had given the check with sentiments written on it for her [sic] (staff member) to have. She had no concerns." The report did indicate the ED and state agency were immediately informed. R44's Verification of Investigation dated 7/22/15, indicated R44 "had coins in a pouch in his room. Spouse [sic] alleges that approximately $13 in quarters were taken from the pouch in residents room." The report did indicate the ED and state agency were immediately informed. R35's Verification of Investigation dated 7/22/15,	F 226		

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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 here, and she was unsure what happened. ED-A

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F 226	Continued From page 14 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 about the missing money. 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 was discharged in late December early January. Although the former resident R68 had been discharged the faciltiy had two additional allegations of missing money on February 8, and 12, 2016. Although the facility had nine incidents of misappropriation of resident property from June 2015 through February 2016, there was no indication the facility completed a thorough investigation of the missing resident money, as identified in the facility policy.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident preferences were honored for getting up in the	F 242	**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 whom 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.	4/4/16

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F 242	Continued From page 15 morning for 1 of 3 residents (R50) reviewed for choices and preferences. Findings include: R50's quarterly Minimum Data Set (MDS), dated 1/15/16, indicated she was moderately impaired and required extensive assistance with activities of daily living (ADL's) including dressing, grooming, bathing and toileting. During interview on 2/22/16, at 4:40 p.m., R50 stated that she does not get to sleep in as she would like to in the morning. 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.	F 242	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. 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.	

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F 242	Continued From page 16 At 9:37 a.m., R50 was assisted from the dining room by nursing assistant (NA)-A and was brought back to her room. On 2/24/16, at 6:58 a.m. R50 was asleep in her bed. At 7:05 a.m., NA-D, entered R50's room, and ask the resident if she would like to get up or not. R50 stated that she wanted to sleep in until later and NA-D left the room. NA-D stated the resident likes to sleep in until second seating and usually gets up about 8:10-8:15 a.m. and is aware of R50's preference to sleep in. At this time, licensed practical nurse (LPN)-B joined in the conversation and stated that R50 is a "night owl". LPN-B stated that R50 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 R50 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 a 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, smiling, 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	F 242		

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F 242	Continued From page 17 outlined on the care sheets. This information is typically 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 on 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. A facility policy entitled Preservation of Resident Rights, dated 2/26/15, under Resident Choice identifies that "staff will communicate residents preferences, needs, and choices to ensure integration into the residents care schedule and care plan. "	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to fully explore bathing options for 1 of 1 residents (R56) who had difficulty accessing the facility bathing facility. R56's quarterly Minimum Data Set (MDS) dated 1/7/2016, indicated intact cognition, and had diagnoses which included amputation,	F 246	**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.	4/4/16

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F 246	Continued From page 18 osteoarthritis and obesity. The MDS further indicated R56 required extensive, two-person physical assistance with transferring, was not steady and only able to stabilize with assistance for surface to surface transfers. R56's care plan, revised 1/4/2016, identified physical functioning deficit related to self care and mobility impairments. R56's care plan directed "transfer assistance of 2 using Sarah lift" [a mechanical standing lift] and "encourage choices with care." R56's care plan did not identify any special needs/assistance for bathing. During an interview on 2/22/2016 at 6:00 p.m., R56 said he did not get to chose whether he could have a shower, or bath. R56 stated "They only give me a bed bath." R56 also said "they wont let me" use the whirlpool because of some restriction, but "don't know why I can't use the shower." R56 currently receives a weekly bed bath, but would prefer to have a shower. R56 went on to say he was getting showers, using a special chair, and "we never had an issue with that," and then suddenly "around Thanksgiving [staff] talked to me about getting just bed baths," and I no longer gets showers even though he had received showers previously. In an interview on 2/24/2016 at 11:26 a.m., nursing assistant (NA)-D said R56 "used to get a whirlpool" bath, but they had to change because of some restrictions with the tub. NA-D said R56 then "was getting a shower" but positioning him in the shower was difficult. NA-D then stated "I think he talked with the nurse" and since then "[R56] has been getting a bed bath." A review of R56 nursing progress notes indicated on 11/23/2015, executive director (ED)-A	F 246	Other residents will shower or bathe per their preference and assuring the safety of resident and staff. 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. 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.	

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assessed R56 during a transfer using a mechanical standing lift, and was assessed to safely transfer with the lift and assist of 2 staff. The note indicated the ED-A and R56 discussed various concerns, with activities of daily living (ADLs). However the note did not identify why R56 was changed to a bed bath, and was no longer able to shower.

In an interview on 2/24/2016 at 11:30 a.m., the ED-A acknowledged R56 was currently receiving "bed baths" because of tube restrictions in last August. The ED-A stated she had assessed and determined there was a safety issue placing the chair into the shower and felt their physical plant could not accommodate that. The ED said she did not want the residents legs to scrape on the wall and needed to be pushed backwards to get into the shower because of the limited shower space. The ED stated she discussed concerns with R56 and was actively seeking placement at another facility but the resident did not want to leave the facility.

During a tour of the north unit resident shower room with ED-A on 2/24/2016 at 1:40 p.m., ED-A, demonstrated the use of R56's shower chair in the shower room. ED-A explained the difficulties moving the chair around in the shower with R56 seated, and expressed her safety concerns if R56 was bathed there. At 1:59 p.m., ED-A used R56's shower chair into the south unit bathing room, where the whirlpool tub was located. The left side of the room had a toilet, and a sink with a faucet. There was a drain in the tile floor with the floor sloped towards the drain. Above the drain was a curtain attached to the ceiling. ED-A stated she "had not considered" use of the south unit bathing room as an alternative location for R56's

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F 246	Continued From page 20 shower. Although the facility assessed the facility shower to be unsafe for R56, the facility did not fully explore all bathing options, including a possible alternative bathing location for R56 within the facility. A facility policy regarding resident accommodation of needs was requested, but none provided.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This 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: R4's admission Minimum Data Set (MDS), dated 1/22/16, identified she was cognitively intact and required assistance with activities of daily living. The MDS activity preference identified that it was very important to R4 to have reading materiel's, keep up with the news, be around animals, participate in religious services, and participate in her favorite activities. The MDS identified that R4	F 248	F248 • Facility will increase one to one activities with resident R4. These visits might include social engagement, spiritual support, pet visits, and visits involving food or bedside activity. Activity Director will also ensure resident has leisure activities at her bedside (books, latch hook, or puzzles). Will also continue to encourage participation in group activities when appropriate, utilizing headphones if resident desires. • Activity Director will review attendance logs to identify additional residents who desire and benefit from one to one visits. • Leisure preference forms will be completed when residents are admitted to the facility. Activities will be individualized for each resident based on their preferences. • Random audits will be completed weekly by the Activity Director of designee to ensure residents are	4/4/16

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F 248	Continued From page 21 had a significant hearing deficit and was able to understand others but was able to make herself understood. R4's care plan, dated 1/18/16, indicated " I don't have much interest in joining in facility programs. I can not hear". The goal identified, "I would like to participate in my independent activities daily as I choose, please give me supplies as needed." The interventions included encourage my family to bring in reading material, puzzle books, hometown newspaper, etc. for me, inform other staff of my leisure preferences, invite me to "sit-in" during activity programs, allowing me to join in at my own comfort level. invite volunteers to come in and visit with me, offer me activities later in the day after I'm finished with rehab, offer me and my family recreation materials so that we can do things together during our visits, and please help me participate in my favorite activities at my highest level. Review of the facility Recreation Services Assessment Sheet, 1/22/16, identified that although R4 had a visual and significant hearing deficit, she was alert and communicated clearly, but tires easily. The assessment identified R4's leisure preferences of casino games, bingo, puzzles, computer/video games, television, reading books, collections, dogs, outdoor activities, parties, Baptist religion, and significant other visit daily. R4's program preferences are indicated on assessment form as being both "independent" and "with friends/family". An additional note indicated that, "resident is independent with leisure needs and significant other is here daily assisting with supplies."	F 248	receiving leisure activities according to their preferences. • Results will be reviewed quarterly by the Quality Assurance Committee. • Executive Director of designee will be responsible for monitoring compliance.	

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F 248	Continued From page 22 During observations on 2/23/16 4:00 p.m. R4 was in her room lying in bed, she did not have her television on in the room. There were no books or puzzles noted in the residents room. On 2/24/2016 8:54 a.m. R4 was dressed for the day, in her room lying in bed. There was no television on, or any books, puzzles noted in her room. During interview on 2/24/16 at 2:20 p.m. nursing assistant (NA)-F stated (R4) likes to lay in bed, because she is more comfortable and they try to get her out of her room but she says "No". She really enjoys talking to people, which is the one thing she really likes to do. The nurses and NA's try to spend time talking to her but we just do not have the time to spend with her. (R4) will take as much time as she can get talking with people, she loves it. During interview on 2/25/16, at 9:08 a.m. R4 stated that she spends her day in her room, in bed because she is more comfortable laying on her right side. R4 stated that she enjoys visiting with others and has a television on in her room with closed caption and a white board so her visitors can communicate with her using the white board, because "I am deaf.". R4 stated that she watches her gold fish on her bedside table, and her "sister is brining in latch hook". R4 stated it would be difficult for her to participate in group activities at facility because, "I'm deaf, there's not much" and was more comfortable in bed. During interview on 2/24/16, at 2:45 p.m., licensed practical nurse (LPN)-A stated that R4 remains in room, even for meals and eats in her , eating her meals in bed. LPN-A further stated she	F 248		

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works the evening shift and R4 is always in bed with television on with her eyes closed. She has not seen R4 read or do other independent leisure activities in her room.

