

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 17, 2016

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

Subject: Golden LivingCenter - Meadow Lane - IDR CMS Certification Number (CCN): 24 5313 Project Number: S5313026

Dear Ms. Dillon:

This is in response to your letter of May 25, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F 314 42 CFR §483.25(c) Pressure Sores, issued pursuant to the survey event NH3C11, completed on April 29, 2016.

The information presented with your letter, the CMS 2567 dated April 29, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F314 S/S – G 42 CFR §483.25(c) Pressure Sores Based on the comprehensive Assessment of a resident, the facility must ensure that—

- 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Summary of facility's reason for IDR of tag F314:

The facility indicates the requirements under 483.25(c) were met because they assert there is clear evidence and documentation exists and supports that the area on buttocks (gluteal fold) for resident (R24) is NOT a current unstageable pressure ulcer but an erosive dermatitis. Thus R24 did not sustain actual harm as defined under tag F314. The facility request the removal of citation issued at F314.

Golden LivingCenter - Meadow Lane October 17, 2016 Page 2 Summary of facts:

R24 was admitted to the facility on December 12, 2013, from an acute care hospital stay.

Surveyor notes from CMS 2567 tag F314 read, On 4/26/16, during continuous observations from 1:44 p.m. to 4:40 p.m., R24 was observed lying in bed on her right side without being offered, or assisted to reposition during the entire observation (a total of 2 hours and 56 minutes).

On 4/27/16, during continuous observations from 8:33 a.m. to 11:07 a.m., R24 was observed seated in her wheelchair without being offered, or assisted to reposition during the entire observation (a total of 2 hours and 34 minutes).

R24's comprehensive annual Minimum Data Set (MDS) dated December 9, 2015 assessed R24 as being at risk for developing pressure ulcers. "Functional Status showed R24 was assessed to need 2 to 3 staff support to meet activities of daily living (ADLs) needs. Was assessed to be always incontinent (no episodes of continent voiding) and no toileting program in place. Also to be cognitively impaired at a severe range. The Care Area Assessment dated December 9, 2015 included a history of skin concerns related to a bullous disorder which show as elevated, fluid-filled blisters greater or equal to 10 millimeters in diameter. Clinically, the earliest lesions may appear urticarial (like hives). Tense bullae eventually erupt, most commonly at the inner thighs and upper arms, but the trunk and extremities are frequently both involved. Any part of the skin surface can be involved.

The quarterly MDS dated March 1, 2016 R24 was assessed to include no current pressure ulcers, at risk to develop pressure ulcers, activities of daily living (ADLs) status no change and incontinence had improved to frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of content voiding) and again is not on a toileting program schedule.

A quarterly and significant change tissue tolerance review notes, dated March 1, 2016 included, Quarterly Tissue Tolerance review. No tissue tolerance (an assessment to determine how long pressure on/over bony prominences can remain before damage to tissue could develop) concerns identified at this time. R24 does have open areas on buttocks that were blanchable (blood flow returns quickly after pressure applied by finger). R24 is prone to excoriation (act of abrading or wearing off the skin). Braden score is 14 which indicated high risk of developing ulcers, current medications, and diagnosis of dementia with behavioral disturbance, bullous disorder, hypertension and diabetes. History of non-pressure skin concerns, limited mobility and assist needed with mobility, sitting for long periods, needs extensive assist with bed mobility, transfer, and toileting. Interventions include pressure relieving mattress on bed and pressure relieving cushion in wheelchair. Skin checks with cares, licensed nurse to assess skin with weekly shower. Treatment for skin concerns as ordered by medical doctor, reposition resident every 2 hours while in bed and in wheelchair. Tissue Tolerance Testing form used by the facility to determine repositioning needs dated 4/4/16 from 9 p.m. to 11 p.m. showed skin red, blanches with gentle pressure, reposition every two-hours.

The Weekly Skin Review dated March 30, 2016 included, "Resident has a pre-existing open area on her coccyx area that measures 2.5 cm L [long] X 0.7 cm W [wide] and is shallow with a slough covered wound bed."

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Physician visit dated March 10, 2016 included observation of skin breakdown on the left side of her gluteal fold. There is a surrounding are of erythema which represents earlier skin breakdown was as clear somewhat. The only one is an area about 4.5 centimeters by 2 centimeters in the middle which was a layer of eschar (Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound) over the top. Staff used Mepilex bandage treatment but the nurses felt it was keeping area to wet. Physician had encouraged staff to keep open to air more to dry out site especially after it sits in moisture such as if she had just voided or had a bowel movement the problem is more noticeable. The "Assessment: 1. Pressure sore on the right side of gluteal fold." Order Summary Report dated April 13, 2016 included doctors' orders for "Butt cream to coccyx erosion BID [twice daily]/healed." And "Continue wound pack as ordered."

The facility provided progress notes from R24's certified nurse practitioner who worked with R24's primary physician visit/assessment dated 4/28/16 at 2:00 p.m. which included in her physical exam an observation of a right gluteal fold located parallel and approximately 2 centimeters (CM) to the right of the intergluteal cleft with is approximately 2 cm by 5 cm open lesion. Surrounding the lesion is a 2 cm annular area of flaking skin. This area is not on a bony prominence and to view the lesion the fold must be lifted. The wound is beefy red around the edges, which are not rolled. There is a small amount of slough in the center of wound. No drainage, odor erythema or induration to the site. Assessment: Erosive dermatitis.

Also provided by the facility was a letter completed by R24's primary physician dated 5/20/2016 in regards to R24's skin concern located on the left buttock fold. The doctor included he had been taking care of R24 for many years, clarified in his notes of his visit dated 4/19/16 he mistakenly described the lesion in progress note as a level III ulcer, but on re-view of that description of the wound he felt it was mislabeled as there was no evidence of subdermal or muscle damage and no evidence of penetration of the subdermal layer and referencing a well-accepted medical resource it is more accurately described as a level 1 erosions as caused by shear effect in a situation which there is excessive moisture and that often these occur in area other than those with bony prominence, As R24 is incontinent of urine and stool, those conditions could exist in the area of the area of the described erosion and he (R24's doctor) feels that a level 1 erosion in reevaluation is an accurate description of the buttock fold open wound.

Summary of findings:

After reviewing F314 citation, documents provided after the exit from the facility and the medical doctor, interview with the administrator, Director of nursing, surveyor who was the author of the citation and the supervisor and assistant program manager these are my findings.

The physician and certified nurse practitioner had determined the open wound located on the right buttocks (gluteal fold) is an erosion over an area that had sustained skin damage due to bullous disorder. This open skin wound does not meet the definition of a pressure ulcer according to F314.

Having said this, R24's findings meets the definition according to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.13 dated October 2015, as a chronic erosion/s as

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a moisture associated skin damage (MASD) according to MDS 3.0 M1040: Other ulcers, wounds and skin problems. The definition reads, "Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown."

Also R24 was assessed on quarterly MDS dated 3/13/16 section H to be frequently incontinent with less than 7 episodes of incontinence and occasional bowel incontinence and interventions for bowel and bladder were to offer toileting with every two hour repositioning which went over the two hours limit on 4/26/16 and again on 4/27/16. Also was assessed under section G to need extensive assistance with toilet use, hygiene assistance and bed mobility.

This is not a valid deficiency under F314 and will be moved in its entirety to F309 and will stay at a scope and severity level of G due to bowel/bladder services not being provided according to assessed needs.

F309 S/S – G 42 CFR §483.25 Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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

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

Sincerely,

Sary gederhoff

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Health Regulation Division Gary.nederhoff@state.mn.us Telephone: 507-206-2731 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care Maria King, APM, Assistant Program Manager Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245313	B. WING			04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification. A recertification sur complaint investigat the time of the stan An investigation of H5313029 was com	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with rvey was conducted and tion(s) were also completed at					
		and F353. complaint H5313028 was nd not to be substantiated.					
F 241 SS=D	Be advised, this CM a result of an inform As a result of the ID upheld however, F3 F309 as it was dete was more accurate associated macera	AS 2567 has been modified as hal dispute resolution (IDR). DR, the survey findings were 314 findings were moved to ermined the skin breakdown ly described as a moisture tion versus a pressure ulcer. YAND RESPECT OF	F 2	241			6/8/16
		DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed						05/20/2016

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

PRINTED: 10/27/2016

		& MEDICAID SERVICES			<u>MB NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· /	E SURVEY PLETED
		245313	B. WING _		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
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F 241	Continued From pa	age 1	F 24	11		
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.				
	by: Based on interviev facility failed to pro-	NT is not met as evidenced v and document review the vide cares to maintain dignity (R5, R30) reviewed for		1. Resident interviews were comp R5 and R30 to identify preference care. Plan of care was reviewed updated as indicated for both resid	s in and	
	2/18/16, identified I had a diagnoses w myositis and osteo R5 required extens daily living. Addition oriented. Further, the frequently incontine dated 8/20/15, indite of bowel. Review of R5's car R5 required extenses standing lift for trans one staff for toiletin R5's care plan indite elimination of bowe briefs/pads for inco to provide one assist to toilet.	mum Data Set (MDS) dated R5 was cognitively intact and hich included depression, arthritis. The MDS identified sive assistance with activities of hally, the MDS noted R5 to be he MDS indicated R5 was ent of bowel. R5's annual MDS cated R5 was always continent e plan dated 9/10/13, revealed sive assistance of one staff and asfers, extensive assistance of ig, bed mobility and bathing. cated an alteration in el and bladder, used ontinence protection and staff st with standing lift as needed		 To ensure residents are received in a dignified manner: staff education regards to resident rights and dign Resident interviews completed on Choices and Dignity with interviews residents. Resident interviews and observations are completed quart PRN with changes updated on car and NAR sheets. Weekly audits to include: call lign room appearance audit, resident of observation and resident interview completed by DNS/designee. And negative findings at the time of the will be addressed immediately. A from the prior week are reviewed management team to identify area concerns and need for further action 4. Results will be reviewed monthin QAPI. Identified areas of concern addressed and needed changes we discussed and implemented. 	ion in hity. hrable d erly and re plan ght, care y audits y audits with as of ons. y at will be	

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). 0938-039 TE SURVEY
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COMPLETED	
		245313	B. WING		04	/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
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F 241	get to the toilet for I he doesn't make it because the staff d time, so he was ince there were three nut facility now, but that happened. R5 state going on. R5 state work very hard, the around like crazy, t	age 2 aff and the mechanical lift to powel movements. R5 stated as often as he used to, o not answer his call light in ontinent of stool. R5 reported arsing assistants working at the t was not what normally ed it was because survey was d the workers at the facility nursing assistants "ran here just isn't enough [nursing ated sometimes he waited for eone to answer the call light. Ily had to wait a long time on e early morning hours. R5 16, he put the call light on at ody answered it until 5:00 it was too late" as he had been . R5 stated he had expressed ng incontinent of bowel due to acility management at his care as told if he didn't like it at the hould move. R5 stated he has obone to call the nurses help because they don't t. R5 reported he now wore a d he never used to wear one. the incontinence product as it es easier if he was incontinent d, nobody liked to be . R5 again expressed the enough staff scheduled and incontinent of stool because of d a bowel movement every	F 2	41		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI	FIPLE CONSTRUCTION	(Y2) DA	TE SURVEY	
ND PLAN C	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		COMPLETED	
		245313	B. WING _			/29/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
GOLDEN	LIVINGCENTER - ME	ADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
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F 241	be that difficult to fighim. On 4/29/16 at 9:45 confirmed R5 did ha movements once in mornings. NA-B sta when he needed to reported staff often because there was confirmed R5 did se was incontinent of b was more incontine had his light on toda this morning. NA-B get to him in time at incontinent of bowe worked she went to and asked him if he bathroom, in an effo he was not incontine On 4/29/16 at 12:05 (LPN)-A reported R bowels, but did wea case he did not mal LPN-A confirmed R have a bowel move by activating his cal have been times wf R5's call light in time	y predictable, and it wouldn't gure out to know when to toilet a.m., nursing assistant (NA)-B ave incontinent bowel a while, usually early in the ated R5 was able to tell staff get to the bathroom. NA-B do not get to R5's call light, not enough staff. NA-B eem embarrassed when he bowel. NA-B then stated R5 nt of stool. NA-B reported R5 ay when she got to work early stated night shift staff did not nd R5 had already been I. NA-B stated when she R5 right away in the morning was ready to use the ort to anticipate his needs so	F 2	41			

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		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE	E SURVEY PLETED	
		245313	B. WING		04/:	29/2016	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 241	Continued From page 4 staff.		F 241				
	(DON) and social w were both aware of bowel movements i staff not answering reported R5 voiced the same issue in the 4/26/16. Both the D	2 a.m., the director of nursing vorker (SW) confirmed they i R5's concerns of having in his pants and bed due to his call light timely. They his concern again regarding he resident council meeting on DON and SW stated they felt is more of a behavioral to R5's care plan.					
		requested regarding honoring reatment, the facility referred f Rights.					
	3/22/16, identified F impairment and req with all activities of further identified R3	nimum data set (MDS), dated R30 had severe cognitive quired extensive assistance daily living (ADLs). The MDS 30 was frequently incontinent er and was not on a scheduled					
	dated 12/24/15, ide incontinent of bowe checked for incontin	I and bladder assessment entified R30 was frequently and bladder and was to be nence and changed every 2 receive good pericare after es.					
	occasionally inconti incontinent of bladd to improve bladder than 2 episodes of and less than 2 epis	ted 4/27/16, identified R30 was inent of bowels and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day sodes of bowel incontinence e plan further identified R30					

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245313	B. WING		04	/29/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE		
GOLDEN	N LIVINGCENTER - ME			BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 241	staff to assist him w offered toileting ever indicated staff were symptoms of urinar odors. On 4/25/16, at 5:07 overwhelming smel filled R30's room. T and coming from R On 4/26/16, at 1:58 and R30's entire roo of concentrated urin observed from 1:58 not toileted for 2 ho On 4/27/16, at 7:08 seated in his wheel smelled strongly of 1:05 p.m. R30's roo an overwhelming sr On 4/26/16, at 9:42 hallway always sme has asked staff to o visit because he sm On 4/27/16, at 1:11 always incontinent of She stated R30 cor urine and was dependent incontinence cares. R30's urine odor by and stated she felt	 d toileting program, required 2 vith toileting, and was to be ery 2 hours. The care plan to report any signs or y tract infection including p.m. there was an l of concentrated urine which he smell was heavy in the air 30's body. p.m. R30 was in bed asleep om continued to smell strongly he. R30 was continuously p.m. until 4:40 p.m., R30 was urs and 40 minutes. a.m. R30 was in his room chair. R30's room and body urine and other body odor. At om and body continued to have nell of urine and stool. a.m. FM-A stated R30's entire elled of urine. FM-A stated she shange R30 during a family helled so strongly of urine. p.m. NA-A stated R30 was of both bowel and bladder. 	F 2	41		

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TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245313	B. WING		0/	04/29/2016	
NAME OF	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP C		29/2010	
GOLDEI	N LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
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F 241	On 4/27/16, at 2:00 be changed "at lease was R30's pattern to brief every time he R30 always smeller was so "thick and so referred to it as "R3 stated R30 required incontinence care as She stated R30 was there just wasn't er On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake a She stated staff we benefit from more to there just wasn't time bath a week becau On 4/28/16, at 4:06 interview FM-A state go to the bathroom take him when he so she was upset. FM smelled of urine an also complained ab On 4/28/16, at 4:29 expected the facility all times with no ex unaware of any resp problems. She state individualized with of DON confirmed R3	p.m. NA-B stated R30 should st" every 2 hours. She stated it to have stool and urine in his was changed. NA-B stated d of urine because his urine trong." NA-B stated staff 80's stinky problem." NA-B d total assistance with and smelled of urine every day. s not toileted on time because hough staff. a.m. NA-C stated R30 got 1 I she felt it was not enough to odor. NA-C stated R30 always rine odor because he had nd his urine was so strong. re aware that R30 would han one shower a week, but he to give R30 more than 1 se she was the only bath aide. p.m. during a follow-up ed R30 had to wait and wait to . FM-A stated staff just don't says he has to go. FM-A stated -A stated most of the time R30 d other family members have	F 24	41			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		245313	B. WING		04/29/2016	
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	BENSON, MN 56215 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO	
F 241	registered nurse as to join the interview confirmed R30 was incontinence care. aware of R30's urin Upon review of the	sessment coordinator (RNAC) . The RNAC and DON totally dependent on staff for The RNAC stated she was e and stool odor. facility policy, Incontinence	F 24			
F 242 SS=D	Management/Bladder Function Guidelines dated 6/9/15, it identified a schedule would be developed with toileting times specific to each resident to avoid UTI and skin problems and to improve morale, dignity, and restore or maintain bladder function as possible. The policy indicated the care plan for each resident would include each resident's schedule. 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES		F 24	2	6/8/16	
	schedules, and hea her interests, asses interact with membrinside and outside t	e right to choose activities, alth care consistent with his or sements, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident.				
	by: Based on observat review the facility fa preferences for 1 of for choices. Findings include:	NT is not met as evidenced ion, interview and document iled to honor resident f 4 residents (R66) reviewed inimum Data Set (MDS) dated		1. Resident R66 has the right to cl her healthcare consistent with her interests, assessments and plan of Resident interview and observatior completed to identify choices and preferences. Plan of care was rev and updated as indicated. NAR sh were updated with preferences.	f care. 1 iewed	

Facility ID: 00930

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETIOI DATE
F 242	Continued From pa	ige 8	F 2	42		
	and a diagnosis of The MDS identified assistance with act Review of R66's ini revealed R66 requi one staff for transfe toileting and bathin facility staff to help daily living. Review of an undat Resident Tidbits fro R66 had no memor and preferred to ge On 4/25/16, at 7:15 help to get up and of R66 stated she would about an hour for s stated she would us know her needs, ar anxious waiting for afraid she would we accident. R66 state felt bad when it did her leg she always time and did not ha staff would routinel people to get up so had occurred as re On 4/29/16, at 9:08	a fracture to the right femur. R66 required extensive ivities of daily living. tial care plan dated 4/19/16, red extensive assistance of ers, bed mobility, dressing, g. R66's care plan directed maintain her preferences in red facility form titled, "New om Social Services" revealed cy concerns, was very sharp t up at 6:00 a.m. p.m. R66 stated she needed but of bed in the mornings. uld routinely have to wait for taff to help her get up. R66 se her call light to let staff nd would often become them. R66 stated she was et herself or have a bowel ad this has happened and she . R66 said before she broke made it to the bathroom in ve accidents. R66 stated the y tell her they have other she had to wait. R66 stated it cently as this morning.		 2. To ensure residents have the r make choices regarding cares. S education in regards to resident r dignity. Resident interviews com on Choices and Dignity with inter residents. Resident interviews al observations are completed quar PRN with changes updated on c and NAR sheets. 3. Staff was educated on resident and choices. Weekly audits to in call light, room appearance audit care observation and resident int audits completed by DNS/design negative findings at the time of th will be addressed immediately. A from the prior week are reviewed management team to identify are concerns and need for further ac 4. Results will be reviewed at QA Identified areas of concern will be addressed and needed changes discussed and implemented. 	Staff ights and ipleted viewable nd terly and are plan t rights nclude: , resident erview ee. Any ie audit audits with eas of tions.	
	interview R66 state admitted, her usual at 6:00 a.m. and sh p.m. R66 stated thi 8:00 a.m. to get he	d she told staff when she was routine has been to wake up le would go to bed around 9:00 s morning she had to wait until p to get out of bed. R66 stated by a nursing assistant that she				

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TATEMEN	F OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245313	B. WING		04	04/29/2016	
NAME OF	PROVIDER OR SUPPLIER		l I	STREET ADDRESS, CITY, STATE, ZIP C		/20/2010	
GOLDE	N LIVINGCENTER - ME	EADOW LANE	2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 242	was 1 out of 10 res had to wait. R66 states and stated she felt last one. R66 states member about not time but she did no staff. R66 stated sl enough staff to help and worried that at her. R66 stated she because they had to On 4/29/16, at 9:30 stated R66 was ale assistance and was her needs. NA-E st assistance of one for toileting, dressing, k NA-E stated she was out of bed until arous shortage. NA-E state able to help R66 an her as soon as she On 4/29/16, at 11:1 assessment coordin unaware R66 prefe RNAC confirmed R past few mornings between 7:00 a.m. The RNAC stated she preferences to be h patient bill of rights. On 4/29/16, at 12:0 (DON) stated she for based on her preferences to be h patient bill of rights.	idents she had to help, so she ated she had heard that a lot as though she was always the d she spoke to a family getting up at her preferred t feel comfortable telling the ne felt the facility did not have o everyone. She felt helpless times staff would forget about e felt horrible for the staff too many people to help. a.m. nursing assistant (NA)-E rt, used the call light for able to let the staff know of ated R66 needed extensive or bed mobility, transfers, bathing and personal hygiene. as not able to assist R66 up und 8:00 a.m. due to a staffing ted she felt horrible not being id had told her she would help could. 3 a.m. registered nurse nator (RNAC) stated she was rred to get up at 6:00 a.m. The 66's call light had been on the when she arrived at work and 8:00 a.m. the would expect residents ionored, as it was in the	F 2	42			

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		& MEDICAID SERVICES			NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) G	DATE SURVEY COMPLETED	
		245313	B. WING		04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIC DATE	
F 242	Continued From pa	ge 10	F 242	2		
	assisted R66 out of	bed at least one day of the ated she felt R66's preferences				
		requested regarding honoring the RNAC referred the the s.				
F 253 SS=E	483.15(h)(2) HOUS MAINTENANCE SI		F 253	3	6/8/16	
	maintenance servic	ovide housekeeping and ces necessary to maintain a nd comfortable interior.				
	This REQUIREMEI	NT is not met as evidenced				
	Based on observation review the failed to	tion, interview and document maintain a clean and sanitary vent unnecessary odors for 2 cility.		1. Both wings in the facility have maintained a sanitary, orderly, and comfortable environment to prevent unnecessary odors. Mattresses were		
	Findings include:			removed and replaced for all residents identified. R30 had an additional bath scheduled weekly and diet intake was		
	General Environme must provide the re	ed policy, Maintaining the ent, identified housekeeping esidents with clean and		reviewed and changes were implement to diet. Rooms identified with odor concerns had floors stripped and waxe	ed.	
	floors, walls, ceiling	gs, and the cleanliness of the is, furniture, showers, toilets ted to the comfort and sident.		Toileting plans and needs were review for all residents identified and care plan were updated as indicated.		
	On 4/25/16, at 1:00 urine odor was han	p.m. a strong, concentrated ging in the air immediately ront door of the facility.		2. The entire facility will maintain a sanitary, orderly, and comfortable environment to prevent unnecessary odors. Weekly cleaning schedule/dutie	es	
		p.m. during the initial facility y smell of concentrated urine		were reviewed and updated by housekeeping management. Executiv Director/Designee completes daily wal		

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED	
		245313	B. WING			29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE	2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 253	Continued From pa	ae 11	F 25	3			
		east and west resident		through of facility to ide cleaning concerns. An immediately corrected.			
	and R30's room an strongly of concent On 4/26/16, at 9:42 stated the entire we urine. On 4/27/16, at 1:05 strongly of urine an On 4/27/16, at 2:00 was aware of R30's "R30's stinky proble hadn't tried anythir but they really need was aware R30 had had been done. NA bad feminine odor. bought R17 feminir own money, but co resident odor control	e a.m. family member (FM)-A est hallway always smelled of 5 p.m. the west hallway smelled d stool. 9 p.m. NA-B stated leadership s urine odor and had called it em." She stated the facility ng to control R30's urine odor ded to. She stated everyone d an odor problem but nothing A-B stated R17 used to have a NA-B stated she went and ne hygiene products with her uldn't afford to buy every		 Re-educate staff on a an odor has been ident room odor audits will be ED/Healthcare Supervi audit is completed by v assessing individual roor room audits are complet facility management to needs and rooms have Any negative findings a audit will be addressed Audits from the prior we with management team of concerns and need f Results will be revie Identified areas of concaddressed and needed discussed and implement 	ified. Resident e completed by sor/Designee. The isualizing and oms. Resident eted weekly by identify cleaning good appearance. It the time of the immediately. eek are reviewed to identify areas for further actions. wed at QAPI. cern will be changes will be		
	director (ESD) stat responsible for the resident rooms unti p.m. it was up to th stated housekeepir cleaning urine as u fluid and the NAs w biohazard cleaning are cleaned daily, e day, and once a mo cleaned. She stated R22, R30 and R34	red housekeeping was cleaning and maintenance of il 2:30 pm each day. After 2:30 e NAs to clean up spills. She ng was not responsible for rine was considered a bodily vere responsible for any . She stated resident rooms each hall is completed every onth each room is deep d she was aware R17, R19, s rooms had urine odor ed at some point she would					

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		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245313	B. WING			04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - M	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
0(0)15		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	4	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	Continued From pa	age 12	F 2	253			
		of a R17's recliner as she felt					
		of odor on the west wing. The					
		room had a urine odor related e on his rug in the past. She					
	stated R30's fleece	e blankets, body pillow,					
		Ichair smelled of urine and					
		there was a layer of grime ess that needed to be					
		rther stated she had a lot of					
		d replace R30's items that					
		he stated when you got close					
		oms there was a urine odor. the room floors need to be					
		ors were a source of urine					
		hen urine spilled onto the floor					
		vax if it was not cleaned up it					
		D said they needed to look at dthe entire east and west					
		done. She stated the last time					
		ked was 8/15, and before that it					
		since the floors had been					
	currently doing was	cknowledged what they are					
	contentity doing wat	hot working.					
		p.m. the environmental tour					
		h the executive director (ED),					
		ne maintenance director (MD). Iu can usually smell urine right					
		R34's room. ESD stated they					
	could clean R34's	floor mat daily to better control					
		ne East side. The ESD stated					
		d of body odor and stated she					
		eded to look at the mattress, ner and try to replace them.					
		elt the odor in R19's room was					
		n his wheelchair, and they					
		Ichair cleaning and wiping off					
		D director stated R22's room odor and there was nothing					

Facility ID: 00930

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PRINTED: 10/27/2016 FORM APPROVED

		& MEDICAID SERVICES				0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245313	B. WING _		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 253 F 282 SS=D	they could do. The smelled of body and stated they would c replacing R30's flee R30's room had sm The ESD stated the that had urine spille them up to clean ur did not have any int odors and that he le On 4/28/16, at 4:29 (DON) stated she e and odor free at all stated she was una urine odor problems were identified, the individualized with c DON confirmed R3 toileted every 2 hou registered nurse co interview. The RNA was totally depende care. The RNAC sta urine and stool odo could clean rooms, often to better contr 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b accordance with ea care.	ESD stated R30's room d urine odor. The ED and ESD heck with the family about ece blankets. LPN-A stated ielled since he was admitted. ay used to spray off floor mats d on them, but would now lift inderneath. The MD stated he erventions in place for the eff that up to the ESD. p.m. the director of nursing expected the facility to be clean times with no exceptions. She ware of any residents with s. She stated If odor problems resident's care plan would be odor control interventions. The 0's care plan was to be ins. The DON called in the ordinator (RNAC) to join the C and DON confirmed R30 ent on staff for incontinence ated she was aware of R30's r, and stated she felt they chairs and equipment more of the odor. RVICES BY QUALIFIED	F 24			6/8/16