During interview on 2/25/16, at 8:36 a.m. with registered nurse (RN)- A , stated that R4 does not typically go outside of room due to her physical comfort level, and has not seen R4 participate in any other activities.

A review of the R4's Recreation Attendance Record for January 2016 identified participation in the following activities; TV/Radio/Room Projects (10), and Reading/Writing, Puzzles (10). A review 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 24 not received any of these 1:1 visits since admission to the facility.	F 248		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plan interventions for turning and repositioning were followed by staff for 1 of 3 residents (R81) reviewed for pressure ulcers. 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). R81's care plan dated 1/26/16, indicated he had pressure ulcer of sacral region, paraplegia,	F 282	**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. Skin checks are completed weekly by licensed staff and upon admission. Skin is also monitored daily by nursing assistants with cares. 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.	4/4/16

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F 282	Continued From page 25 osteomyelitis (inflammation and infection of the bone or bone marrow). The care plan directed staff to provide pressure reduction/relieving mattress, weekly wound assessment and to turn and reposition in bed every two hours. R81's Assignment Sheets (nursing assistant care sheet) undated, indicated he was bed bound and staff to turn and reposition every two hours. During continuous observation 2/24/16, at 6:35 a.m. to 9:55 a.m. (3 hours and 20 minutes) R81 was observed to lying in bed. At 6:35 a.m. R81 was slightly turned to the right side only lifting part of his left buttock facing the window. At 7:00 a.m. R81 was lying on his back watching television. At 7:55 a.m. licensed practical nurse (LPN)- F entered his room and give him his medication, but did not assist or offer R81 to turn or reposition. At 8:25 a.m. R81 was still lying on his back watching television. At 9:11 a.m. nursing assistant (NA)-C entered R81's room and give him his breakfast tray on his tray table, and left the room. She did not offer or assist R81 with turning or repositioning. At 9:30 a.m. R81 remained on his back watching television and at 9:55 a.m. R81 remained in the same position lying on his back, for 3 hour and 20 minutes. During interview 2/24/16, at 9:55 a.m. nursing assistant (NA)-C stated R81 should be repositioned every two hours and she entered his room at 6:30 a.m. he was on his right side and she did not have a chance to turn or reposition him yet, "I'm sorry". 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	F 282		

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F 282	Continued From page 26 reposition himself. During interview 2/25/16, at 11:01 a.m. with the executive director (ED) who stated R81 can off load himself a little but staff should be repositioning him every two hours, as directed by the care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure bathing was completed for 1 of 3 residents (R90) reviewed for activities of daily living and were dependent upon staff for cares. Findings include: R90's Clinical Health Status, completed on 2/12/16, indicated the resident had no cognitive impairment, was a new admission. R90's Medicare 5 day scheduled assessment, dated 2/18/16, identified R90 was totally dependent for bathing. During an interview on 2/22/16 at 7:00 p.m., R90 stated he felt, "Dirty," because he had not had a bath for several days.	F 312	**F 312** It is the policy of Golden Living Center Twin Rivers that a resident receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Plan of correction for identified resident: Resident will receive a bath weekly per plan of care. Bath schedules for individual will be followed by nursing staff. Bathing schedule is set for all residents depending on resident preference. Nursing staff are to follow schedule. Resident's should be reproached if refused. Refusals shall be documented by the licensed nurse in the progress notes. All nursing staff will be trained to follow the bathing schedule and communicate refusals to the licensed nurse. DNS or designee will complete random resident audits to assure resident has received scheduled baths per schedule. QAPI Committee will provide direction or change when necessary based on the compliance noted.	4/4/16

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F 312	Continued From page 27 During a follow up interview on 2/24/16, at 11:13 a.m., R90 stated he still had not had a bath and "I keep asking and nobody seems to connect that I need a bath." Review of the LTC (Long Term Care) Bath Schedule identified R90 was scheduled for a bath one time per week, on Saturday evening. Review of R90's medication administration record, dated 2/1/16-2/29/16, identified R90 had one bath with skin check which on 2/13/16, and has not had a bath since. R90 should have had a bath and skin check on 2/20/16. During an interview on 2/24/16, at 11:38 a.m., licensed practical nurse (LPN)-B stated R90 was scheduled to receive his bath on Saturday evenings. LPN-B confirmed R90 received a bath on 2/13/16, but there was no indication that he has had a bath since then. Staff should have charted in the progress notes if R90 refused his bath, however there was no indication in the progress notes that R90 had refused. During an interview on 2/25/16, at 8:25 a.m., executive director (ED) stated each resident should have a minimum of one bath per week, and stated R90 did not get his weekly bath as scheduled and would receive a bath today. A policy for bathing was requested, but none was provided.	F 312	Date of Completion: 4/4/16 DNS or designee is responsible for monitoring compliance.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	**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.	4/4/16

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F 314	Continued From page 28 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide timely repositioning for 1 of 3 residents (R81) reviewed for pressure ulcers. 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, which measured length 09.1 centimeters (cm) by width 06.7 and depth 02.9 cm. The description was eschar-black, brown or tan tissue that adheres firmly to wound bed or ulcer edges, maybe softer or harder than surrounding skin. The MDS further indicated R81 had a pressure reducing device, supra pubic catheter, and a colostomy (alternative channel for feces to leave the body to a pouch). R81's Care Area Assessment (CAA) dated 1/11/16, indicated R81 had unstageable pressure ulcer to his sacrum and a wound vac (therapy for wounds promotes healing through negative pressure wound therapy (npwt), or the delivery of	F 314	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. Skin checks are completed weekly by licensed staff and upon admission. Skin is also monitored daily by nursing assistants with cares. 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.	

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F 314	Continued From page 29	F 314		

negative pressure (a vacuum) to the wound site). The CAA further indicated he needed a special mattress, was immobile, had poor nutrition, limited range of motion, and was a paraplegic (paralysis of lower part of body).

R81's care plan dated 1/26/16, indicated he had a pressure ulcer of sacral region, was a paraplegia, and had osteomyelitis (inflammation and infection of the bone or bone marrow). The care plan further indicated he had pressure ulcers present, was bed fast, had a stage two pressure ulcer to hip and right buttocks, and a stage four pressure ulcer to the sacrum. The care plan directed staff to provide pressure reduction/relieving mattress, weekly wound assessment, and to turn and reposition in bed every two hours. R81's Assignment Sheets (nursing assistant care sheet) undated, indicated he was bed bound and staff were to turn and reposition every two hours.

A Progress Note from R81's nurse practitioner (NP) dated 1/25/16, indicated the patient was followed by the wound doctor and had wound vac in place. Staff were to Continue oral antibiotic per wound care, and had a sacral ulcer with granulation tissue filling in and no exposed bone. Underlying disease comorbidities include: paraplegia, and noncompliance, and medical therapy will need to maximize for best outcomes by primary care provider. The surface will be changed to pressure relieving and maintaining good positioning and consistent rotation will be important for wound healing.

During continuous observation on 2/24/16, at 6:35 a.m. to 9:55 a.m. (3 hours and 20 minutes) R81 was observed to lying in bed. At 6:35 a.m. R81 was observed to be slightly turned to the

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F 314	Continued From page 30 right side only lifting part of his left buttock facing the window. At 7:00 a.m. R81 was observed to be lying on his back watching television. At 7:55 a.m. licensed practical nurse (LPN)- F was observed to enter his room and give him his medication, she did not turn or reposition him. At 8:25 a.m. R81 was still lying on his back watching television. At 9:11 a.m. nursing assistant (NA)-C was observed to enter R81's room and give him his breakfast tray on his tray table, she did not turn or reposition him. At 9:30 a.m. R81 was still on his back watching television. At 9:55 a.m. R81 was still in the same position lying on his back, 3 hour and 20 minutes later. During observation and interview 2/24/16, at 9:45 a.m. R81 stated he had no feeling from his nipple line on his chest down, and he was unable to move that area. R81 stated he can use the trapeze bar with his arms to lift him self slightly, but not completely off of the bed. R81 was observed to grab the trapeze bar and lift himself for 20 seconds with his bottom slightly touching the bed. R81 stated he was able to move himself this morning from his side to his back but is not able to completely lift himself up. R81 confirmed staff had not come in and repositioned him on the day shift. During interview 2/24/16, at 9:55 a.m. (NA)-C stated R81 should be repositioned every two hours and she entered his room at 6:30 a.m. and he was on his right side and she did not have a chance to turn or reposition him, NA-C stated "I'm sorry." During interview 2/24/16, at 11:15 a.m. registered nurse (RN)-A stated R81 should be repositioned	F 314		

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F 314	Continued From page 31 every two hours. During observation 2/24/16, at 11:40 a.m. RN-A removed R81's old dressing and began measuring his wounds. R81 had a stage four pressure ulcer to his sacrum measuring length 5 cm x width 3.5 cm x depth 1.3. He also had a right ischial tuberosity stage two pressure ulcer that measured 2.8 cm x 1.7 cm x .1 cm depth, and a left hip pressure ulcer stage two 5 cm x 4.4 cm with no depth. During interview 2/25/16, at 11:01 a.m. the executive director (ED) stated R81 can off load himself a little, however, staff should be repositioning him every two hours. A facility policy titled Skin Integrity Guideline undated indicated "Reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan."	F 314		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based observation, interview, and document review the facility failed to ensure 1 of 1 resident (R4) was free of a potential, significant medication error. This had the potential to affect 13 residents who receive insulin administered via insulin pen.	F 333	**F 333** It is the policy of Golden Living Center Twin Rivers that the facility must ensure that residents are free of any significant medication errors. Plan of correction for resident identified: Medication error did not reach resident identified. Immediate education provided to nurse. Staff are to update MD/NP if they are questioning if a resident received the prescribed amount of medication. The MD/NP shall give further orders in regards to the medication in question.	4/4/16