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TATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
			A. BUILDI	NG _			
		245313	B. WING			04/2	29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 282	review the facility fa 2 of 4 residnets (R2 of daily living, urina residents (R24) rev urinary incontinence Findings Include: Review of R24's ca identified R24 was program every 2 ho were to refer to R2- repositioning needs various interventior mattress (added 2/ weekly skin checks facility policy. On 4/26/16, during 1:44 p.m. to 4:40 p bed on her right sic assisted to reposition observation. -At 1:44 p.m. R24 w right side with an a R24's eyes were cl her chest and the b torso. -At 2:32 p.m. R24 r right side in bed, ar chest and a blanke staff were observed	tion, interview and document ailed to follow a plan of care for 24, R30) reviewed for activities ary incontinence and 1 of 4 riewed for pressure ulcers and	F 2	82	 Resident R24 and R30 care pla were reviewed and revised as indi and are receiving care per care pla related to activities of daily living, u incontinence and in addition R24 r to altered skin integrity and urinary incontinence. To ensure residents plan of care being followed we identify changes daily clinical start up and update car plans and NAR sheets with identified changes. Re-educate staff on importance timely repositioning and following interventions per individual care pla Random weekly audits on toileting repositioning per care plan interven to be completed by DNS/designee. Results will be reviewed at QAF Identified areas of concern will be addressed and needed changes w discussed and implemented. 	cated in urinary elated e are at are ed of ans. and ntions	

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STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
				G		
		245313	B. WING		04	/29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 282	to mid torso with a walk up and down i but did not enter R2 observed to offer a -At 3:34 p.m. R24 r right side in bed, ey to mid torso with a snacks to various r NA-A walked past I not stop or enter R2 -At 4:03 p.m. NA-D hallway past R24's R24's room. NA-D enter R24's room. -At 4:32 p.m. R24 r her right side, eyes to mid torso with a observed to offer a -At 4:40 p.m. R24 r her right side, eyes blanket covering he nursing (DON) was room at this time at R24 had not been r 4:40 p.m. a total of On 4/27/16, during 8:33 a.m. to 11:07 a seated in her whee	blanket. NA-A was observed to the hall in front of R24's room, 24's room. No staff were ssistance. remained lying, tilted on her yes were closed and covered blanket. NA-A was passing out esidents on R24's hallway. R24's room, however NA-A did 24's room. and NA-F walked down the room and briefly looked into and NA-F did not stop, talk or remained lying in bed, tilted on were closed and was covered blanket. No staff were ssistance or enter R24's room. remained lying in bed, tilted on were closed and had a er to mid torso. The director of a observed to enter R24's nd shut the door. repositioned from 1:44 p.m. to 2 hours and 56 minutes. continuous observations form a.m., R24 was observed lchair without being offered, or on during the entire	F 28	2		

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STATEMEN		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245313	B. WING		04	/29/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		/20/2010
GOLDE	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 282	wheeled R24 to the R24 to a table in the NA-A proceeded to breakfast. R24 rem until 9:03 a.m. when activity. -At 9:22 a.m. R24 re wheelchair in the activity. -At 10:16 a.m. NA-A following the activity wheelchair with her the wheelchair betw inside of the room. would be coming to NA-A immediately e offer assistance wit -At 10:39 a.m. R24 wheelchair inside he (RN)- A was observed removed a mechan was stationed at the not offer or assist R -At 10:55 a.m. R24 wheelchair inside he closed and head was chest position. No s assistance with rep -At 10:58 a.m. NA-C attempted to wake and chin was restin R24 a shower whice	dining room and assisted e front of the dining room. o assist R24 with eating her ained seated in the wheelchair is staff wheeled her to a group emained seated in the staff wheeled her to a group emained seated in the staff wheeled her to a group emained seated in the staff wheeled R24 was seated ind listened to the news which ivity director. A wheeled R24 to her room y. R24 was seated in the eyes closed. NA-A positioned yeen her bed and the wall NA-A stated the bath aid get R24 shortly for a shower. exited the room and did not h repositioning at this time. remained seated in her er room. Registered nurse red to enter R24's room, ical lift from her room which e end of R24's bed. RN-A did i24 with repositioning. remained seated in her er room. R24's eyes were as dropped down in a chin to staff were observed to offer	F 2			

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		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	assist R24 with rep	ositioning.	F 282			
	wheelchair. NA-C a and offered a show shower room in her to stand with a med R24's incontinent b moderate amount of observed on R24's area measured app (cm) long, 1 cm wid border which was re could not be visual thick whitish matter ulcer was pink and the open area on R confirmed R24's ind soiled. NA-C confirm with repositioning p	repositioned from 8:33 a.m. to				
	On 4/27/16, at 8:07 unable to turn herse assistance to turn a hours in a sitting ar staff needed to anti severe cognitive im was aware R24 had for at least 3 month recent changes to F last few months oth mattress. On 4/27/16, at 11:0 been really busy wi	f 2 hours and 34 minutes. Y a.m. NA-A stated R24 was elf in bed and required staff and reposition at least every 2 nd lying position. NA-A stated icipate R24's needs due to upairment. NA-A stated she d had the sore on her coccyx ns. NA-A was not aware of any R24's plan of care within the her than an air alternating 19 a.m. NA-C stated she had th various residents baths and to start R24's shower right				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245313	B. WING			1/00/0010		
NAME OF	PROVIDER OR SUPPLIER	240010		STREET ADDRESS, CITY, STATE, ZIF		/29/2016		
GOLDEN	N LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE		
F 282	including reposition due to not enough with another bath. not enough staff in were assisted with On 4/27/16, at 11:1 had not repositione On 4/27/16, at 11:1 unable to turn hers repositioning every her left side at all d hip. RN-A stated th had been there for improved and wors few months. RN-A located on a bony p On 04/28/2016, at nursing (DON) con directed facility stat based on assessed hours. The DON st reposition R24 time requested to the Do provided by the DC Upon review of the Care Plan dated 4/ interdisciplinary can provision of care an maintain the highes and psychological of	she felt many residents cares, ning, were not completed timely staff. away due to an issue NA-C stated she felt there was the facility to ensure residents repositioning timely. 0 a.m. NA-A confirmed she ed R24 since prior to breakfast. 1 a.m. RN-A stated R24 was elf in bed, required 2 hours and could not be on ue to an abscess on R24's left e ulcer on R24's right coccyx quite a while and had sened multiple times in the past a confirmed R24's ulcer was brominence (coccyx). 9:04 a.m. the director of firmed R24's care plan ff to assist R24 to reposition d need, which was every 2 ated she would expect staff to ely. A copy of the grid was ON and a copy was not	F 24	82				

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		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING			04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	2 of 4 residents (R2 of daily living, urina residents (R24) rev urinary incontinence Findings include: R30's care plan dat occasionally inconti incontinent of blador to improve bladder than 2 episodes of and less than 2 epis per week. The care was on a scheduled staff to assist him w offered toileting eve indicated staff were symptoms of urinar odors. On 4/25/16, at 5:07 overwhelming smel filled R30's room. T and coming from R On 4/26/16, at 1:58 and R30's entire ro concentrated urine. -04/26/16, 2:27 p.m position. -3:02 p.m. nursing a R30's room and pla on bedroom counte room. -04/26/16, 3:25 p.m room when licensed opened R30's bedro	24, R30) reviewed for activities ary incontinence and 1 of 4 iewed for pressure ulcers and e. ted 4/27/16 identified R30 was inent of bowel and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day, sodes of bowel incontinence e plan further identified R30 d toileting program, required 2 with toileting, and was to be ery 2 hours. The care plan e to report any signs or by tract infection including f. p.m. there was an II of concentrated urine which the smell was heavy in the air 30's body. a p.m. R30 was in bed asleep om smelled strong of	F 2	282			

Facility ID: 00930

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	KIN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245313	B. WING			/20/2016
NAME OF	PROVIDER OR SUPPLIER	210010		STREET ADDRESS, CITY, STATE, ZIP CODI		/29/2016
GOLDE	N LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 282	immediately enterer R30's roommate w -04/26/16, at 4:03 p R30's room, peeke down the hallway t -04/26/2016 4:32 p asleep in the same -04/26/2016 4:32 p and stated she just confirmed R30's built. On 4/27/16, at 7:08 seated in his whee hallway. R30's root urine and other boot On 4/27/16, at 7:08 smelled sickening On 4/26/16, at 9:42 stated there was m had to go to the ba call light and they w she had to physica and told them, "R3 FM-A stated R30's of urine. FM-A stat change R30 during smelled so strong On 4/27/16, at 1:11 always incontinent She stated R30 co and urine and was incontinent cares. R30's urine odor by and stated she felt	 ad R30's room and provided with a snack and left the room. p.m. NA-D and NA-F passed and in and continued to walk owards nursing station. p.m. R30 remained in bed a position. p.m. NA-A exited R30's room to changed R30's brief and rief had both urine and stool in B a.m. R30 was in his room load body smelled of strong dy odor. 5 p.m. R30's room and body with urine and stool. 2 a.m. family member (FM-A) hany times R30 had told her he throom, she tuned on R30's waited for over an hour until lly go and find a staff person 0 had to use the bathroom." entire hallway always smelled ed she has asked staff to g a family visit because he 	F 28	82		

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		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING			04/;	29/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - MI	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	smelled of urine, ar very strong. NA-A R30 hadn't been to minutes yesterday of and stated they wor confirmed R30's ca needed to be toilete On 4/27/16, at 2:00 be changed every 2 it is R30's pattern to brief every time he R30 always smelled was so thick and st was aware of R30's stinky problem." NA assistance with incourine every day. Sh on time and get on to aware that R30 sm done. On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake at She stated staff we benefit from more t there just wasn't tim bath a week becaus On 4/28/16, at 11:1	nd stated R30's urine smelled stated she was unaware that ileted for 2 hours and 40 during continuous observation, uld have to work on that. She are plan and stated R30		82			

Facility ID: 00930

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		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	resided. LPN-A stat a load for just those the DON and ED ar to adequately care west side. LPN-A st hours and 40 minut on the west side. On 4/28/16, at 4:06 interview FM-A stat to go to the bathroo take him when he s was upset. FM-A st smelled of urine an also complained ab R30's cares and gr because the facility On 4/28/16, at 4:29 resident was identif that resident's care with odor control int R30's care plan wh toiled every 2 hours on staff for incontin Upon review of the Managment/Bladde 6/9/15 identified a s with toileting times a avoid UTI and skin morale, dignity, and function as possible plan for each reside resident's schedule	ted she felt it was too heavy of e 2 and had went to went to nd told them they needed help for all of the residents on the tated R30 wasn't toileted for 2 tes because of the lack of staff 6 p.m. during follow-up ted R30 had to wait, and wait om. FM-A stated they just don't says he has to go and FM-A cated most of the time R30 d other family members have bout his odor. FM-A stated ooming weren't getting done was short staffed. 9 p.m. DON stated If any fied with urine odor problems, plan would be individualized terventions. DON confirmed ich included R30 was to be s, and was totally dependnet ent cares. facility policy, Incontinence er Function Guidelines dated schedule would be developed specific to each resident to problems and to improve d to restor or maintain bladder e. The policy indicated the care ent would include each s.	F 282			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION	(X3) DATI	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED	
		245313	B. WING _		04/2	29/2016	
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 282 F 309	interdisciplinary car provision of care ar maintain the highes and psychological v	ge 23 e plan guided the facility in the of services to attain or st practible physical, mental vell being of each resident. CARE/SERVICES FOR	F 28 F 30			10/18/16	
SS=G	provide the necessa or maintain the high mental, and psycho	EING receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment					
	by: Based on observat review, the facility facomprehensive ass non-pressure relate consistently implem promote healing an further non-pressur 2 residents (R24) w moisture associated buttocks. R24 susta of timely repositioni incontinence to kee The findings include R24's quarterly Min 3/1/16, identified R2 impairment and had dementia, diabetes	essment related to a ed skin ulcer and failed to nent assessed interventions to d prevent the development of e related skin ulcers, for 1 of vith a chronic history of open d skin damage (MASD) on ained actual harm due to lack ng and care for bladder up the area clean and dry.		 Resident R24 skin plan of care been reassessed. Care plan has reviewed and is receiving skin car the assessment. All residents identified needing assistance with repositioning are r care per care plan with weekly UD reviews. Every resident has a wer review completed and skin alterati issues identified are addressed, p notified and a plan is individualized each resident need. Re-educated all staff on skin int guidelines, identification, assessm proper notification to the MD and I update and implement the plan of Policies on skin care guidelines re with all nursing staff. Random aud 	eceiving A ekly skin on hysician d per egrity ent, how to care. viewed		

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED	
				i			
		245313	B. WING		04/29/2016		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 309	for all activities of d identified R24 had bed and chair, and repositioning progra had no skin probler Review of R24's pr Assessment (CAA) was at risk for skin mobility and inconti repositioning progra CAA also identified concerns related to disorder in which flu- skin, not generally a R24's care plan rev was on a turning ar hours in wheelchain R24's assessment Also for Focus are bowel and bladder, bowel and bladder, Interventions includ schedule toileting p repositioning. R24's interventions of a p (added 2/19/16) an checks and skin as On 4/26/16, during 1:44 p.m. to 4:40 p bed on her right sid assisted to repositio observation (a total	laily living (ADL's.) The MDS a pressure relieving device in was on a turn and am. The MDS identified R24	F 309	risk for pressure ulcer audit and repositioning audits to be comple- the DNS/designee. 4. Results will be reviewed at QA	-		