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F 333	Continued From page 32 R4's diagnosis, identified on the Admission Record dated 1/15/16, included diabetes mellitus. R4's Order Summary Report dated 2/3/16, included Humulin N Suspension (medication used to treat diabetes) 100 units/milliliter (ml), 6 units subcutaneously in the evening. During observation of medication administration on 2/22/16, at 5:13 p.m. licensed practical nurse (LPN)-G attached a disposable needle to R4's Humulin insulin pen, dialed the insulin pen to 2 units and primed the needle, then dialed the pen to 6 units, and entered R4's room to administer the insulin. LPN-G placed the insulin pen against R4's left lower abdomen, pressed the button on top of the pen to administer the insulin, and after removing the pen, stated, "I'm not sure if the needle engaged." LPN-G walked back to the North medication cart and stated, "I'm going to try this again. There's no way of telling that [R4] got any [insulin]." LPN-G went back to the drawer of the medication cart, took out another disposable needle, and screwed it on to R4's insulin pen. LPN-G dialed the insulin pen to 6 units, and walked down the hallway toward R4's room. Before reaching R4's room, LPN-G was questioned about giving another dose of insulin. LPN-G stated he was planning to administer another 6 units of insulin because he did not feel R4 got any insulin because he observed insulin on R4's skin when giving the last dose. LPN-G was questioned about consulting with the registered nurse (RN) on duty, and after discussing with RN-A, they called the nurse practitioner and were instructed to not give an additional dose of insulin, and to check R4's blood sugar at bedtime.	F 333	Insulin pen competency to be completed with all licensed staff. Education also provided in regards to updating the MD/NP for further instructions if a medication was potentially not received. DNS or designee will complete random weekly audits of insulin pen administration to ensure continued compliance with the plan of correction. 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.	

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F 333	Continued From page 33 During interview on 2/22/16, at 5:24 p.m., RN-A stated she would expect staff to call the RN on call or the nurse practitioner if there was any question as to how much insulin a resident received in this situation, before deciding to give an additional dose to prevent the resident from receiving too much insulin and becoming hypoglycemic (low blood sugar). During interview on 2/25/16, at 8:35 a.m., executive director (ED) stated staff should call the nurse practitioner if they were questioning whether or not a resident received the amount of medication ordered. Review of the facility's policy, Medication Error and Adverse Drug Reaction Reporting, dated 10/07, included, "The prescriber is notified promptly of any significant error or adverse medication reaction."	F 333		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354	**F 354** Golden Living Twin Rivers has designated Kimberly Bongartz, registered nurse to serve as the director of nursing on a full time basis. Kimberly Lyon, LNHA, has been named as the executive director. Ongoing the facility will assure there is a full time director of nursing in the position. QAPI Committee will provide direction or change when necessary based on the compliance noted. Date of Completion: 3/7/16 ED or designee is responsible for monitoring compliance.	4/4/16

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F 354	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a full time director of nursing (DON) was working in the facility. This had the potential to affect all 46 residents currently residing in the facility. Findings include: A facility job description titled Director of Nursing Services; Temporary dated 10/15/14, indicated the" General purpose provides services to assigned location in the absence of Director of Nursing Services on a temporary basis until the position is no longer required or has been filled by a permanent Director of Nursing Services, Plans, coordinates and manages the nursing department. Responsible of the overall direction, coordination, and evaluation of nursing care and services provided to residents. Maintains quality care that is consistent with company and regulatory standards. Assumes responsibilities of daily operations in the absence of Executive Director." During entrance interview 2/22/16, at 1:15 p.m. the executive director (ED)-A stated she had been the DON and was now the interim ED. ED-A stated the Minimum Data Set (MDS) coordinator registered nurse (RN)-A was acting as the interim DON, as this time. During interview on 2/25/16 at 8:54 a.m. registered nurse (RN)-A, identified as interim DON, stated she continues with her roles as RNAC (Registered Nurse Assessment Coordinator), including completion of the MDS	F 354		

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F 354	Continued From page 35	F 354		

and careplan development. As the DON, she participates in weekly care management meetings, weekly behavior meetings, daily stand up meetings, and providing assistance as delegated by interim ED-A including recent assistance in grievance investigations. RN-A estimated time spent in this role as the DON was between 5-10 hours per week, although the former DON (ED-A) continues to fill most of the roles of DON for the facility.

During interview on 2/24/16, at 9:44 a.m., nursing assistant (NA)-B, stated the DON at the facility was ED-A, and had not identified RN-A as the interim DON.

During interview on 2/24/16, at 2:45 p.m. licensed practical nurse (LPN)-A stated she would contact the DON, (referring to ED-A), if she had any questions or concerns.

During observation on 2/24/16 at 3:15 p.m. LPN-A was overheard talking with NA-H who had concerns about giving R8 a bath. LPN-A directed NA-H to bring her concern to ED-A, and not RN-A who was the interim DON.

During interview 2/25/16, at 11:38 a.m. LPN-F stated the DON was also the ED-A, and the MDS coordinator (RN-A) was helping ED-A when she needed help, but if she had any nursing concerns she would talk with ED-A, and not RN-A (who was the interim DON).

During interview 2/25/16, at 1:37 p.m. ED-A stated the MDS coordinator (RN-A) continues her role as MDS nurse, in addition to filling in as acting DON since October 7th 2015. RN-A helps review the 24 hour report board to see if there is

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F 354	Continued From page 36 any changes, helps with grievances, and depending on the week, works about 5-10 hours a week as the interim DON. The ED-A stated the facility ED-B had on an extended leave with no indication when he will return to his role. She needed to take on the role as no one has applied for the DON position. ED-A stated she has been very busy with her roles in the facility as the ED, and the DON role.	F 354		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	**F 441** It is the policy of Golden Living Center Twin Rivers that the facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction for identified incidents: Residents identified remain free from infection due to nurse not wearing personal protective equipment (gloves). Education has been completed with nurses involved in incidents noted during survey. Education will be provided to all nursing staff in regards to the Infection Control Policy and the need to wear protective personal equipment when there is possible contact with blood or body fluids. DNS or designee will complete weekly audits of insulin administration and blood sugar checks to assure ongoing compliance with Infection Control policy. QAPI Committee will provide direction or change when necessary based on the compliance noted.	4/4/16

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F 441	Continued From page 37 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control practices were implemented for 1 of 1 resident (R49) observed during a blood sugar check, and 1 of 1 resident (R4) observed during insulin administration. Findings include: R49's medication administration record (MAR) indicated diagnoses including diabetes mellitus type II, received a sliding scale insulin, and was to have her blood sugar checked three times a day. During observation on 2/24/16, at 6:38 a.m. LPN-E retrieved a blood glucose monitor from the medication cart, entered R49's room, and proceeded to check her blood sugar with no gloves. LPN-E then left R49's room, returned to the medication cart, and proceeded to clean the blood glucose machine with sanitizing wipes, and then washed her hands. During interview 2/25/16, at 1:40 p.m. the executive director (ED) stated the facility policy directed staff to wear gloves when checking blood	F 441	Date of Completion: 4/4/16 DNS or designee is responsible for monitoring compliance.	

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F 441	Continued From page 38 sugars, and LPN-E should have worn gloves. A facility policy titled Blood Sugar Monitoring dated 1/13/16, directed, "Check physician order for blood sugar testing frequency 2. put on gloves 3. Follow manufacturer's directions for use and care of the equipment used in your facility 4. Discard used lancet in sharps container 5. Check puncture site to be sure bleeding has stopped. Apply Band-Aid as needed." R4's diagnosis identified on the Admission Record dated 1/15/16, included diabetes mellitus. R4's Order Summary Report dated 2/3/16, included Humulin N Suspension (medication used to treat diabetes) 100 units/milliliter (ml), 6 units subcutaneous in the evening. During observation of medication administration on 2/22/16, at 5:13 p.m., licensed practical nurse (LPN)-G attached a disposable needle to R4's Humulin insulin pen, dialed the pen to 6 units, and entered R4's room to administer the insulin. Without donning gloves, LPN-G used an alcohol wipe to clean the area, placed the insulin pen against R4's left lower abdomen, pressed the button on top of the pen, held it in place for a few seconds, and then removed the pen. Without performing any hand hygiene, LPN-G left R4's room, walked back to the North medication cart, opened the top drawer, and touched items in the drawer while preparing to give the next medication. During interview on 2/25/16, at 8:35 a.m. ED stated gloves should be worn when administering insulin.	F 441		

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F 441	Continued From page 39 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 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on 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, R34, R16, R2, R46, 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. The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, or 75 square foot per	F 458	**F 458** Bedrooms measure at least 80 sq ft/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 residing in the aforementioned rooms. The residents' health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. The Director of Maintenance is responsible for the monitoring of this waivered requirement.	4/4/16