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	()		E CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _		COM	PLETED
		245313	B. WING			04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - MEADOW LANE					209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	R24's eyes were cl her chest and the b torso. -At 2:32 p.m. R24 r right side in bed, ar chest. No staff were -At 3:02 p.m. R24 r right side in bed, ey assistant (NA)-A wa down the hall in fro enter R24's room. I assistance. -At 3:34 p.m. R24 r right side in bed, ey passing out snacks hallway. NA-A walk NA-A did not stop of -At 4:03 p.m. NA-D hallway past R24's R24's room. NA-D enter R24's room. -At 4:32 p.m. R24 r her right side, eyes observed to offer a -At 4:40 p.m. R24 r her right side, eyes nursing (DON) was room at this time an	ir alternating mattress in place. osed, her arms were across planket was covering her to mid remained lying, tilted on her rms were crossed over her e observed to offer assistance. remained lying, tilted on her yes were closed. Nursing as observed to walk up and nt of R24's room, but did not No staff were observed to offer remained lying, tilted on her yes were closed. NA-A was s to various residents on R24's ed past R24's room, however, or enter R24's room. and NA-F walked down the room and briefly looked into and NA-F did not stop, talk or remained lying in bed, tilted on were closed. No staff were ssistance or enter R24's room.	F 3	09			
	8:33 a.m. to 11:07	a.m., R24 was observed Ichair without being offered, or					

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STATEMEN		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/29/2016	
		245313	B. WING _			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 309	assisted to reposition observation (a total nor checked for incr assistance. -At 8:33 a.m. R24 w with a seat cushion NA-A wheeled R24 assisted R24 to a tar room. NA-A procee her breakfast. R24 wheelchair until 9:0 to a group activity. -At 9:22 a.m. R24 re wheelchair in the activity. -At 9:22 a.m. R24 re wheelchair in the activity. -At 10:16 a.m. NA-A following the activity. wheelchair with her the wheelchair betw inside of the room. would be coming to NA-A immediately e offer assistance wit check for bladder/b -At 10:39 a.m. R24 wheelchair inside her (RN)-A was observer removed a mechan was stationed at the not offer or assist R	on during the entire of 2 hours and 34 minutes) ontinence or offered toileting was seated in a wheelchair in place in her room. to the dining room and able in the front of the dining ded to assist R24 with eating remained seated in the 3 a.m. when staff wheeled her emained seated in the ctivity room. R24 was seated nd listened to the news which ivity director. A wheeled R24 to her room y. R24 was seated in the eyes closed. NA-A positioned yeen her bed and the wall NA-A stated the bath aide get R24 shortly for a shower. exited the room and did not h repositioning at this time or	F 30	09		

Facility ID: 00930

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TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245313	B. WING		. 04	/29/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STAT		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETIC DATE
F 309	assistance with reprinced assistance with reprinced incontinence. -At 10:58 a.m. NA-C attempted to wake incontinence incontinence. -At 11:07 aam. R2 wheelchair. NA-C a and offered a show shower room in her to stand with a mec R24's incontinent by moderate amount of observed on R24's area measured app (cm) long, 1 cm wid border which was recould not be visually thick whitish matter ulcer was pink and the open area on R confirmed R24's incontinence. On 4/27/16, at 8:07 unable to turn herse assistance to turn a staff needed to anti-severe cognitive im was aware R24 had	ge 27 taff were observed to offer ositioning or check for C entered R24's room and R24. R24's eyes were closed. a shower which she declined. eft R24's room and did not with repositioning or check for 4 remained seated in her nd RN-A entered R24's room er. NA-C wheeled R24 to the wheelchair and assisted R24 hanical lift. NA-C removed rief which was soiled with a f urine. An open area was right side of coccyx. The open roximately 2.5 centimeters le, had an irregular shaped ed and raised. The wound bed zed as it was covered with a . The skin surrounding the blanchable. RN-A confirmed 24's right coccyx and continent brief was moderately A-C confirmed she had not epositioning or checked for e prior to the shower. a.m. NA-A stated R24 was elf in bed and required staff nd reposition at least every 2 d lying position. NA-A stated cipate R24's needs due to pairment. NA-A stated she I the sore on her coccyx for at -A was not aware of any	F 3	09		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION). 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		G	CO	MPLETED
		245313	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - M	IEADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	recent changes to last few months of mattress. On 4/27/16, at 11:0 been really busy w had not been able away. NA-C stated including reposition due to not enough there was not enou- residents were ass On 4/27/16, at 11:1 had not repositione On 4/27/16, at 11:1 unable to turn hers repositioning every her left side at all of hip. RN-A stated th coccyx had been to improved and wors few months. RN-A located on coccyx current measurem centimeters (cm) loc could be determine (non-viable yellow, tissue; usually moi mucinous in textur the base of the wo throughout the wor bed. RN-A confirm	R24's plan of care within the her than an air alternating 09 a.m. NA-C stated she had with various residents baths and to start R24's shower right a she felt many residents cares, ning, were not completed timely staff. NA-C stated she felt ugh staff in the facility to ensure sisted with repositioning timely. 10 a.m. NA-A confirmed she ed R24 since prior to breakfast. 11 a.m. RN-A stated R24 was self in bed, required (2 hours and could not be on due to an abscess on R24's left here for quite a while and had sened multiple times in the past A confirmed R24's ulcer was area. RN-A indicated the ents of R24's ulcer were 2.5 ong and 0.7 cm wide, no depth ed due to slough tissue tan, gray, green or brown st, can be soft, stringy and e. Slough may be adherent to und or present in clumps und bed) present on the wound ed R24 was at risk for re ulcers due to pressure,		θ		

Facility ID: 00930

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	COI	COMPLETED	
		245313	B. WING		04/29/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
GOLDEN	LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 309	coccyx or more on aware R24 had rec buttocks. MD stated assisted to be repo hours. MD stated R go over 2 hours and policy for reposition he had visualized F at that time identifie ulcer. At that time th R24's medical cond the last 3 months a assistance. MD sta was not very good a needs when change stated he had cond communication, lea over rate within the that staff lacked RN and lacked training The MD provided u the provided's recei deficiencies and as dispute resolution p provided by the MD diagnosis of [R24] f been made in error indicated that in acd medical resource, if caused by shear ef is excessive moistu areas other than the As [R24] is incontin conditions could ex	rea was directly on R24's right the sacrum. MD stated he was urrent open areas on her d he would expect R24 to be sitioned routinely, every 2 224's repositioning should not d stated the facility had a sing residents. MD confirmed R24's wound in March and had ed the open area as a pressure he MD also stated he felt dition had overall changed in nd now required more ted he had concerns nursing about re-assessing residents' es in condition occurred. MD erns with nursing idership and high staff turn last year. MD stated he felt J management in the facility with clinical assessments. pdated information following pt of their statement of a part of an IDR (informal process). Updated information 0 dated 5/20/16, indicated his naving a pressure sore had . The information provided cordance with "Well-accepted t describes level I erosions as fect in a situation which there ire and often these occur in ose with a bony prominence. ent of urine and stool, those ist in the arc of the area of the and I feel that a level I erosion n accurate description of the	F 3				

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	COMPLETED	
		245313	B. WING		04	/29/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=		
GOLDEN LIVINGCENTER - MEADOW LANE			2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 309	Continued From pa	age 30	F 309	9			
	On 04/28/2016, at 9:04 a.m. the director of nursing (DON) and the executive director (ED) stated they were unaware R24's MD had diagnosed R24's coccyx sore as a pressure ulcer. The DON stated she did not feel R24's coccyx ulcer was a pressure ulcer, but an "erosion," (surface material, such as skin, broken down by external factors such as moisture, pressure and friction). The DON stated the facility nurses did not use the Resident Assessment Instrument (RAI) to identify pressure ulcers but did use a facility grid as a guideline. The DON stated she expected the facility RNs to complete weekly assessments on wounds. The DON confirmed R24's care plan directed facility staff to assist R24 to reposition based on assessed need, which was every 2 hours. The DON stated she would expect staff to reposition R24 timely. A copy of the grid was requested to the DON and a copy was not provided by the DON.						
	completed R24's s coccyx ulcer. RN-A have slough type ti surrounding skin w measurements of 1 cm x 0.9 cm, not a the wound bed not she felt R24's ulce R24's weekly wour to 4/21/16, reveale -On 3/16/16, identi on the coccyx whic	nd assessments from 3/16/16,					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	mattress and a whe -On 3/23/16, identif measured 4 cm x 1 tissue in the wound identified current in Calmoseptine creat -On 3/30/16, reveal measured 2.5 cm x tissue in the wound defined. -On 4/21/16, reveal measured 2.5 cm x tissue in the wound defined. -On 4/21/16, reveal measured 2.5 cm x tissue in the wound defined. The assess interventions of pre wheelchair cushion program and protei The assessments lawound. The assess factors, and an ass ulcer. R24's weekly skin r 4/27/16, revealed th -On 12/22/15, skin buttock cheek was applied. -On 2/1/16, continu sacrum with no sign -On 2/2/16, continu	m,) a pressure redistribution eelchair cushion. fied R24 coccyx ulcer cm and had 100% slough bed. The assessment terventions application of m after each incontinence. led R24's coccyx ulcer c 0.7 cm had 100% slough bed, wound margins were led R24's coccyx ulcer c 1.0 cm had 100% slough bed, wound margins were essment identified current essure redistribution mattress, a, specific turn/reposition in supplements. acked identification of type of sments also lacked causative sessment/analysis of R24's	F 309			

Facility ID: 00930

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		APPROVED
		& MEDICAID SERVICES	, 			MB NO.	0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(-)	E SURVEY IPLETED
		245313	B. WING			04/:	29/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLÉTION DATE
F 309	Continued From pa	ine 32	E S	309			
	infection.	90.02		100			
	-On 2/16/16, had a sacrum.	a pre-existing open area on the					
	-On 3/1/16, had a p continued to be ope	pre-existing open area which en on the buttocks.					
	which was covered foam dressing, desi exuding chronic and secondary healing v	small open sore on buttocks with Mepilex (is an all-in-one igned for a wide range of d acute wounds as well as wounds,) bandage, changed I prn. The skin review revealed e-existing.					
	-On 3/6/16, had a p buttocks.	pre-existing open area on the					
		pre-existing open area on covered with Mepilex bandage.					
	the buttock which m	nued to have an open area on neasured 3 cm in diameter, as pink and the area was					
		ued to have a pre-existing uttocks which measured 4 cm d the sore was pink.					
	open area to the co	ued to have a pre-existing occyx which measured 2.5 cm ow and had slough covering					
		pre-existing open area on the sured 2.5 cm x 0.7 cm, had ring the wound bed.					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · ·	E SURVEY PLETED
		245313	B. WING			04/:	29/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME				2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 33	FS	309			
	-On 4/14/16, had a buttocks.	pre-existing sore on the					
	-On 4/20/16, lacked ulcer on the coccyx	d any documentation of R24's					
	measured 1.7 cm x	a pre-existing open area which 0.9 cm 1.0 cm and the skin tify the location of the open					
	comprehensive wou	d lacked documentation of a und assessment completed for hich developed on 12/22/15.					
	R24's physician pro 3/10/16, revealed th	ogress notes from 2/18/16, to ne following:					
	in her neurological	ied R24 had a gradual decline status and in her function. The R24 had any skin concerns.					
	for a concern regard that was not healing a pressure sore on note identified the p cm x 2.0 cm and had devitalized tissue the usually black, brown appear scab like,) of revealed the current	led R24 was seen in the facility ding open sore on buttocks g. The note identified R24 had the right side gluteal fold. The pressure sore measured 4.5 ad a layer of eschar (dead or hat is hard or soft in texture; n, or tan in color, and may over the top. The note further at treatment was a Mepilex sing felt was keeping the					
	measures tissue to	nce test (TTT, a test which lerance for sitting and lying to ate repositioning schedule)					

Facility ID: 00930

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PRINTED: 10/27/2016

	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION	0		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG			PLETED
		245313	B. WING			04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CI 2209 UTAH AVENUE			
GOLDE	N LIVINGCENTER - ME	EADOW LANE		BENSON, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 309	dated 3/29/16, revessitting, however, do not completed. R24's TTT dated 4/ skin was red and bl R24 was to be repo- lying position, howe sitting TTT was com Review of R24's sig transcribed date of written note indicati cream" to coccyx et healed. R24's physio order to document to computerized electra assessment, as wa and a description of R24's electronic nu 12/30/15, to 4/27/16 -On 12/29/15, had a included a current t application of Mepil -On 12/30/16, a car with R24's family. T was in good condition -On 2/17/16, had 4 area. The note reve characteristics: coc appeared as an ope Left buttocks meast with no drainage. Left red area Right inn	A/16, revealed at lying R24's anched. The TTT revealed sitioned every 2 hours in a ever, no documentation for npleted. and physician orders with a 4/14/16, revealed a hand ng R24 was to have "Butt rosion BID (twice daily) until ician orders also revealed an wound status weekly in a ronic medical record would s to include measurements f the wounds on buttocks. rsing progress notes from 6, revealed the following: a sore on the buttocks which reatment of cleansing and ex boarder. re conference had been held the note identified R24's skin on.	F3	09			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Calmoseptine was a revealed R24 was r 2 hours as was to la (relieve pressure to -On 3/1/16, a quart identified R24 had a scratch mark, a line usually covered with her left buttock and revealed current int alternating mattress The note identified breakdown based of measure risk for de 14. -On 3/1/16, a quarte identified R24 had of which were blanch excoriation. The not for pressure ulcers non-pressure skin of need for assist with periods, bladder an incontinence. The r staff to anticipate he repositioning every wheelchair. The not ulcer interventions i mattress on bed an in the wheelchair. -On 3/3/16, reveale wound was change soiled. The note did characteristics of R	applied. The note further repositioned and toileted every ay on her side to offload o area). terly bowel and bladder review an area of excoriation (a ear break in the skin surface, th blood or serous crusts) on d in the "fold." The note terventions of an pressure s and treatment per MD order. R24 was at high risk for skin on a Braden score (tool to eveloping pressure ulcers) of rerly tissue tolerance review open areas on the buttocks able and R24 was prone to ote identified R24 was at risk related to a history of concerns, limited mobility, n mobility, sitting for long nd occasional bowel note identified R24 required	F 309			

		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa cm and had a deep blanchable, had a fi the dressing. The n recommended to le apply Calmoseptine -On 3/23/16, reveal been held with R24 R24 had skin conce were identified as e -On 4/5/16, had a p buttocks which mea cm. was without sig The note lacked an location of the wour -On 4/7/16, sore or cm x 0.5 cm. The n characteristic or loc -On 4/10/16, contir the coccyx, reddene and did not appear -On 4/13/16, had 2 "watched." The note looked the same. A R24's sore on butto was red and withou -On 4/14/16, buttoo remained red. The repositioned every fare.	Ige 36 ored wound bed, area was oul odor and drainage covered iote revealed R24's MD eave the dressing off and to eave the buttocks which eaver 2.8 cm x 0.8 cm x 0.2 gns or symptoms of infection. y further characteristics or nd. In the buttocks measured 1.5 tote lacked any further eation of the wound. In ued to have open an area on ed areas on hips and buttocks worse. It "areas" currently being e revealed R24's coccyx another later note revealed boks measured 4 cm x 2.5 cm,	F 309	DEFICIENCY)		
	coccyx erosion BID					

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		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245313	B. WING _			04/:	29/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	identify any other cl pressure ulcer. -On 4/25/16, reveal kept clean and left coccyx and repositi On 4/28/16, during copy of a facility for appointment, which by a Nurse Practitic examined R24's ulc was not on a bony p erosion, not a press Review of an undat Clinical Services Sk revealed a facility p comprehensive app conditions, decreas formation by identify implementing appro- promote healing of The policy directed optimal care to pror wounds by routine a documentation, imp and monitoring of c interventions. The definition of a r damage (MASD) as Facility Resident As User 's Manual ver as a chronic erosion skin damage (MAS	 1 cm. The note did not haracteristics of R24's ed R24's coccyx had been open to air, was kept off of her oned every 2 hours. survey the ED provided a m titled Problem sheet, Future revealed R24 had been seen oner (NP)-C at that time. NP-C cer and had indicated the ulcer orominence and was an sure ulcer. ed facility policy titled, Golden kin Integrity Guidelines, urpose to provide a oroach for monitoring skin sing pressure ulcer, wound ying residents at risk, opriate interventions and to 	F 3	09			

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					NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	OMPLETED
		245313	B. WING		04/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From pa	age 38 s, " Moisture associated skin	F 309		
F 312 SS=D	caused by moisture caused by sustaine can be caused, for wound exudate and characterized by in occurs with or with infection. MASD is incontinence-assoc cause other condit skin areas may tou periwound moisture peristomal moisture Provision of optima identification and tr MASD can help av breakdown. " 483.25(a)(3) ADL (DEPENDENT RES A resident who is u daily living receives maintain good nutr and oral hygiene.	flammation of the skin, and out skin erosion and/or also referred to as ciated dermatitis and can ions such as intertriginous [two ich or rub together] dermatitis, e-associated dermatitis, and e-associated dermatitis. al skin care and early reatment of minor cases of oid progression and skin	F 312		6/8/16
	by: Based on observa review the facility fa incontinence cares	tion, interview and document ailed to provide timely for 2 of 4 residents (R24, urinary incontinence.		1. Resident R24 and R30 care plans were reviewed and revised as indicate and are receiving care per care plan related to activities of daily living, urina incontinence and in addition R24 relat to altered skin integrity and urinary incontinence. R30 had an additional b	iry ted

Event ID:NH3C11

Facility ID: 00930

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	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	C TIPLE CONSTRUCTION		0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		ING	· · /	PLETED	
		245313	B. WING		04/29/201		
	PROVIDER OR SUPPLIER I LIVINGCENTER - MI	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO	D BE	(X5) COMPLETIOI DATE	
F 312	Review of R24's qu (MDS) dated 3/1/16 cognitive impairment included: dementia disorders. The MDS extensive assistance (ADL's,) and was f and bladder. The M toileting plan. Review of R24's un Assessment (CAA) was totally incontine CAA identified R24 check and change repositioning. Review of R24's ca identified R24 was staff were to offer to Review of R24's qu review dated 3/1/16 frequently incontine incontinent of bowe required extensive mobility, transfers a identified R24 requi repositioning, and c incontinence pad er identified R24 had a scratch mark; a line usually covered wit her left buttock and revealed current int pressure mattress The note identified breakdown based of	arterly Minimum Data Set 5, identified R24 had severe nt and had diagnoses which , diabetes and other skin 5 identified R24 required ce for all activities of daily living requently incontinent of bowel IDS identified R24 had no inary incontinence Care Area dated 12/9/15, identified R24 ent of bowel and bladder. The required staff assistance to	F 3	 reviewed and updated as indicated address toileting and turning and repositioning schedule. 2. Staff received education on the importance of adhering to the turn repositioning schedule and toiletin schedule to ensure all residents habeen provided timely incontinence per individualized plan of care. To and repositioning schedules are completed upon admission, quarter prn with change in conditions. 3. Nursing staff have been re-educe regarding ensuring residents receit timely incontinence cares. Toiletin repositioning audits to be complete weekly by DNS/designee. Any negfindings at the time of the audit will addressed immediately. Audits from prior week are reviewed with management team to identify area concerns and need for further active. 4. Results will be reviewed at QAP Identified areas of concern will be addressed and needed changes we discussed and implemented. 	ing and g ave cares ileting erly, and cated ve g and ed gative l be om the us of ons. Pl.		

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						0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245313	B. WING _		04	/29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
GOLDEN	LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 312	Continued From pa	ige 40	F 31	2		
	1:44 p.m. to 4:40 p. bed on her right sid assisted to toilet du Although staff was entered the room o 4:40 p.m. the direct observed to enter th On 4/27/16, during 8:33 a.m. to 11:07 a seated in her whee assisted to repositio observation. Althou room following brea 10:16 a.m. R24 was the shower room at At that time R24's b with a moderate an nurse (RN)-A confir was moderately so confirmed she had prior to the shower. On 4/27/16, at 8:07 unable to turn hers assistance to turn a hours in a sitting ar staff needed to anti severe cognitive im was aware R24 has at least 3 months. If recent changes to F	gh R24 was returned to her akfast and a group activity at s not toileted until brought to t 11:07 a.m. orief was found to be soiled nount of urine. Registered med R24's incontinence brief iled. Nursing assistant (NA)-C not assisted R24 with toileting f a.m. NA-A stated R24 was elf in bed and required staff and reposition at least every 2 nd lying position. NA-A stated cipate R24's needs due to pairment. NA-A stated she s had a sore on her coccyx for NA-A was not aware of any R24's plan of care within the her than an air alternating a.m. NA-A confirmed she had				

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		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 41	F 312			
	been really busy with had not been able t away. NA-C stated including reposition due to not enough s with another bath. N not enough staff in were assisted with On 04/28/2016, at S nursing (DON) conf directed facility staf change incontinent on assessed need, DON stated she wo cares with R24 tim Upon review of the Managment/Bladde 6/9/15 identified a s with toileting times avoid UTI and skin morale, dignity, and function as possible plan for each reside resident's schedule R30's quarterly min 3/22/16, identified R3 of bowel and bladde toileting program. R30's annual bowe	facility policy, Incontinence er Function Guidelines dated schedule would be developed specific to each resident to problems and to improve d to restor or maintain bladder e. The policy indicated the care ent would include each				

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		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING			04/:	29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	incontinent of bowe checked for incontin hours, and was to r incontinent episode R30's care plan dat occasionally inconti incontinent of bladder to improve bladder than 2 episodes of and less than 2 epis per week. The care was on a scheduled staff to assist him w offered toileting eve indicated staff were symptoms of urinar odors. On 4/25/16, at 5:07 overwhelming smel filled R30's room. T and coming from R On 4/26/16, at 1:58 and R30's entire roo of concentrated urin assistant (NA)-A en clean towels and go the sink and left the outside R30's room (LPN)-A opened R3 family member (FM FM-C and LPN-A le R30's room and pro snack and left the r NA-F passed R30's continued to walk d	el and bladder and was to be nence and changed every 2 eccive good pericare after es. ted 4/27/16, identified R30 was inent of bowels and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day sodes of bowel incontinence e plan further identified R30 d toileting program, required 2 with toileting, and was to be ery 2 hours. The care plan e to report any signs or by tract infection including	F 3	312			

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		& MEDICAID SERVICES				<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		245313	B. WING		— 0	4/29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIO DATE
F 312	room and stated sh confirmed R30's bri it. During continuou toileted for 2 hours On 4/27/16, at 7:08 seated in his wheel smelled strongly of 1:05 p.m. R30's roc overwhelming smel On 4/26/16, at 9:42 many times R30 tol bathroom, she tune waited for over an h physically go and fin them, "[R30] had to stated R30's entire urine. FM-A stated s R30 during a family strongly of urine. On 4/27/16, at 1:11 always incontinent of She stated R30 cor urine and was depe- incontinence cares. R30's urine odor by and stated she felt getting some spray.	e just changed R30's brief and ef had both urine and stool in s observation, R30 was not and 40 minutes. a.m. R30 was in his room chair. R30's room and body urine and other body odor. At om and body had an I of urine and stool. a.m. FM-A stated there were d her he had to go to the d on R30's call light and they hour. She would have to nd a staff person and tell use the bathroom." FM-A hallway always smelled of she has asked staff to change visit because he smelled so p.m. NA-A stated R30 was of both bowel and bladder. histstently leaked stool and	F3	12		
	minutes on 4/26/16 they would have to R30's care plan was On 4/27/16, at 2:00 be changed "at leas	n toileted for 2 hours and 40 . yesterday NA-A further said work on that. NA-A confirmed s to toilet every 2 hours. p.m. NA-B stated R30 should st" every 2 hours. She stated it o have stool and urine in his				

Facility ID: 00930

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		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - MEADOW LANE				2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	brief every time he R30 always smelled was so "thick and s referred to it as "R3 stated R30 required incontinence care a She stated R30 was there just wasn't en On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake an She stated staff we benefit from more t there just wasn't tim bath a week becaus On 4/28/16, at 11:1 the continuous obse NA-A were respons where R30 resided too heavy a load for went to the director executive director (needed help to ade residents on the we wasn't toileted for 2 because of the lack On 4/28/16, at 4:06 interview FM-A stat go to the bathroom take him when he s she was upset. FM- smelled of urine an also complained ab	was changed. NA-B stated d of urine because his urine strong." NA-B stated staff 80's stinky problem." NA-B d total assistance with and smelled of urine every day. s not toileted on time because	F 312			

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		E & MEDICAID SERVICES	T			. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
		245313	B. WING		04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312		age 45 y was short staffed.	F 312			
F 353 SS=F	expected the facilit all times with no ex- unaware of any res- problems. She stat identified, the resid individualized with DON confirmed R3 toileted every 2 hor registered nurse as to join the interview confirmed R30 was incontinence care. aware of R30's urin Upon review of the Management/Blade 6/9/15, it identified developed with toil resident to avoid U improve morale, di bladder function as the care plan for ea each resident's sch 483.30(a) SUFFIC PER CARE PLANS The facility must hap provide nursing an maintain the highe	e facility policy, Incontinence der Function Guidelines dated a schedule would be eting times specific to each ITI and skin problems and to ignity, and restore or maintain s possible. The policy indicated ach resident would include nedule. IENT 24-HR NURSING STAFF S ave sufficient nursing staff to d related services to attain or st practicable physical, mental, well-being of each resident, as				6/8/16

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		& MEDICAID SERVICES		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG	COMPLETED
		245313	B. WING _		04/29/2016
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETIO
F 353	Continued From pa	age 46	F 35	53	
	personnel on a 24-hour basis to pro care to all residents in accordance care plans:				
		ed under paragraph (c) of this urses and other nursing			
	section, the facility	ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of			
	by:	NT is not met as evidenced			
	review the facility fa staffing was availab life and quality of ca practice had the po residing in the facili practice, the facility	tion, interview, and document ailed to ensure sufficient facility ole to meet resident quality of are needs. This deficient otential to affect all 47 residents ity. Because of the deficient or caused actual harm to R24.		1. Schedule sufficient staff resident needs to ensure ac coverage. Staff survey was identify areas of staff conce for delivering quality of care Results of survey were revie ED/DNS and additional NAI were added.	dequate completed to rns and needs to residents. ewed by
	Finding Include: R24 did not receive timely assessments and repositioning for pressure ulcer treatment and prevention due to insufficient staffing. As a result R24 was harmed, see F309.			2. Address ongoing staffing making changes as needed resident needs. Ensure floo utilizing cordless phones an to increase communication to best meet resident needs	based on or staff is id 2 way radios between staff s. Time
	hygiene as directed insufficient staffing,	ot receive timely personal d by the care plan due to , see F312 and F282.		management education was to nursing staff. DNS will re needs at clinical startup and staffing as needed.	eview staffing
		er preference for waking times d by the patient bill of rights staffing, see F241.		 Resident interview and tool to be completed weekly DNS/designee to identify is 	/ by

Facility ID: 00930

If continuation sheet Page 47 of 55

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				G		
		245313	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	04/29/2016	
	PROVIDER OR SUPPLIER	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 353	R5 and R30 were m manner as directed due to insufficient s R28's annual MDS had intact cognition assistance with toil bed mobility and oc On 4/28/16, at 3:25 staff assistance wit tried to space out h staff would be less certified nursing as able to walk with he staffed. She was or physical therapist w work week. On 4/26/16, at 9:16 stated she felt her f met due to staffing 4/28/16, at 4:06 p.n FM-A stated R30 ro bathroom and staff when he would ask R30 was left sitting to a mechanical lift received assistance a staff member to a stated R30 routinely his body. FM-A stated R30's wife if they co due to worry over F had asked facility s times a week, to as odor. FM-A stated F	ot treated in a dignified I by the patient bill of rights	F 35	 related sufficient staff. ED and DN educated staff on bringing staffing concerns to them so they can be addressed. Additional time manaresources have been presented to nursing staff. Any negative finding time of the audit will be addressed immediately. Audits from the priorare reviewed with management teidentify areas of concerns and nee further actions. Results will be reviewed at QAF Identified areas of concern will be addressed and needed changes v discussed and implemented. 	gement o the gs at the r week am to ed for Pl.	