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F 458	Continued From page 40 resident, (R81) Room 7 = 152.5 square feet, or 76.2 square foot per resident, (R94 and R34) Room 17 = 150 square feet, or 75 square foot per resident, (R16) Room 20 = 150 square feet, or 75 square foot per resident, (R2 and R46) Room 21 = 150 square feet, or 75 square foot per resident, (R96 and R69) Room 29 = 150 square feet, or 75 square foot per resident, (R1 and R8) Room 35 = 150 square feet, or 75 square foot per resident, (R43 and R45 Room 36 = 155 square feet, or 77.5 square foot per resident, (R4 and R37) R69, who lived in room 21, stated on 2/22/2016, at 3:03 p.m., "The room is working" and he did not need much space, "As long as I got TV and a bed, a window, and it's close to the bathroom for me." R96, who also lived in room 21, stated in an interview at 4:36 p.m., it would be "nice" if the room were a little bigger, however, stated, "It's comfortable for me, that is what I say." During interview 2/22/16, at 6:33 p.m. with R34 who lived in room 7 stated her room size is adequate and she had no concerns with the room size. During Interview with R94 on 2/22/16 at 6:35 p.m. stated they thought the room was small, however, staff were able to complete the	F 458		

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F 458	Continued From page 41 cares they needed to do and R94 had no significant concerns. During interview 2/22/16, at 6:36 p.m. with R81 who lived in room 4, they stated they had no concerns with the room size. During interview 2/25/16, at 9:15 a.m. R4 who lived in room 36 stated her room is small. On 2/22/16, at 7:37 p.m. R2 who lived in room 20 was observed being transferred into bed with staff using the mechanical lift. Staff were able to provide adequate cares and room size did not appear to be an issue. R20 was not able to be interviewed. During interview on 02/24/2016, at 1:40 p.m. with R1 who stated he had no concerns with the size of the room. WHAT ROOM????? Interview on 2/25/16 at 9:51 a.m., with R37 who lived in room 36 stated he had no concerns with the size of his room. R45, who lived in room 35, was interviewed on 2/22/16, at 3:15 p.m. and stated there were no concerns with the size of their room. R43, who also lived in room 35, was interviewed on 2/22/16, 7:52 p.m., and had no concerns with the size of their room. R8, who lived in room 29, was interviewed on 2/23/16, at 8:10 a.m. and stated they had no concerns regarding the size of the room. R4, who lived in room 36, was interviewed on 2/23/16, at 9:12 a.m., and stated she had no	F 458		

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F 458	Continued From page 42 concerns with the size of her room. During interview on 2/22/2016, at 6:37 p.m. nursing assistant (NA)-B stated she had no concerns with room sizes in room 4 or room 7, and staff were able to provide cares without problems. During an interview on 2/24/16, at 7:04 a.m., NA-G and NA-B stated the above named rooms were difficult to maneuver when getting residents ready for the day, however, they were able to provide the necessary cares. During interview on 2/24/2016 at 7:12 a.m. licensed practical nurse (LPN)-E stated the rooms were small, but staff would just rearrange things to make it work. During interview on 2/24/2016, at 9:23 a.m. LPN-B stated staff were able to complete resident cares despite the smaller room sizes. During interview on 2/24/2016, at 9:32 a.m. NA-E stated providing cares, especially with a hoyer lift, "is more challenging, but we manage and have been doing it for some time." . During interview 02/24/2016, at 9:39 a.m. NA-B stated it can get tight in R2's room when using the mechanical lift, however, staff is able to provide the necessary cares. During interview on 2/24/16, at 9:46 a.m. NA-D stated in room 29 it can be difficult because staff need to use a mechanical lift for the resident, however, staff is able to provide the necessary cares for the resident.	F 458		

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F 458	Continued From page 43 During interview on 2/24/16, at 11:59 a.m. LPN-B stated room 29 is "tight" due to using a lift, however, staff had it arranged so it is manageable. During interview on 2/24/2016, at 2:33 p.m. NA-F stated the biggest challenge in working the small rooms, "is to give the resident privacy." However, NA-F stated staff was still able to provide the necessary cares. During interview on 2/25/16, at 8:33 a.m. executive director (ED) stated she had not had any complaints regarding the room size of the above named rooms and stated they look at resident safety and staff safety to make sure they can safely care for a resident in that size of a room. During interview 2/25/2016, at 9:26 a.m. NA-A stated R4's room is small but they are able to provide cares for her adequately. During interview on 2/25/2016, at 9:49 a.m. NA-G who stated although R37's quarters are close, they are able to provide cares without problems. During a follow up interview on 2/25/2016 at 12:18 p.m., the ED said she will reapply for the room waiver, and monitor the residents who reside in those rooms to ensure their needs are being accommodated.	F 458		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	**F465** • Edge protector will be replaced and wall will be repaired in room 21, Closet doors in rooms 22, 24, 25, 31, and 39 will be repaired or replaced. Door guard will be installed on the bathroom door in room 28. Per unit supervisor,	4/4/16

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F 465	Continued From page 44 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a homelike environment in 8 of 14 resident rooms on the south unit which had the potential to affect 13 residents (R69, R96, R62, R12, R71, R35, R56, R55, R87, R44, R8, R1, R50, R90, and R18) whose rooms either lacked or had malfunctioning closet doors; or whose rooms were in general disrepair; or who resided between the kitchen and dining area and expressed concerns related to noise; or who expressed concerns regarding room temperatures that were too hot. Findings include: CLOSET DOORS/ROOMS IN DISREPAIR R69's quarterly Minimum Data Set (MDS) dated 1/22/2016, indicated he had moderately intact cognition. During an interview on 2/22/2016, at 4:34 p.m., R69 pointed out there were gouges, marks, and holes at the foot of the bed, with a metal, wall edge protector standing in the corner. R69 said he was not aware of how the gouges got there, and stated the disrepair in his room "Really does not bother me, it just an old building." After assisting R71 with cares in her room on 2/24/16, at approximetly 8:00 a.m. nursing assistant (NA)-D tried to close the closet door, but it was off of its track and non-functional. NA-D stated she had put numerous requests for repair	F 465	the floor needing tiles repaired is room 33, not 29 – the tiles in front of the dresser will be replaced. Thermostats connected to the boiler will be replaced to control temperature. Dietary carts and equipment will be repaired or replaced to reduce noise while transporting food and dishes. • All rooms will be looked at to address broken and missing closet doors, resident room and bathroom doors, floor tiles, and wall repairs needed. A maintenance schedule will be set up to repair issues identified in a timely manner. • Staff will be educated on putting in Maintenance request and proper follow up of Maintenance requests. Education will be provided on reducing noise levels during meal delivery and at night. • Audits will be completed weekly by Maintenance or designee to look for environmental repairs needed. This will include closet doors, resident room doors and bathroom doors, resident room flooring and walls. The Maintenance supervisor or designee will also be responsible for monitoring resident room temps several times weekly and making adjustments as necessary. Audits will be completed weekly to determine resident's satisfaction will temperature and noise level in facility. • Results will be reviewed quarterly by the Quality Assurance Committee.	

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F 465	Continued From page 45 in "care tracker" [the facility's maintenance tracking system] and stated "Evidently it doesn't get done, sorry to say." NA-D then listed other room numbers where the residents' closet doors were either off track, missing, or had been replaced with a curtain. During environmental tour on 2/25/2016, at 10:05 a.m. with maintenance specialist (MS) the following issues were noted: Room 21, wall gouges, exposed sheet rock with holes, wall edge protector removed Room 22, outer closet door stuck on its track Room 24, no closet doors Room 25, inner closet door off its track Room 28, had 3" (inches) x 4" veneer missing on inside bathroom door Room 29, chipped and missing 12"x 12" floor tiles near resident dresser Room 31, no closet doors Room 39, no closet doors During interview on 2/25/2016, at 10:41 a.m. MS stated he was aware many resident closet doors were, "stuck on the tracks," and some of the closet doors were missing or removed from other resident rooms. MS stated he had spent, "Countless hours of work on this [closet doors]" and the doors were especially troublesome because the closet doors were custom custom size doors, and there, "wasn't much we could do." MS acknowledged the environmental concerns of missing and broken tile flooring, gouges in the sheet rock, and missing door veneer in resident rooms. The MS stated he received "80 to 100 maintenance requests," and could have "2-3 guys," working on the repairs to try to get them completed.	F 465	• Executive Director or designee will be responsible for monitoring compliance.	