If continuation sheet Page 48 of 55

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY	
	ST CONTLECTION		A. BUILDIN	NG		00	
		245313	B. WING _		04/29/2016		
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 353	was unaware if R3 showers to assist v On 4/27/16, at 8:56 pattern for staffing and then 3 NA's for stated the 4th NA v ago and the facility On 4/28/16, at 11:4 assists R18 to get almost daily R18 w NA-B stated she ha room a few weeks with urine. NA-B st saturated with urine stated on a routine it to the dining room residents with eatin the weekends she 12-14 hours due to most dependent re repositioning on a staffing. NA-B state would only be 2 NA evening shift. NA-E recently on 4/26/16 On 4/29/16, at 8:46 basis R60 would be beginning of her sh routinely short staff a night over into da the weekdays. NA- dependent residen checked and chang stated she had rep done time due to s	0 had received increased with the foul urine body odor. 6 a.m. NA-A stated the usual was 4 NA's on until 10:00 a.m. r the rest of the shift. NA-A vas brought in about 2 weeks had a bath aid to do baths. 46 a.m. NA-B stated she up on the days she works and ould be saturated with urine. ad brought the DON into R18's ago due R18 being saturated ated R18 continued to be e at the start of her shift. NA-B basis the NA's could not make n until 9:00-9:30 a.m. to assist ng breakfast. NA-B stated on would get frozen into staying o short staffing. NA-B stated sidents will go 3-4 hours for routine basis due to short ed on a routine basis there N's working on a day and 8 stated this occurred most	F 35	53			

Facility ID: 00930

If continuation sheet Page 49 of 55

		AND HUMAN SERVICES				FORM	10/27/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245313	B. WING			04/	29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2009 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	stated staffing level facility. RN- A state thin and would rout weekends she would hour shifts. RN-A s DON a few weeks lacking quality. RN- responded that the the amount of staff RN-A stated the NA about resident care which most recently On 4/29/16, at 12:0 (ED) stated she dic not getting done du they had added a th weeks to help as no a.m. to help with m confirmed this was but was based upo stated the facility ha and they had impro- stated she made at staff, and adjusted unlicensed nursing call-ins could result frozen to the next s	 a.m. registered nurse (RN)-A ls have been a concern at the d the staff were stretched too inely be frozen on the ld work which resulted in 16 tated she had spoken with the ago about resident cares -A stated the DON had facility census only required the facility had on the floors. A's have voiced their concerns as not getting done timely, y occurred last week. 00 p.m. the executive director in the feel residents care were the to staffing. The ED stated hird aid in the last couple of eeded from 6:00 a.m. to 10:00 orning cares. The ED not a routinely scheduled shift, n resident acuity. The ED ad been working on staffing by d significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff in a staff member being shift which could last up to a 16 	F	353			
	when asked how of rather than freezing On 4/29/16, at 12:0 and R24's cares we answering question	and the DON did not respond ften staff call-ins were replaced g staff. 05 p.m. the DON stated R30 ere not completed due to staff his for surveyors on 4/26/16, 00N confirmed the master					

If continuation sheet Page 50 of 55

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245313	B. WING			04/	29/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	schedule for the lor care units of the fac would complete ran included coming to cares on the night a DON had no conce received a complain getting done about the facility added a shift aid) in the mor routinely scheduled usual staffing patter the day shift 5:30 a evening shift, 2 NA' and 1 NA from 5:00 on the night shift fro Review of facility st and unlicensed nur 4/27/16, revealed th have the staffing nu The following incon The day shift did no identified by the ED days - day shift lack The evening shift The night shift did r identified by the ED days - the night shift On 4/29/16, at 12:1 (AD) stated they rec residents since 2/25	ng term care and board and cility. The DON stated she adom audits of cares. This the facility and observing and the evening shifts. The rns. The DON stated she nt from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short ning, however this was not a shift. The DON stated the rns were as follows, 3 NA's on m. to 2:00 p.m., 3 NA's on the s from 2:00 p.m. to 10:00 p.m. p.m. to 9:00 p.m., and 2 NA's om 10:00 p.m. to 6:00 a.m. affing schedule for licensed sing staff from 2/14/16, to he facility did not consistently imbers identified by the DON. sistencies were identified: and DON for 46 out of 60 ad 1-2 aides id not have the staffing levels and DON for for 48 out of 60 f lacked 1-2 aides not have the staffing levels and DON for 28 out of 60 f lacked 1 aide 0 p.m. the activity director ceived 3 complaints from 9/16, related to long call wait 67, R5. R5 reported being	F 3	853			

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		AND HUMAN SERVICES				FORM	: 10/27/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245313	B. WING	B. WING			29/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - MI	EADOW LANE	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 51 for staffing was requested,	FS	353	8		
F 441 SS=E	none was provided		F4	141			6/8/16
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whi (1) Investigates, co in the facility; (2) Decides what pu should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					
		ndle, store, process and as to prevent the spread of					

If continuation sheet Page 52 of 55

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	10/27/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245313	B. WING		04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
GOLDEN	LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa infection.	ge 52	, F∠	441		
	by: Based on observat review, the facility fa handwashing techn personal cares for observed. In additia a mechanical lift wa for 1 of 1 resident (Findings include: R65's admission Mi 4/15/16, identified F included dementia diabetes and arthrit had both short term problems. Further, incontinent of urine assistance for trans During observation 4:20 p.m., nursing a observed to assist I to the wheelchair. A disposable gloves of mechanical standin bed to the toilet. NA was soiled with urin disposable gloves. hands, NA-H applie and proceeded to c with wet wipes. Wi disposable gloves,	NT is not met as evidenced ion, interview and document ailed to ensure proper iques were followed during 1 of 3 residents (R65) on, the facility failed to ensure as properly sanitized after use R65). inimum Data Set (MDS) dated R65 had diagnoses which with behavioral disturbance, is. The MDS identified R65 and long term memory the MDS identified R65 was and required extensive afters and toileting activities. on 4/26/16, from 4:03 p.m. to assistant (NA)-H was R65 to transfer from the toilet at 4:03 p.m., NA-H applied on both hands and utilized a g lift to transfer R65 from the At 4:10 p.m., without sanitizing d fresh disposable gloves, leanse R65's perineal area thout removing the soiled NA-H continued to pull up hence product and pants,		 NA H has been individually re-educated regarding proper hygiene technique. Improper hygiene could adversely affect residents. During plan of correction s staff were re-educated regard hand hygiene and proper infect practices. Hand washing audits comp by each department and follow ED/DNS/Designee. Any neg- findings at the time of the aud addressed immediately. Audi prior week are reviewed with management team to identify concerns and need for further Results will be reviewed at Identified areas of concern wi addressed and needed chang discussed and implemented. 	hand hand t all taff meeting ling proper ction control leted weekly wed up by ative lit will be ts from the areas of actions. QAPI. II be	

If continuation sheet Page 53 of 55

		AND HUMAN SERVICES			FORM	10/27/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	grabbed the mecha gloved hands, and the sling when rema- remove the soiled of hands until after R6 wheelchair. At 4:18 mechanical lift into the soiled utility roo handwashing. During interview on confirmed cares we confirmed she had and sanitized her ha mechanical lift and should have taken of hands after personal further cares. NA-H product was soiled personal ca	age 53 anical lift handles with both touched the plastic buckles of oved from R65. NA-H did not disposable gloves and wash 55 was transferred to the p.m., NA-H pushed the the hallway, delivered trash to om and then performed 4/26/16, at 4:20 p.m. NA-H ere completed for R65, and not removed the soiled gloves ands prior to operating the sling. NA-H reported she off the gloves and washed her al cares before continuing 4 confirmed R65's incontinence with urine and required -H confirmed she was finished cal lift and it was ready for firmed the mechanical lift was 4/28/16, at 3:20 p.m., sessment coordinator (RNAC) expected to take off gloves and roviding perineal cares before else. Further, the RNAC stated a should be cleaned with tween each resident use.	F 441			

If continuation sheet Page 54 of 55

		AND HUMAN SERVICES			FORM	: 10/27/2016 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
245313		B. WING _		04/	29/2016		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 441	Policy dated 8/14, c hygiene after remov The facility's Cleani Resident Care Item 8/14, indicated reus	Hygiene and Handwashing directed staff to perform hand	F 44	41			

Facility ID: 00930

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: NH3C		
	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00930		
1. MEDICARE/MEDICAID PROVI (L1) 245313	DER NO.	3. NAME AND AI (L3) GOLDEN L	IVINGCENTE		DOW LANE	 TYPE OF ACTION: <u>7</u> (L8) Initial 2. Recertification 		
2.STATE VENDOR OR MEDICAIE (L2) 306920600) NO.	(L4) 2209 UTAH (L5) BENSON, N			(L6) 56215	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE O (L9) 04/01/2006	F OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 06/	17/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		12/31		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11. LTC PERIOD OF CERTIFICATI	ON	10.THE FACILITY	Y IS CERTIFIED	AS:				
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :			equirements		2. Technical Personnel6. Scope of Services Limit			
		· ·	e Based On:		3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds	62 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	· _		
13.Total Certified Beds	62 (L17)	B. Not in Comp	liance with Progra	um	5. Life Safety Code	9. Beds/Room		
		Requirements	s and/or Applied W	Vaivers:	* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKI	DOWN				15. FACILITY MEETS			
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
43	19							
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Denise Erickson, HFE	NEII	0	07/05/2016	(L19)	Mark meath			
P	ART II - TO BE	COMPLETED I	BY HCFA RE	. /	OFFICE OR SINGLE S	(L20) TATE AGENCY		
19. DETERMINATION OF ELIGIE	BILITY	20. COM	IPLIANCE WITH	I CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to			HTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligil	-				3. Both of the Above	· · · · · · · · · · · · · · · · · · ·		
2. Facility is not Engli	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNINC	G DATE	ENDING DAT	ſΈ	VOLUNTARY 00	INVOLUNTARY		
05/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	e		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
	D. Reseniu Si	aspension Date.	(L45)					
28. TERMINATION DATE:	20	. INTERMEDIARY			30. REMARKS			
28. TERMINATION DATE.	25		CARRIER NO.		50. REMARKS			
	(1.26)	00454		(121)				
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE				
	(1.22)	06/13/2016		(1.22)		NOV41		
	(L32)			(L33)	DETERMINATION APPE	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: NH3C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00930 C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS Facility ID: 00930

CCN: 24 5313

On June 17, 2016 a Post Certification Revisit was completed to verify Golden LivingCenter Meadow Lane achieved and maintained compliance with Federal participation regulations and to verify compliance related to the investigations of complaint numbers H5313026 and H5313029. Based on our revisit, we have determined the facility has corrected deficiencies issued pursuant to the survey including the substantiated complaints (H5313026 and H5313029) cited at F241, F242, F282, F312, F314 and F353, as of June 8, 2016. Refer to the CMS 2567b forms for the results of this revisit.

Effective June 8, 2016, the facility is certified for 62 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245313

July 26, 2016

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

Dear Ms. Dillon:

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 June 8, 2016 the above facility is certified for:

- 43 Skilled Nursing Facility/Nursing Facility Beds
- 19 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 5, 2016

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

RE: Project Number S5313026, H5313026 and H5313029

Dear Ms. Dillon:

On May 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 29, 2016 that included an investigation of complaint number H5313026 and H5313029. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On June 17, 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 April 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 29, 2016, effective June 8, 2016 and therefore remedies outlined in our letter to you dated May 13, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely, mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
245313 _{Y1}	B. Wing	Y2	6/17/2016	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN LIVINGCENTER - MEAD	OW LANE	2209 UTAH AVENUE				
		BENSON, MN 56215				

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

ITE	м	DAT	E	ITEM			DATE	ITEM			DATE
Y4		Y5	5	Y4			Y5	Y4			Y5
ID Prefix Reg. #	F0241 483.15(a)	Correct		ID Prefix Reg. #	F0242 483.15(b)	Correction Completed	ID Prefix Reg. #	F0253 483.15(h)(2)		Correction Completed
LSC		06/08/20	016	LSC			06/08/2016	LSC			06/08/2016
ID Prefix	F0282	Correct	tion	ID Prefix	F0312		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)	Comple	eted	Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(c)		Completed
LSC		06/08/20	016	LSC			06/08/2016	LSC			06/08/2016
ID Prefix	F0353	Correct	tion	ID Prefix	F0441		Correction	ID Prefix			Correction
Reg. #	483.30(a)	Comple	eted	Reg. #	483.65		Completed	Reg. #			Completed
LSC		06/08/20	016	LSC			06/08/2016	LSC			
ID Prefix		Correct	tion	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Comple	eted	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
ID Prefix		Correct		ID Prefix			Correction	ID Prefix			Correction
Reg. # LSC		Comple	eted	Reg. # LSC			Completed	Reg. # LSC			Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA	/mm	DATE 07/05/2	016	SIGNATURE OF SL	JRVEYOR 31256	L		date 06/17	/2016
REVIEWED BY CMS RO			DATE		TITLE				DATE		
FOLLOWUP TO SURVEY COMPLETED ON 4/29/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?								