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F 465	Continued From page 46 During interview on 2/25/2016, at 11:27 a.m. the interim executive director (ED) stated she was aware many of the resident rooms had non-working closet doors and, "has been working with my team" to remove the doors. The ED stated the facility had been looking at using a flame-retardant material for a curtain to replace the closet doors. ED stated she was aware of the rooms with cracked tile floors, and baseboards coming off, however, there was no current plan in place for repair, but the facility would be looking, "At all the resident rooms." 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. following the evening meal, dietary staff was moving a dining cart from the dining room to the short hall toward the main resident hallway, and toward the kitchen. The cart was laden with food tubs, containing resident silverware, plates, and various pans used at the meal. As the cart neared the intersection of the hallways, a small bowl and a stacked pile of cups tipped over and fell out from the cart, landing on the floor, resulting in crashing sounds heard in the hallway and in nearby resident rooms.	F 465		

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F 465	Continued From page 47 During interview on 2/23/2016, at 9:15 a.m. R71 stated that staff, "Could be more quieter than they are." R71 stated, "I hear at lot more than staff are aware of." R71 stated she heard the lifts going by, staff talking, and, "I hear the dishes going by." During interview on 2/22/2016, at 6:13 p.m., R56 stated staff, "talk loud in the hallway," and when the kitchen brings their things to the dining room, "It's like a racetrack with the dishes going by." R56 stated at least once a day, "Something gets dumped over on the food carts." R56 also stated the noise issue had been discussed at resident council meetings, but no improvement had been made. During interview on 2/22/2016, at 4:46 p.m. R50 stated she heard noises as the dishes and food pass by, and also stated it was noisy at night, and often couldnt get to sleep and, "I lay there and hope it quiets down." During observation on 2/24/2016, at 7:31 a.m. dietary assistant (DA)-A exited the kitchen door on the main hallway and was pushing a cart loaded with foil-covered food trays and going to the short hall to the dining room. While DA-A maneuvered the cart, a rhythmic sound came from the wheels of the cart, as if they needed oil and were unevenly worn. DA-A pushed the cart further, and as the cart rounded the corner and moved toward the dining area, the noise continued and announced the cart's arrival. During interview on 2/25/2016, at 8:02 a.m., dietary manager (DM) stated the facility was the residents home, and sometimes staff were in a hurry and did not think about that. The DM stated she would need to, "review that with staff [the	F 465		

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	245298	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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F 465	Continued From page 48 noise made with the dishes]." In regard to the noise from the carts, the DM stated more tubs were perhaps needed, so the plates and cups would not come off the cart. The DM stated she would have maintenance look at the carts, "Maybe they need a little WD40." In a subsequent interview at 9:35 a.m., the DM stated a new cart was just ordered, and they would be looking to see if more bins were needed to use on the carts. In an interview on 2/25/2016, at 10:29 a.m. the MS stated he, "Was told the carts were noisy a few months ago." The MS stated there used to be carpeting in the hallway, and the carts were much quieter then. The MS stated he had not looked at the carts to see if the wheels were cut and uneven or if they just needed oiling, and stated he had many maintenance requests to try to complete. The MS stated the dietary manager would also be working a a solution, and he would be looking at the carts to see what the issue is with the noisy wheels. In an interview on 2/25/2016, at 11:27 a.m., the ED stated while moving the food carts, "The noise level is high" and there were more complaints in the rooms nearest the hallway where the kitchen was. The ED stated the facility was the residents home, and they would, "Talk to staff" about the noise level, and, "Be more mindful" when moving the carts. ROOM TEMPERATURES R62's quarterly MDS, dated 12/30/2015, indicated intact cognition. In an interview on 2/22/2016, at 4:56 p.m. R62 stated his room was always, "way	F 465		

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F 465	Continued From page 49	F 465		

too hot." R62 stated he had complained to staff 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, near hallway to dining area: 79 deg. F (thermostat was set at 73 deg F).
Resident room #25 82 deg. F
Resident room #28 81 deg. F
Resident room #31 81 deg. F

In an interview on 2/25/2016, at 10:29 a.m. MS stated he monitored the resident room temps once a week and when it is colder outside he monitors, "More frequently." The MS stated he did not log any of the temperatures in the building, and he was aware of the building temps by going around the building and he had, "A good memory" of what the temperatures were. MS stated there were two roof-top units to heat the dining area, and the hallway of the facility also had roof top units, each controlled by thermostats, and there were a total of 8 separate units. The MS stated resident rooms were heated by a boiler, and there were no individual controls to set the heat in each room; but rather, room temperature was regulated by "sectional thermostats." The MS stated the boilers were

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	245298	A. BUILDING _____ B. WING _____	02/25/2016

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GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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F 465	Continued From page 50 difficult to control to maintain a consistent temperature. MS stated he was unaware some residents only covered themselves in bed sheets because of the excessive warm room temperatures. The MS stated if residents were too hot, they could open a window, "I ask the nurses to do that." The MS also stated he had fans available for residents if rooms were too warm. 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.	F 465		

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	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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K 000	INITIAL COMMENTS 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

MDH
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	02/25/2016

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GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 22-25, 2016, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. In addition to the standard survey a complaint investigation for H5298053, H5298054 and H5298055 were completed, and were not substantiated during this survey.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and return the original to the address below: Brenda Fischer, RN Unit Supervisor Minnesota Department of Health 3333 West Division St, Suite 212 St Cloud, MN 56301	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: Based on observation, interview and document review the facility failed to ensure care plan interventions for turning and repositioning were followed by staff for 1 of 3 residents (R81) reviewed for pressure ulcers. 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). R81's care plan dated 1/26/16, indicated he had pressure ulcer of sacral region, paraplegia, osteomyelitis (inflammation and infection of the bone or bone marrow). The care plan directed staff to provide pressure reduction/relieving mattress, weekly wound assessment and to turn and reposition in bed every two hours. R81's Assignment Sheets (nursing assistant care sheet) undated, indicated he was bed bound and staff to turn and reposition every two hours. During continuous observation 2/24/16, at 6:35 a.m. to 9:55 a.m. (3 hours and 20 minutes) R81 was observed to lying in bed. At 6:35 a.m. R81 was slightly turned to the right side only lifting part	2 565		

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2 565	Continued From page 3 of his left buttock facing the window. At 7:00 a.m. R81 was lying on his back watching television. At 7:55 a.m. licensed practical nurse (LPN)- F entered his room and give him his medication, but did not assist or offer R81 to turn or reposition. At 8:25 a.m. R81 was still lying on his back watching television. At 9:11 a.m. nursing assistant (NA)-C entered R81's room and give him his breakfast tray on his tray table, and left the room. She did not offer or assist R81 with turning or repositioning. At 9:30 a.m. R81 remained on his back watching television and at 9:55 a.m. R81 remained in the same position lying on his back, for 3 hour and 20 minutes. During interview 2/24/16, at 9:55 a.m. nursing assistant (NA)-C stated R81 should be repositioned every two hours and she entered his room at 6:30 a.m. he was on his right side and she did not have a chance to turn or reposition him yet, "I'm sorry". 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. During interview 2/25/16, at 11:01 a.m. with the executive director (ED) who stated R81 can off load himself a little but staff should be repositioning him every two hours, as directed by the care plan. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that resident care plans are implement; provide staff education; develop monitoring systems or audit to ensure ongoing compliance.	2 565		

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2 565	Continued From page 4 Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide timely repositioning for 1 of 3 residents (R81) reviewed for pressure ulcers. 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	2 900		

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2 900	Continued From page 5	2 900		

had not transferred or walked. The MDS indicated he had one stage two pressure ulcer, and one unstagable pressure ulcer, which measured length 09.1 centimeters (cm) by width 06.7 and depth 02.9 cm. The description was eschar-black, brown or tan tissue that adheres firmly to wound bed or ulcer edges, maybe softer or harder than surrounding skin. The MDS further indicated R81 had a pressure reducing device, supra pubic catheter, and a colostomy (alternative channel for feces to leave the body to a pouch).

R81's Care Area Assessment (CAA) dated 1/11/16, indicated R81 had unstageable pressure ulcer to his sacrum and a wound vac (therapy for wounds promotes healing through negative pressure wound therapy (npwt), or the delivery of negative pressure (a vacuum) to the wound site). The CAA further indicated he needed a special mattress, was immobile, had poor nutrition, limited range of motion, and was a paraplegic (paralysis of lower part of body).

R81's care plan dated 1/26/16, indicated he had a pressure ulcer of sacral region, was a paraplegia, and had osteomyelitis (inflammation and infection of the bone or bone marrow). The care plan further indicated he had pressure ulcers present, was bed fast, had a stage two pressure ulcer to hip and right buttocks, and a stage four pressure ulcer to the sacrum. The care plan directed staff to provide pressure reduction/relieving mattress, weekly wound assessment, and to turn and reposition in bed every two hours. R81's Assignment Sheets (nursing assistant care sheet) undated, indicated he was bed bound and staff were to turn and reposition every two hours.

A Progress Note from R81's nurse practitioner

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2 900	Continued From page 6 (NP) dated 1/25/16, indicated the patient was followed by the wound doctor and had wound vac in place. Staff were to Continue oral antibiotic per wound care, and had a sacral ulcer with granulation tissue filling in and no exposed bone. Underlying disease comorbidities include: paraplegia, and noncompliance, and medical therapy will need to maximize for best outcomes by primary care provider. The surface will be changed to pressure relieving and maintaining good positioning and consistent rotation will be important for wound healing. During continuous observation on 2/24/16, at 6:35 a.m. to 9:55 a.m. (3 hours and 20 minutes) R81 was observed to lying in bed. At 6:35 a.m. R81 was observed to be slightly turned to the right side only lifting part of his left buttock facing the window. At 7:00 a.m. R81 was observed to be lying on his back watching television. At 7:55 a.m. licensed practical nurse (LPN)- F was observed to enter his room and give him his medication, she did not turn or reposition him. At 8:25 a.m. R81 was still lying on his back watching television. At 9:11 a.m. nursing assistant (NA)-C was observed to enter R81's room and give him his breakfast tray on his tray table, she did not turn or reposition him. At 9:30 a.m. R81 was still on his back watching television. At 9:55 a.m. R81 was still in the same position lying on his back, 3 hour and 20 minutes later. During observation and interview 2/24/16, at 9:45 a.m. R81 stated he had no feeling from his nipple line on his chest down, and he was unable to move that area. R81 stated he can use the trapeze bar with his arms to lift him self slightly, but not completely off of the bed. R81 was observed to grab the trapeze bar and lift himself	2 900		

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2 900	Continued From page 7 for 20 seconds with his bottom slightly touching the bed. R81 stated he was able to move himself this morning from his side to his back but is not able to completely lift himself up. R81 confirmed staff had not come in and repositioned him on the day shift. During interview 2/24/16, at 9:55 a.m. (NA)-C stated R81 should be repositioned every two hours and she entered his room at 6:30 a.m. and he was on his right side and she did not have a chance to turn or reposition him, NA-C stated "I'm sorry." During interview 2/24/16, at 11:15 a.m. registered nurse (RN)-A stated R81 should be repositioned every two hours. During observation 2/24/16, at 11:40 a.m. RN-A removed R81's old dressing and began measuring his wounds. R81 had a stage four pressure ulcer to his sacrum measuring length 5 cm x width 3.5 cm x depth 1.3. He also had a right ischial tuberosity stage two pressure ulcer that measured 2.8 cm x 1.7 cm x .1 cm depth, and a left hip pressure ulcer stage two 5 cm x 4.4 cm with no depth. During interview 2/25/16, at 11:01 a.m. the executive director (ED) stated R81 can off load himself a little, however, staff should be repositioning him every two hours. A facility policy titled Skin Integrity Guideline undated indicated "Reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan."	2 900		

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2 900	Continued From page 8 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents with current or at risk for pressure ulcers receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure bathing was completed for 1 of 3 residents (R90) reviewed for activities of daily living and were dependent upon staff for cares. Findings include: R90's Clinical Health Status, completed on 2/12/16, indicated the resident had no cognitive impairment, was a new admission. R90's Medicare 5 day scheduled assessment, dated	2 920		

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2 920	Continued From page 9 2/18/16, identified R90 was totally dependent for bathing. During an interview on 2/22/16 at 7:00 p.m., R90 stated he felt, "Dirty," because he had not had a bath for several days. During a follow up interview on 2/24/16, at 11:13 a.m., R90 stated he still had not had a bath and "I keep asking and nobody seems to connect that I need a bath." Review of the LTC (Long Term Care) Bath Schedule identified R90 was scheduled for a bath one time per week, on Saturday evening. Review of R90's medication administration record, dated 2/1/16-2/29/16, identified R90 had one bath with skin check which on 2/13/16, and has not had a bath since. R90 should have had a bath and skin check on 2/20/16. During an interview on 2/24/16, at 11:38 a.m., licensed practical nurse (LPN)-B stated R90 was scheduled to receive his bath on Saturday evenings. LPN-B confirmed R90 received a bath on 2/13/16, but there was no indication that he has had a bath since then. Staff should have charted in the progress notes if R90 refused his bath, however there was no indication in the progress notes that R90 had refused. During an interview on 2/25/16, at 8:25 a.m., executive director (ED) stated each resident should have a minimum of one bath per week, and stated R90 did not get his weekly bath as scheduled and would receive a bath today. A policy for bathing was requested, but none was provided.	2 920		

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2 920	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with bathing. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control practices were implemented for 1 of 1 resident (R49) observed during a blood sugar check, and 1 of 1 resident (R4) observed during insulin administration. Findings include: R49's medication administration record (MAR) indicated diagnoses including diabetes mellitus type II, received a sliding scale insulin, and was to have her blood sugar checked three times a day.	21375		

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During observation on 2/24/16, at 6:38 a.m. LPN-E retrieved a blood glucose monitor from the medication cart, entered R49's room, and proceeded to check her blood sugar with no gloves. LPN-E then left R49's room, returned to the medication cart, and proceeded to clean the blood glucose machine with sanitizing wipes, and then washed her hands.

During interview 2/25/16, at 1:40 p.m. the executive director (ED) stated the facility policy directed staff to wear gloves when checking blood sugars, and LPN-E should have worn gloves.

A facility policy titled Blood Sugar Monitoring dated 1/13/16, directed, "Check physician order for blood sugar testing frequency 2. put on gloves 3. Follow manufacturer's directions for use and care of the equipment used in your facility 4. Discard used lancet in sharps container 5. Check puncture site to be sure bleeding has stopped. Apply Band-Aid as needed."

R4's diagnosis identified on the Admission Record dated 1/15/16, included diabetes mellitus.

R4's Order Summary Report dated 2/3/16, included Humulin N Suspension (medication used to treat diabetes) 100 units/milliliter (ml), 6 units subcutaneous in the evening.

During observation of medication administration on 2/22/16, at 5:13 p.m., licensed practical nurse (LPN)-G attached a disposable needle to R4's Humulin insulin pen, dialed the pen to 6 units, and entered R4's room to administer the insulin. Without donning gloves, LPN-G used an alcohol wipe to clean the area, placed the insulin pen against R4's left lower abdomen, pressed the button on top of the pen, held it in place for a few

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21375	Continued From page 12 seconds, and then removed the pen. Without performing any hand hygiene, LPN-G left R4's room, walked back to the North medication cart, opened the top drawer, and touched items in the drawer while preparing to give the next medication. 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. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while passing medications, use of glucometer. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		

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21426	Continued From page 13 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 1 of 6 newly admitted residents (R4) had a second step tuberulin skin test (TST) administered. In addition, the facility failed to ensure 2 of 6 residents (R4 and R8) had a tuberculosis (TB) symptom screening completed upon admssion as required per State guidelines. Findings include: R4 was admitted to the facility on 1/15/16 and the medical record lacked documentation of receiving the second step TST or having completed the tuberculosis symptom screening upon admission. During an interview on 2/24/16, at 2:30 p.m., director of nursing (DON) stated R4 was transferred from another facility and had received the first step TST at that facility, but did not	21426		

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21426	Continued From page 14 receive the second step TST or complete the TB symptom screening upon admission to this facility as required. R8 was admitted to the facility on 1/14/16. The medical record lacked documentation of a completed TB symptom screening upon admission as required per State guidelines. During an interview on 2/24/16, at 2:34 p.m., DON verified R8's TB symptom screening form was blank and was not completed upon admission. DON stated, "The admitting nurse should have completed this." Review of the facility's policy, Tuberculosis Exposure Control Plan, undated, included all new admissions will receive a 2-step TST to be administered upon admission, as well as assessing for signs and symptoms of TB. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, could review and revise policies and procedures for TB surveillance. The administrator, director of nursing, could monitor resident and TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to	21435		

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21435	Continued From page 15 meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. 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: R4's admission Minimum Data Set (MDS), dated 1/22/16, identified she was cognitively intact and required assistance with activities of daily living. The MDS activity preference identified that it was very important to R4 to have reading materiel's, keep up with the news, be around animals, participate in religious services, and participate in her favorite activities. The MDS identified that R4 had a significant hearing deficit and was able to understand others but was able to make herself understood. R4's care plan, dated 1/18/16, indicated " I don't have much interest in joining in facility programs. I can not hear". The goal identified, "I would like to participate in my independent activities daily as I choose, please give me supplies as needed." The interventions included encourage my family to bring in reading material, puzzle books, hometown newspaper, etc. for me, inform other staff of my leisure preferences, invite me to	21435		

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21435	Continued From page 16 "sit-in" during activity programs, allowing me to join in at my own comfort level. invite volunteers to come in and visit with me, offer me activities later in the day after I'm finished with rehab, offer me and my family recreation materials so that we can do things together during our visits, and please help me participate in my favorite activities at my highest level. Review of the facility Recreation Services Assessment Sheet, 1/22/16, identified that although R4 had a visual and significant hearing deficit, she was alert and communicated clearly, but tires easily. The assessment identified R4's leisure preferences of casino games, bingo, puzzles, computer/video games, television, reading books, collections, dogs, outdoor activities, parties, Baptist religion, and significant other visit daily. R4's program preferences are indicated on assessment form as being both "independent" and "with friends/family". An additional note indicated that, "resident is independent with leisure needs and significant other is here daily assisting with supplies." During observations on 2/23/16 4:00 p.m. R4 was in her room lying in bed, she did not have her television on in the room. There were no books or puzzles noted in the residents room. On 2/24/2016 8:54 a.m. R4 was dressed for the day, in her room lying in bed. There was no television on, or any books, puzzles noted in her room. During interview on 2/24/16 at 2:20 p.m. nursing assistant (NA)-F stated (R4) likes to lay in bed, because she is more comfortable and they try to get her out of her room but she says "No". She	21435		

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really enjoys talking to people, which is the one thing she really likes to do. The nurses and NA's try to spend time talking to her but we just do not have the time to spend with her. (R4) will take as much time as she can get talking with people, she loves it.

During interview on 2/25/16, at 9:08 a.m. R4 stated that she spends her day in her room, in bed because she is more comfortable laying on her right side. R4 stated that she enjoys visiting with others and has a television on in her room with closed caption and a white board so her visitors can communicate with her using the white board, because "I am deaf.". R4 stated that she watches her gold fish on her bedside table, and her "sister is brining in latch hook". R4 stated it would be difficult for her to participate in group activities at facility because, "I'm deaf, there's not much" and was more comfortable in bed.

During interview on 2/24/16, at 2:45 p.m., licensed practical nurse (LPN)-A stated that R4 remains in room, even for meals and eats in her , eating her meals in bed. LPN-A further stated she works the evening shift and R4 is always in bed with television on with her eyes closed. She has not seen R4 read or do other independent leisure activities in her room.