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COMI						D: NH3C acility ID: 00930
1. MEDICARE/MEDICAID PROVIDER N (L1) 245313 2.STATE VENDOR OR MEDICAID NO. (L2) 306920600 (L2)	3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - MEADOW (L4) 2209 UTAH AVENUE (L5) BENSON, MN				56215	 TYPE OF ACTION: Initial Termination Validation 	<u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>03</u> (L7) 13 PTIP 22 CLIA		7. On-Site Visit 8. Full Survey After Co	9. Other mplaint	
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 43 (L37) (L38)	62 (L18) 62 (L17) 19 SNF 19 (L39)	X B. Not in Comp	ce With quirements	rs:	2. Tecl 3. 24 H 4. 7-D	hnical Personnel Iour RN ay RN (Rural SNF) Safety Code <u>B*</u> MEETS	EFollowing Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12) (L15)	ices Limit tor
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date : Beth Nowling, HFE NEII 06/09/2016						VEY AGENCY AP		Date:
Beth Nowling, HFE NEII 06/09/2016 (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY								
19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 1. Facility is Eligible to Participate 2. Facility is not Eligible					21. 1. 2.	Statement of Financi	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	L-1513)
22. ORIGINAL DATE OF PARTICIPATION 05/01/1986	23. LTC AGREEM BEGINNING		4. LTC AGREEMEN ENDING DATE		26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closu 02-Dissatisfactio	00	INVOLUNT 05-Fail to Mo	L30) <u>ARY</u> eet Health/Safety eet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	A. Suspension of Admissions: (L44)					03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active		
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS			
00454 (L28) (L31)								
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C	OF APPROVAL DAT	E (L33)	DETERMINA	ATION APPRO	VAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NH3C Facility ID: 00930

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

		· · · · · · · · · · · · · · · · · · ·
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

CCN: 24 5313

On April 29, 2016 a recertification survey was completed to verify Golden LivingCenter Meadow Lane maintain compliance with Federal participation regulations. Deficiencies were cited at a Scope and Severity of G, whereby correction are required. In addition during the recertification survey, Investigations were conducted, investigation of complaint numbers H5313026 and H5313029 were found to be substantiated at F241, F242, F312, F314 and F353. Investigation of complaint number H5313028 was found to be unsubstantiated. The facility has been given an opportunity to correct before remeidies would be imposed. Refer to the CMS 2567 for both health and life safety code along with the plan of correction for health. Post Certification Revisit to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 13, 2016

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

RE: Project Number S5313026, H5313026, H5313028, H5313029

Dear Ms. Dillon:

On April 29, 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. In addition, at the time of the April 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313026, H5313028, H5313029.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5313026 and H5313029 and found both to be substantiated with the following deficiencies: F241, F242, F282, F312, F314 and F535. The complaint investigation number H5313028 was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

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 June 8, 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 June 8, 2016 the following remedy will be imposed:

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

Golden LivingCenter - Meadow Lane May 13, 2016 Page 3

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

Golden LivingCenter - Meadow Lane May 13, 2016 Page 4

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 29, 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 October 29, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Golden LivingCenter - Meadow Lane May 13, 2016 Page 6

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697
							APPROVED
		& MEDICAID SERVICES		TID			. 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY IPLETED
		245313	B. WING			04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	I LIVINGCENTER - MI			2	2209 UTAH AVENUE		
GOLDEN				E	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electror be used as verificat Upon receipt of an on-site revisit of you validate that substa	of correction (POC) will serve of compliance upon the obtance. Because you are your signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with					
	complaint investiga the time of the stan An investigation of H5313029 was con	complaints H5313026 and pleted. Both complaints was siencies issued at F241, F242,					
F 241 SS=D	completed and four 483.15(a) DIGNITY INDIVIDUALITY The facility must pro-	complaint H5313028 was nd not to be substantiated. AND RESPECT OF omote care for residents in a provironment that maintains or	F 2	241			6/8/16
	enhances each res full recognition of hi This REQUIREMEN	ident's dignity and respect in is or her individuality. NT is not met as evidenced PER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electror	nically Signed						05/20/2016

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

PRINTED: 06/09/2016

TATEMEN	FOF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245313	B. WING _		04/	29/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 241	facility failed to profor 2 of 2 residents dignity. Findings include: R5's quarterly Mini 2/18/16, identified had a diagnoses w myositis and osteo R5 required extens daily living. Additio oriented. Further, t frequently incontine dated 8/20/15, indi of bowel. Review of R5's car R5 required extens standing lift for tran one staff for toiletin R5's care plan indi elimination of bowe briefs/pads for inco to provide one ass to toilet. During interview or reported he was pr assistance from sta get to the toilet for he doesn't make it because the staff of time, so he was ino there were three m facility now, but tha	age 1 w and document review the vide cares to maintain dignity (R5, R30) reviewed for mum Data Set (MDS) dated R5 was cognitively intact and which included depression, arthritis. The MDS identified sive assistance with activities of nally, the MDS noted R5 to be he MDS indicated R5 was ent of bowel. R5's annual MDS cated R5 was always continent re plan dated 9/10/13, revealed sive assistance of one staff and nsfers, extensive assistance of ng, bed mobility and bathing. cated an alteration in el and bladder, used ontinence protection and staff ist with standing lift as needed in 4/28/16, at 10:46 a.m., R5 retty independent, but required aff and the mechanical lift to bowel movements. R5 stated as often as he used to, do not answer his call light in continent of stool. R5 reported ursing assistants working at the at was not what normally ed it was because survey was	F 24	 41 1. Resident interviews of R5 and R30 to identify p care. Plan of care was updated as indicated for 2. To ensure residents in a dignified manner: si regards to resident right Resident interviews con Choices and Dignity with residents. Resident interviews con Choices and Dignity with residents. Resident interviews and NAR sheets. 3. Weekly audits to inclur room appearance audit, observation and resider completed by DNS/desi negative findings at the will be addressed imme from the prior week are management team to id concerns and need for f 4. Results will be review QAPI. Identified areas of addressed and impleme 	preferences in reviewed and both residents. are receiving care taff education in s and dignity. mpleted on n interviewable erviews and eted quarterly and ated on care plan ude: call light, resident care to interview audits gnee. Any time of the audit diately. Audits reviewed with entify areas of urther actions. red monthly at of concern will be changes will be	

Facility ID: 00930

If continuation sheet Page 2 of 54

		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY IPLETED
		245313	B. WING		04/;	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	going on. R5 state work very hard, the around like crazy, the assistants]". R5 sta 30 minutes for som R5 reported he real the night shift, in the confirmed on 4/27/ 4:25 a.m., and nobe a.m R5 reported " incontinent of stool. his concerns of bein the lack of staff to f conferences. He was facility, maybe he s had to use his cell p station to summon answer the call ligh "diaper", and stated He stated he wore f made personal care of stool. On 4/29/16 at 9:52 call light on that mo time staff answered of stool, then stated incontinent of stool. facility did not have he had been more it. R5 stated he have morning. It was ver be that difficult to fig him. On 4/29/16 at 9:45 confirmed R5 did h movements once in	age 2 d the workers at the facility e nursing assistants "ran here just isn't enough [nursing ated sometimes he waited for beone to answer the call light. Ily had to wait a long time on e early morning hours. R5 16, he put the call light on at ody answered it until 5:00 it was too late" as he had been . R5 stated he had expressed ng incontinent of bowel due to acility management at his care as told if he didn't like it at the hould move. R5 stated he has phone to call the nurses help because they don't t. R5 reported he now wore a d he never used to wear one. the incontinence product as it es easier if he was incontinent d, nobody liked to be . R5 again expressed the enough staff scheduled and incontinent of stool because of d a bowel movement every y predictable, and it wouldn't gure out to know when to toilet a.m., nursing assistant (NA)-B ave incontinent bowel n a while, usually early in the ated R5 was able to tell staff				

Facility ID: 00930

If continuation sheet Page 3 of 54

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245313	B. WING		04	/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	29/2010	
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 241	reported staff often because there was confirmed R5 did se was incontinent of k was more incontine had his light on tod this morning. NA-B get to him in time a incontinent of bowe worked she went to and asked him if he bathroom, in an effe he was not incontin On 4/29/16 at 12:09 (LPN)-A reported R bowels, but did wea case he did not ma LPN-A confirmed R have a bowel move by activating his ca have been times wil R5's call light in tim episodes. LPN-A s call light in time he LPN-A confirmed R and a mechanical li LPN-A stated when bowel movements i embarrassed. R5 re staff. On 4/29/16 at 11:12 (DON) and social w were both aware of bowel movements i staff not answering	get to the bathroom. NA-B do not get to R5's call light, not enough staff. NA-B eem embarrassed when he powel. NA-B then stated R5 ent of stool. NA-B reported R5 ay when she got to work early stated night shift staff did not nd R5 had already been el. NA-B stated when she o R5 right away in the morning e was ready to use the port to anticipate his needs so	F 2	41			

If continuation sheet Page 4 of 54

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	age 4	F 241	1		
	4/26/16. Both the D	he resident council meeting on DON and SW stated they felt s more of a behavioral to R5's care plan.				
		requested regarding honoring reatment, the facility referred f Rights.				
	3/22/16, identified F impairment and req with all activities of further identified R3	nimum data set (MDS), dated R30 had severe cognitive quired extensive assistance daily living (ADLs). The MDS 30 was frequently incontinent ler and was not on a scheduled				
	dated 12/24/15, ide incontinent of bowe checked for incontin	el and bladder assessment entified R30 was frequently el and bladder and was to be inence and changed every 2 receive good pericare after es.				
	occasionally inconti incontinent of bladd to improve bladder than 2 episodes of and less than 2 epis per week. The care was on a scheduled staff to assist him w offered toileting ever indicated staff were	ted 4/27/16, identified R30 was inent of bowels and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day sodes of bowel incontinence e plan further identified R30 d toileting program, required 2 with toileting, and was to be ery 2 hours. The care plan e to report any signs or ry tract infection including				
	On 4/25/16, at 5:07	p.m. there was an				

If continuation sheet Page 5 of 54

		& MEDICAID SERVICES	(X2) MUI	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245313	B. WING		04	/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 241	overwhelming sme	age 5 Il of concentrated urine which The smell was heavy in the air	F 2	41		
	and coming from R					
	and R30's entire ro of concentrated uri observed from 1:58	B p.m. R30 was in bed asleep om continued to smell strongly ne. R30 was continuously B p.m. until 4:40 p.m., R30 was ours and 40 minutes.				
	seated in his wheel smelled strongly of 1:05 p.m. R30's roo	a.m. R30 was in his room Ichair. R30's room and body urine and other body odor. At om and body continued to have mell of urine and stool.				
	hallway always smooth has asked staff to o	2 a.m. FM-A stated R30's entire elled of urine. FM-A stated she change R30 during a family nelled so strongly of urine.				
	always incontinent She stated R30 con urine and was depe incontinence cares R30's urine odor by and stated she felt	p.m. NA-A stated R30 was of both bowel and bladder. Insistently leaked stool and endent on staff for She stated she controlled y changing him every 2 hours, they probably should look into NA-A stated R30 always				
	be changed "at lead was R30's pattern to brief every time he R30 always smelled was so "thick and so referred to it as "R3	p.m. NA-B stated R30 should st" every 2 hours. She stated it to have stool and urine in his was changed. NA-B stated d of urine because his urine strong." NA-B stated staff 80's stinky problem." NA-B d total assistance with				

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		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	incontinence care a She stated R30 was there just wasn't en On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake an She stated staff we benefit from more t there just wasn't tim bath a week becaus On 4/28/16, at 4:06 interview FM-A stat go to the bathroom take him when he s she was upset. FM- smelled of urine an also complained ab On 4/28/16, at 4:29 expected the facility all times with no ex- unaware of any res problems. She state identified, the reside individualized with o DON confirmed R3 toileted every 2 hou registered nurse as to join the interview confirmed R30 was incontinence care. aware of R30's urin	and smelled of urine every day. s not toileted on time because hough staff. a.m. NA-C stated R30 got 1 d she felt it was not enough to odor. NA-C stated R30 always rine odor because he had nd his urine was so strong. The aware that R30 would han one shower a week, but ne to give R30 more than 1 se she was the only bath aide. 6 p.m. during a follow-up ted R30 had to wait and wait to . FM-A stated staff just don't says he has to go. FM-A stated -A stated most of the time R30 d other family members have bout his odor. 9 p.m. DON stated she y to be clean and odor free at ceptions. She stated she was idents with urine odor ed If odor problems were ents care plan would be bodor control interventions. 0's care plan was to be urs. The DON called in the sessment coordinator (RNAC) 7. The RNAC and DON a totally dependent on staff for The RNAC stated she was	F 241			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUT	TIPLE CONSTRUCTION		E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED	
		245313	B. WING		04/	29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 241 F 242 SS=D	Continued From page 7 F 241 6/9/15, it identified a schedule would be developed with toileting times specific to each resident to avoid UTI and skin problems and to improve morale, dignity, and restore or maintain bladder function as possible. The policy indicated the care plan for each resident would include each resident's schedule. 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES F 242 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			6/8/16			
	by: Based on observat review the facility fa preferences for 1 of for choices. Findings include: R66's admission M 4/19/16, identified r and a diagnosis of The MDS identified assistance with act Review of R66's ini revealed R66 requi one staff for transfe	tion, interview and document ailed to honor resident f 4 residents (R66) reviewed inimum Data Set (MDS) dated noderate cognitive impairment a fracture to the right femur. R66 required extensive ivities of daily living. tial care plan dated 4/19/16, red extensive assistance of ers, bed mobility, dressing, g. R66's care plan directed		 Resident R66 has the right her healthcare consistent with interests, assessments and pl Resident interview and observ completed to identify choices a preferences. Plan of care was and updated as indicated. NA were updated with preferences To ensure residents have th make choices regarding cares education in regards to reside dignity. Resident interviews of on Choices and Dignity with in residents. Resident interviews observations are completed q PRN with changes updated o 	her an of care. ration and s reviewed R sheets s. e right to s. Staff nt rights and completed terviewable s and uarterly and		