During interview on 2/25/16, at 8:36 a.m. with registered nurse (RN)- A , stated that R4 does not typically go outside of room due to her physical comfort level, and has not seen R4 participate in any other activities.

A review of the R4's Recreation Attendance Record for January 2016 identified participation in the following activities; TV/Radio/Room Projects (10), and Reading/Writing, Puzzles (10). A review

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21435	Continued From page 18 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 reviewed at the quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435		

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21545	Continued From page 19	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		

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21545	Continued From page 20 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based observation, interview, and document review the facility failed to ensure 1 of 1 resident (R4) was free of a potential, significant medication error. This had the potential to affect 13 residents who receive insulin administered via insulin pen. R4's diagnosis, identified on the Admission Record dated 1/15/16, included diabetes mellitus. R4's Order Summary Report dated 2/3/16, included Humulin N Suspension (medication used to treat diabetes) 100 units/milliliter (ml), 6 units subcutaneously in the evening. During observation of medication administration on 2/22/16, at 5:13 p.m. licensed practical nurse (LPN)-G attached a disposable needle to R4's Humulin insulin pen, dialed the insulin pen to 2 units and primed the needle, then dialed the pen to 6 units, and entered R4's room to administer the insulin. LPN-G placed the insulin pen against R4's left lower abdomen, pressed the button on top of the pen to administer the insulin, and after removing the pen, stated, "I'm not sure if the needle engaged." LPN-G walked back to the North medication cart and stated, "I'm going to try this again. There's no way of telling that [R4] got any [insulin]." LPN-G went back to the drawer of the medication cart, took out another disposable	21545		

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needle, and screwed it on to R4's insulin pen. LPN-G dialed the insulin pen to 6 units, and walked down the hallway toward R4's room. Before reaching R4's room, LPN-G was questioned about giving another dose of insulin. LPN-G stated he was planning to administer another 6 units of insulin because he did not feel R4 got any insulin because he observed insulin on R4's skin when giving the last dose. LPN-G was questioned about consulting with the registered nurse (RN) on duty, and after discussing with RN-A, they called the nurse practitioner and were instructed to not give an additional dose of insulin, and to check R4's blood sugar at bedtime.

During interview on 2/22/16, at 5:24 p.m., RN-A stated she would expect staff to call the RN on call or the nurse practitioner if there was any question as to how much insulin a resident received in this situation, before deciding to give an additional dose to prevent the resident from receiving too much insulin and becoming hypoglycemic (low blood sugar).

During interview on 2/25/16, at 8:35 a.m. executive director (ED) stated staff should call the nurse practitioner if they were questioning whether or not a resident received the amount of medication ordered.

Review of the facility's policy, Medication Error and Adverse Drug Reaction Reporting, dated 10/07, included, "The prescriber is notified promptly of any significant error or adverse medication reaction."

SUGGESTED METHOD OF CORRECTION: The facility could review their policies on medication

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21545	Continued From page 22 administration, provide education on medication administration, and implement an auditing system to ensure safe medication administration and ongoing compliance. TIME PERIOD FOR CORRECTION: twenty one (21) days.	21545		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a homelike environment in 8 of 14 resident rooms on the south unit which had the potential to affect 13 residents (R69, R96, R62, R12, R71, R35, R56, R55, R87, R44, R8, R1, R50, R90, and R18) whose rooms either lacked or had malfunctioning closet doors; or whose rooms were in general disrepair; or who resided between the kitchen and dining area and expressed concerns related to noise; or who expressed concerns regarding room temperatures that were too hot. Findings include: CLOSET DOORS/ROOMS IN DISREPAIR R69's quarterly Minimum Data Set (MDS) dated 1/22/2016, indicated he had moderately intact cognition.	21665		

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During an interview on 2/22/2016, at 4:34 p.m., R69 pointed out there were gouges, marks, and holes at the foot of the bed, with a metal, wall edge protector standing in the corner. R69 said he was not aware of how the gouges got there, and stated the disrepair in his room "Really does not bother me, it just an old building."

After assisting R71 with cares in her room on 2/24/16, at approximetly 8:00 a.m. nursing assistant (NA)-D tried to close the closet door, but it was off of its track and non-functional. NA-D stated she had put numerous requests for repair in "care tracker" [the facility's maintenance tracking system] and stated "Evidently it doesn't get done, sorry to say." NA-D then listed other room numbers where the residents' closet doors were either off track, missing, or had been replaced with a curtain.

During environmental tour on 2/25/2016, at 10:05 a.m. with maintenance specialist (MS) the following issues were noted:

Room 21, wall gouges, exposed sheet rock with holes, wall edge protector removed
Room 22, outer closet door stuck on its track
Room 24, no closet doors
Room 25, inner closet door off its track
Room 28, had 3" (inches) x 4" veneer missing on inside bathroom door
Room 29, chipped and missing 12"x 12" floor tiles near resident dresser
Room 31, no closet doors
Room 39, no closet doors

During interview on 2/25/2016, at 10:41 a.m. MS stated he was aware many resident closet doors were, "stuck on the tracks," and some of the closet doors were missing or removed from other

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resident rooms. MS stated he had spent, "Countless hours of work on this [closet doors]" and the doors were especially troublesome because the closet doors were custom custom size doors, and there, "wasn't much we could do." MS acknowledged the environmental concerns of missing and broken tile flooring, gouges in the sheet rock, and missing door veneer in resident rooms. The MS stated he received "80 to 100 maintenance requests," and could have "2-3 guys," working on the repairs to try to get them completed.

During interview on 2/25/2016, at 11:27 a.m. the interim executive director (ED) stated she was aware many of the resident rooms had non-working closet doors and, "has been working with my team" to remove the doors. The ED stated the facility had been looking at using a flame-retardant material for a curtain to replace the closet doors. ED stated she was aware of the rooms with cracked tile floors, and baseboards coming off, however, there was no current plan in place for repair, but the facility would be looking, "At all the resident rooms."

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. following the evening meal, dietary staff was

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moving a dining cart from the dining room to the short hall toward the main resident hallway, and toward the kitchen. The cart was laden with food tubs, containing resident silverware, plates, and various pans used at the meal. As the cart neared the intersection of the hallways, a small bowl and a stacked pile of cups tipped over and fell out from the cart, landing on the floor, resulting in crashing sounds heard in the hallway and in nearby resident rooms.

During interview on 2/23/2016, at 9:15 a.m. R71 stated that staff, "Could be more quieter than they are." R71 stated, "I hear at lot more than staff are aware of." R71 stated she heard the lifts going by, staff talking, and, "I hear the dishes going by."

During interview on 2/22/2016, at 6:13 p.m., R56 stated staff, "talk loud in the hallway," and when the kitchen brings their things to the dining room, "It's like a racetrack with the dishes going by." R56 stated at least once a day, "Something gets dumped over on the food carts." R56 also stated the noise issue had been discussed at resident council meetings, but no improvement had been made.

During interview on 2/22/2016, at 4:46 p.m. R50 stated she heard noises as the dishes and food pass by, and also stated it was noisy at night, and often couldnt get to sleep and, "I lay there and hope it quiets down."

During observation on 2/24/2016, at 7:31 a.m. dietary assistant (DA)-A exited the kitchen door on the main hallway and was pushing a cart loaded with foil-covered food trays and going to the short hall to the dining room. While DA-A maneuvered the cart, a rhythmic sound came from the wheels of the cart, as if they needed oil

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and were unevenly worn. DA-A pushed the cart further, and as the cart rounded the corner and moved toward the dining area, the noise continued and announced the cart's arrival.

During interview on 2/25/2016, at 8:02 a.m., dietary manager (DM) stated the facility was the residents home, and sometimes staff were in a hurry and did not think about that. The DM stated she would need to, "review that with staff [the noise made with the dishes]." In regard to the noise from the carts, the DM stated more tubs were perhaps needed, so the plates and cups would not come off the cart. The DM stated she would have maintenance look at the carts, "Maybe they need a little WD40." In a subsequent interview at 9:35 a.m., the DM stated a new cart was just ordered, and they would be looking to see if more bins were needed to use on the carts.

In an interview on 2/25/2016, at 10:29 a.m. the MS stated he, "Was told the carts were noisy a few months ago." The MS stated there used to be carpeting in the hallway, and the carts were much quieter then. The MS stated he had not looked at the carts to see if the wheels were cut and uneven or if they just needed oiling, and stated he had many maintenance requests to try to complete. The MS stated the dietary manager would also be working a a solution, and he would be looking at the carts to see what the issue is with the noisy wheels.

In an interview on 2/25/2016, at 11:27 a.m., the ED stated while moving the food carts, "The noise level is high" and there were more complaints in the rooms nearest the hallway where the kitchen was. The ED stated the facility was the residents home, and they would, "Talk to

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staff" about the noise level, and, "Be more mindful" when moving the carts.

ROOM TEMPERATURES

R62's quarterly MDS, dated 12/30/2015, indicated intact cognition. In an interview on 2/22/2016, at 4:56 p.m. R62 stated his room was always, "way too hot." R62 stated he had complained to staff 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, near hallway to dining area: 79 deg. F (thermostat was set at 73 deg F).
Resident room #25 82 deg. F
Resident room #28 81 deg. F
Resident room #31 81 deg. F

In an interview on 2/25/2016, at 10:29 a.m. MS stated he monitored the resident room temps once a week and when it is colder outside he monitors, "More frequently." The MS stated he did not log any of the temperatures in the building, and he was aware of the building temps by going around the building and he had, "A good memory" of what the temperatures were. MS stated there were two roof-top units to heat the

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dining area, and the hallway of the facility also had roof top units, each controlled by thermostats, and there were a total of 8 separate units. The MS stated resident rooms were heated by a boiler, and there were no individual controls to set the heat in each room; but rather, room temperature was regulated by "sectional thermostats." The MS stated the boilers were difficult to control to maintain a consistent temperature. MS stated he was unaware some residents only covered themselves in bed sheets because of the excessive warm room temperatures. The MS stated if residents were too hot, they could open a window, "I ask the nurses to do that." The MS also stated he had fans available for residents if rooms were too warm.

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 METHOD OF CORRECTION: The DM could review and revise the policies, educate

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21665	Continued From page 29 maintenance staff and identify trends of repeated building disrepair. The DM could work with the Director of nursing (DON) to ensure staff are reporting environmental issues appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to fully explore bathing options for 1 of 1 residents (R56) who had difficulty accessing the facility bathing facility. R56's quarterly Minimum Data Set (MDS) dated 1/7/2016, indicated intact cognition, and had diagnoses which included amputation, osteoarthritis and obesity. The MDS further indicated R56 required extensive, two-person physical assistance with transferring, was not steady and only able to stabilize with assistance for surface to surface transfers. R56's care plan, revised 1/4/2016, identified physical functioning deficit related to self care and mobility	21810		

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impairments. R56's care plan directed "transfer assistance of 2 using Sarah lift" [a mechanical standing lift] and "encourage choices with care." R56's care plan did not identify any special needs/assistance for bathing.

During an interview on 2/22/2016 at 6:00 p.m., R56 said he did not get to chose whether he could have a shower, or bath. R56 stated "They only give me a bed bath." R56 also said "they wont let me" use the whirlpool because of some restriction, but "don't know why I can't use the shower." R56 currently receives a weekly bed bath, but would prefer to have a shower. R56 went on to say he was getting showers, using a special chair, and "we never had an issue with that," and then suddenly "around Thanksgiving [staff] talked to me about getting just bed baths," and I no longer gets showers even though he had received showers previously.

In an interview on 2/24/2016 at 11:26 a.m., nursing assistant (NA)-D said R56 "used to get a whirlpool" bath, but they had to change because of some restrictions with the tub. NA-D said R56 then "was getting a shower" but positioning him in the shower was difficult. NA-D then stated "I think he talked with the nurse" and since then "[R56] has been getting a bed bath."

A review of R56 nursing progress notes indicated on 11/23/2015, executive director (ED)-A assessed R56 during a transfer using a mechanical standing lift, and was assessed to safely transfer with the lift and assist of 2 staff. The note indicated the ED-A and R56 discussed various concerns, with activities of daily living (ADLs). However the note did not identify why R56 was changed to a bed bath, and was no longer able to shower.

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21810	Continued From page 31 In an interview on 2/24/2016 at 11:30 a.m., the ED-A acknowledged R56 was currently receiving "bed baths" because of tube restrictions in last August. The ED-A stated she had assessed and determined there was a safety issue placing the chair into the shower and felt their physical plant could not accommodate that. The ED said she did not want the residents legs to scrape on the wall and needed to be pushed backwards to get into the shower because of the limited shower space. The ED stated she discussed concerns with R56 and was actively seeking placement at another facility but the resident did not want to leave the facility. During a tour of the north unit resident shower room with ED-A on 2/24/2016 at 1:40 p.m., ED-A, demonstrated the use of R56's shower chair in the shower room. ED-A explained the difficulties moving the chair around in the shower with R56 seated, and expressed her safety concerns if R56 was bathed there. At 1:59 p.m., ED-A used R56's shower chair into the south unit bathing room, where the whirlpool tub was located. The left side of the room had a toilet, and a sink with a faucet. There was a drain in the tile floor with the floor sloped towards the drain. Above the drain was a curtain attached to the ceiling. ED-A stated she "had not considered" use of the south unit bathing room as an alternative location for R56's shower. Although the facility assessed the facility shower to be unsafe for R56, the facility did not fully explore all bathing options, including a possible alternative bathing location for R56 within the facility. A facility policy regarding resident	21810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 32 accommodation of needs was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies, procedures are updated, implemented, evaluated, monitored and that based on individual assessments, personal care based on individual needs is provided to enable residents to achieve their highest level of physical and mental functioning TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (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	21830		

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an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a

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21830	Continued From page 34 family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident preferences were honored for getting up in the morning for 1 of 3 residents (R50) reviewed for choices and preferences. Findings include: R50's quarterly Minimum Data Set (MDS), dated 1/15/16, indicated she was moderately impaired and required extensive assistance with activities	21830		

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of daily living (ADL's) including dressing, grooming, bathing and toileting.

During interview on 2/22/16, at 4:40 p.m., R50 stated that she does not get to sleep in as she would like to in the morning.

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.

On 2/24/16, at 6:58 a.m. R50 was asleep in her bed. At 7:05 a.m., NA-D, entered R50's room, and ask the resident if she would like to get up or not. R50 stated that she wanted to sleep in until later and NA-D left the room. NA-D stated the

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21830	Continued From page 36 resident likes to sleep in until second seating and usually gets up about 8:10-8:15 a.m. and is aware of R50's preference to sleep in. At this time, licensed practical nurse (LPN)-B joined in the conversation and stated that R50 is a "night owl". LPN-B stated that R50 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 R50 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 a 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, smiling, 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 typically 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 on 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.	21830		

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21830	Continued From page 37 A facility policy entitled Preservation of Resident Rights, dated 2/26/15, under Resident Choice identifies that "staff will communicate residents preferences, needs, and choices to ensure integration into the residents care schedule and care plan. " SUGGESTED METHOD OF CORRECTION: The administrator or designee could re-educate staff on soliciting and assessment of resident preferences, and conduct audits to ensure resident choices are obtained, care planned, and provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to ensure personal visual privacy for 1 of 1 residents (R8) during random observations.	21855		

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21855	Continued From page 38 Findings include: R8's admission Minimum Data Set (MDS) assessment, dated 1/27/16, identified R8 was cognitively intact and required extensive assistance with bed mobility, personal hygiene and dressing. 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. R23 was observed on 2/23/16 at 2:00 p.m. lying in his bed with just a sheet covering his lower body, with his bare chest exposed. The residents room door was open, and could be seen by other residents, visitors and staff who were walking by R8's room from the hallway. During a follow up interview on 2/23/26, at 3:58 p.m., R8 was lying in bed with the door fully open, exposing his unclothed chest and abdomen. Residents, staff and visitor were walking by R8 room with the door open and could be seem from the hallway. R8 stated he had not been offered a different room location or bed that would provide more visual privacy. During an interview on 2/24/16, at 2:20 p.m., family member (FM)-A stated she was "Uncomfortable," to see R8 partially unclothed	21855		

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21855	Continued From page 39 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train staff to ensure the personal privacy of residents, and then perform audits to ensure each resident's right to privacy is maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21855		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a	21980		

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21980	Continued From page 40 vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was 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 reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or	21980		

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21980	Continued From page 41 directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. 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 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.	21980		

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21980	Continued From page 42 A Incident Report-Investigative Report 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	21980		

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time and was encouraged to keep his green pouch locked up. The report indicated the ED was not notified until 6/9/15, seven day after the incident.

A facility Verification of Investigation dated 6/9/15, indicated the report was submitted to the state agency seven days later.

During interview 2/24/16, at 3:33 p.m. SW stated she was waiting to see if the money came back from laundry and stated "I know this incident should have been reported immediately to the state agency."

During interview 2/25/16, at 12:00 p.m. the ED-A stated she does not know why this was reported late to ED-B and state agency, the previous ED-B was no longer at the facility at this time and it should have been reported immediately.

Additional review of the facility's Verification of Investigation reports indicated there were seven additional reports of residnets missing money which identified the following:

R101's Verification of Investigation indicated that on 6/8/15," resident told the business office manger that he was missing $20. Social worker followed up with resident and he then stated it was $10 or $15. He stated he had in his green zipper pouch that was tied to the back of his wheelchair and he also stated the lost the key to his drawer." The ED and state agency were immediately notified.

R100's Verification of Investigation indicated that on 7/09/15, "Reported to nurse that [sic] (staff member) ,nursing assistant registered (NAR) had posted personal note/check on her Facebook

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page about resident [R101] had passed away." Resident Interview Summary on the Investigation further indicated: "Resident had expired. Social Worker spoke with daughter, [sic] , who stated she had given the check with sentiments written on it for her [sic] (staff member) to have. She had no concerns." The report did indicate the ED and state agency were immediately informed.

R44's Verification of Investigation dated 7/22/15, indicated R44 "had coins in a pouch in his room. Spouse [sic] alleges that approximately $13 in quarters were taken from the pouch in residents room." The report did indicate the ED and state agency were immediately informed.

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 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

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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 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 discharged in late December early January. Although the former resident R68 had been discharged the faciltiy had two additional allegations of missing money on February 8, and 12, 2016.

Although the facility had nine incidents of misappropriation of resident property from June 2015 through February 2016, there was no indication the facility completed a thorough investigation of the missing resident money.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could in-service all staff on the need to follow the facility abuse policy in regards to immediately reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 46 missappropriation of money to the designated state agency, throughly investicate and re-education of staff. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21980		