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED	0 <u>39</u> Y
		BERTHIO, THOR HOMBER.	A. BUILDI	NG _			
		245313	B. WING _			04/29/201	6
	PROVIDER OR SUPPLIER	EADOW LANE		22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE	TIO
F 242	Continued From pa	ge 8	F 24	42			
		maintain her preferences in			and NAR sheets.		
	Resident Tidbits from R66 had no memory and preferred to get On 4/25/16, at 7:15 help to get up and of R66 stated she word about an hour for s stated she would us know her needs, ar anxious waiting for afraid she would we accident. R66 state felt bad when it did, her leg she always time and did not ha staff would routinely people to get up so had occurred as rea On 4/29/16, at 9:08 interview R66 state admitted, her usual at 6:00 a.m. and sh p.m. R66 stated thi	red facility form titled, "New om Social Services" revealed by concerns, was very sharp t up at 6:00 a.m. bp.m. R66 stated she needed but of bed in the mornings. Uld routinely have to wait for taff to help her get up. R66 se her call light to let staff ind would often become them. R66 stated she was et herself or have a bowel d this has happened and she . R66 said before she broke made it to the bathroom in ve accidents. R66 stated the y tell her they have other she had to wait. R66 stated it cently as this morning. a.m. during a follow up d she told staff when she was routine has been to wake up he would go to bed around 9:00 s morning she had to wait until p to get out of bed. R66 stated			 Staff was educated on resident in and choices. Weekly audits to incompletely audits to incomplete of the sident inter audits completed by DNS/designed negative findings at the time of the will be addressed immediately. Aufrom the prior week are reviewed with management team to identify areas concerns and need for further action. Results will be reviewed at QAP Identified areas of concern will be addressed and needed changes with discussed and implemented. 	elude: resident rview e. Any audit dits vith s of ons. I.	
	was 1 out of 10 res had to wait. R66 sta and stated she felt last one. R66 state member about not time but she did no staff. R66 stated s	by a nursing assistant that she idents she had to help, so she ated she had heard that a lot as though she was always the d she spoke to a family getting up at her preferred t feel comfortable telling the he felt the facility did not have o everyone. She felt helpless					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2016 APPROVED 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING			04/:	29/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	her. R66 stated she because they had to On 4/29/16, at 9:30 stated R66 was ale assistance and was her needs. NA-E sta assistance of one fo toileting, dressing, k NA-E stated she wa out of bed until arous shortage. NA-E stat able to help R66 an her as soon as she On 4/29/16, at 11:13 assessment coordir unaware R66 prefei RNAC confirmed R past few mornings of between 7:00 a.m. a The RNAC stated s preferences to be h patient bill of rights. On 4/29/16, at 12:0 (DON) stated she fe based on her prefer except the current of believed an occupa assisted R66 out of week. The DON stat were honored. A facility policy was	times staff would forget about e felt horrible for the staff bo many people to help. a.m. nursing assistant (NA)-E rt, used the call light for able to let the staff know of ated R66 needed extensive or bed mobility, transfers, bathing and personal hygiene. as not able to assist R66 up and 8:00 a.m. due to a staffing ted she felt horrible not being d had told her she would help could. 3 a.m. registered nurse hator (RNAC) stated she was rred to get up at 6:00 a.m. The 66's call light had been on the when she arrived at work and 8:00 a.m. he would expect residents onored, as it was in the 07 p.m. the director of nursing elt R66 was helped out of bed rence everyday of the week, date. The DON stated she tional therapy assistant had bed at least one day of the ated she felt R66's preferences requested regarding honoring e RNAC referred the the	F 2	42			

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		AND HUMAN SERVICES				FORM	06/09/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()	,	E SURVEY PLETED
		245313	B. WING	i		04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 253 F 253 SS=E	483.15(h)(2) HOUS MAINTENANCE SE The facility must pro- maintenance service sanitary, orderly, ar This REQUIREMEN by: Based on observator review the failed to environment to pre- of 3 wings in the fact Findings include: The facility's undate General Environment must provide the re- sanitary surroundin	EKEEPING & ERVICES ovide housekeeping and ces necessary to maintain a nd comfortable interior. NT is not met as evidenced tion, interview and document maintain a clean and sanitary vent unnecessary odors for 2		253	1. Both wings in the facility have maintained a sanitary, orderly, and comfortable environment to prevent unnecessary odors. Mattresses wer removed and replaced for all residen identified. R30 had an additional bat scheduled weekly and diet intake wa reviewed and changes were implement to diet. Rooms identified with odor concerns had floors stripped and wa Toileting plans and needs were revie for all residents identified and care p	nts th as ented xed. ewed	6/8/16
	and linens contribut recovery of each re On 4/25/16, at 1:00 urine odor was han upon entering the fit On 4/25/16, at 1:13 tour a strong, heavy filled the air in the e hallways. On 4/26/16, at 1:58 and R30's room an strongly of concent	ted to the comfort and sident. p.m. a strong, concentrated ging in the air immediately ront door of the facility. p.m. during the initial facility y smell of concentrated urine east and west resident p.m. R30 was in bed asleep d west hallway smelled			 were updated as indicated. 2. The entire facility will maintain a sanitary, orderly, and comfortable environment to prevent unnecessary odors. Weekly cleaning schedule/du were reviewed and updated by housekeeping management. Execut Director/Designee completes daily w through of facility to identify odor or cleaning concerns. Any concerns wi immediately corrected. 3. Re-educate staff on who to notify an odor has been identified. Resider room odor audits will be completed by ED/Healthcare Supervisor/Designee 	v uties tive valk ill be when nt Dy	

Facility ID: 00930

TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	G	COM	PLETED
		245313			04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	ADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 253	Continued From pa	ge 11 st hallway always smelled of	F 25	3 audit is completed by visualizing	and	
ן איז איז איז איז איז איז איז איז איז איז	urine.			assessing individual rooms. Res room audits are completed week	ident ly by	
	On 4/27/16, at 1:05 strongly of urine an	p.m. the west hallway smelled d stool.		facility management to identify clo needs and rooms have good app Any negative findings at the time	earance.	
	was aware of R30's	p.m. NA-B stated leadership urine odor and had called it		audit will be addressed immediat Audits from the prior week are re	ely. viewed	
	hadn't tried anythin but they really need	em." She stated the facility g to control R30's urine odor ed to. She stated everyone		with management team to identif of concerns and need for further	actions.	
	had been done. NA	an odor problem but nothing -B stated R17 used to have a NA-B stated she went and		4. Results will be reviewed at QA Identified areas of concern will be addressed and needed changes)	
	bought R17 feminin own money, but cou	e hygiene products with her uldn't afford to buy every		discussed and implemented.		
	director (ESD) stat	p.m. environmental services ed housekeeping was				
	resident rooms unti	cleaning and maintenance of I 2:30 pm each day. After 2:30 e NAs to clean up spills. She				
	stated housekeepin cleaning urine as u	g was not responsible for ine was considered a bodily				
	biohazard cleaning.	ere responsible for any She stated resident rooms ach hall is completed every				
	cleaned. She stated	onth each room is deep I she was aware R17, R19, s rooms had urine odor				
	problems. She state discuss getting rid o	ed at some point she would of a R17's recliner as she felt f odor on the west wing. The				
	ESD stated R30's retor R30 spilling urine	oom had a urine odor related on his rug in the past. She				
	mattress and whee	blankets, body pillow, chair smelled of urine and here was a layer of grime ss that needed to be				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION		TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
		245313	B. WING _		04	/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 253	disinfected. She fur donations and coul smelled of urine. Si to the identified roo She stated a lot of rewaxed as the floo odor. She stated wi it seeped into the w right away. The ES rewaxing floors and sides needed to be the floors were way had been 3 years s waxed. The ESD a currently doing was On 4/28/16, at 2:24 was conducted with ESD, LPN-A and th The ESD stated yo when you walk into could clean R34's the urine odor on th R17's room smelled felt maybe they need comforter and reclin	ther stated she had a lot of d replace R30's items that he stated when you got close ms there was a urine odor. the room floors need to be ors were a source of urine hen urine spilled onto the floor vax if it was not cleaned up it D said they needed to look at d the entire east and west done. She stated the last time ked was 8/15, and before that it ince the floors had been cknowledged what they are a not working. • p.m. the environmental tour n the executive director (KD), u can usually smell urine right R34's room. ESD stated they floor mat daily to better control ne East side. The ESD stated d of body odor and stated she eded to look at the mattress, ner and try to replace them.		53		
	from spilled food or could look at wheel food spills. The ES had a distinct urine they could do. The smelled of body an stated they would or replacing R30's flee R30's room had sm The ESD stated the that had urine spille	elt the odor in R19's room was h his wheelchair, and they chair cleaning and wiping off D director stated R22's room odor and there was nothing ESD stated R30's room d urine odor. The ED and ESD sheck with the family about ece blankets. LPN-A stated helled since he was admitted. ey used to spray off floor mats ed on them, but would now lift nderneath. The MD stated he				

Facility ID: 00930

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245313			04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 253	Continued From pa	ge 13	F 253			
		erventions in place for the oft that up to the ESD.				
F 282 SS=D	(DON) stated she e and odor free at all stated she was una urine odor problems were identified, the individualized with o DON confirmed R3 toileted every 2 hou registered nurse co interview. The RNA was totally depende care. The RNAC sta urine and stool odo could clean rooms, often to better contr 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b	RVICES BY QUALIFIED	F 282			6/8/16
	by: Based on observat review the facility fa 2 of 4 residnets (R2 of daily living, urina	NT is not met as evidenced tion, interview and document tiled to follow a plan of care for 24, R30) reviewed for activities ary incontinence and 1 of 4 iewed for pressure ulcers and e.		1. Resident R24 and R30 care p were reviewed and revised as in and are receiving care per care p related to activities of daily living incontinence and in addition R24 to altered skin integrity and urina incontinence.	dicated blan , urinary I related	

Event ID:NH3C11

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245313	B. WING		04	/29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 282	Review of R24's ca identified R24 was program every 2 ho were to refer to R2 repositioning needs various intervention mattress (added 2/ weekly skin checks facility policy. On 4/26/16, during 1:44 p.m. to 4:40 p bed on her right sid assisted to repositi observation. -At 1:44 p.m. R24 n right side with an a R24's eyes were cl her chest and the b torso. -At 2:32 p.m. R24 n right side in bed, and chest and a blanke staff were observer -At 3:02 p.m. R24 n right side in bed, ey to mid torso with a walk up and down but did not enter R observed to offer a -At 3:34 p.m. R24 n	are plan revised 2/19/16, on a turning and positioning ours in wheelchair and staff 4's assessment for further s. R24's care plan listed ns of a pressure relieving (19/16,) and to complete s and skin assessments per continuous observations from , R24 was observed lying in de without being offered, or on during the entire was lying in bed, tilted on her ir alternating mattress in place. osed, her arms were across blanket was covering her to mid remained lying, tilted on her rms were crossed over her et covered her to mid torso. No d to offer assistance. remained lying, tilted on her yes were closed and covered blanket. NA-A was observed to the hall in front of R24's room, 24's room. No staff were	F 282	 2. To ensure residents plar being followed we identify c daily clinical start up and up plans and NAR sheets with changes. 3. Re-educate staff on imp timely repositioning and foll interventions per individual Random weekly audits on repositioning per care plan to be completed by DNS/de 4. Results will be reviewed Identified areas of concern addressed and needed cha discussed and implemented 	changes at odate care identified ortance of owing care plans. toileting and interventions esignee. at QAPI. will be unges will be	

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		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	snacks to various re NA-A walked past F not stop or enter R2 -At 4:03 p.m. NA-D hallway past R24's R24's room. NA-D enter R24's room. -At 4:32 p.m. R24 re her right side, eyes to mid torso with a f observed to offer as -At 4:40 p.m. R24 re her right side, eyes blanket covering he nursing (DON) was room at this time ar R24 had not been r 4:40 p.m. a total of On 4/27/16, during 8:33 a.m. to 11:07 a	esidents on R24's hallway. R24's room, however NA-A did 24's room. and NA-F walked down the room and briefly looked into and NA-F did not stop, talk or emained lying in bed, tilted on were closed and was covered blanket. No staff were ssistance or enter R24's room. emained lying in bed, tilted on were closed and had a er to mid torso. The director of observed to enter R24's and shut the door. repositioned from 1:44 p.m. to 2 hours and 56 minutes. continuous observations form a.m., R24 was observed lchair without being offered, or	F 282	DEFICIENCY)		
	observation. -At 8:33 a.m. R24 w with a seat cushion wheeled R24 to the R24 to a table in the NA-A proceeded to breakfast. R24 rem until 9:03 a.m. when activity.	vas seated in a wheelchair in place in her room. NA-A e dining room and assisted e front of the dining room. o assist R24 with eating her vained seated in the wheelchair n staff wheeled her to a group				

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CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X) PROVIDER UNPLICE (X) PROVIDER UNPLICE AND FLAN OF CORRECTION (X) PROVIDER UNPLICE (X) PROVIDER UNPLICE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, GITY, STATE ZIP CODE COLDEN LIVINGCENTER - MEADOW CORRECTION CROSS REFERENCE TO THE APPROPRIATE CMAIL TO: STREET ADDRESS, GITY, STATE ZIP CODE CONTINUE FOR THE ADDRESS DATE ADDRESS CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY DEFICIENCY F 282 Continued From page 16 F 282 Wheelchair in the activity room. R24 was seated in the wheelchair in the ede of R24 s boot mand did not offer assistance with repositioning. F 282 At 10:39 a.m. R24 remained seated in her wheelchair inside her room. R24's bed. RN-A did not offer or assist R24 with repositioning. F 10:55 a.m. R24 remained seated in her wheelchair inside her room. R24'			AND HUMAN SERVICES			FORM	06/09/2016 APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITV. STATE. 2IP CODE GOLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS. CITV. STATE. 2IP CODE Image: Contract of the state of the stat	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	E SURVEY
GOLDEN LIVINGCENTER - MEADOW LANE 2209 UTAH AVENUE BENSON, MN 56215 CM ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECUL ORDERIONE ACTION SHOULD BE CROSS-REFERENCE TO TOT MEADUB BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 000 DATE F 282 Continued From page 16 wheelchair in the activity room. R24 was seated in her wheelchair and listened to the news which was read by the activity director. F 282 -At 10:16 a.m. NA-A wheeled R24 to her room following the activity, R24 was seated in the wheelchair in the reyes closed. NA-A positioned the wheelchair between her bed and the wall inside of the room. NA-A stated the bath aid would be coming to get R24 shortly for a shower. NA-A immediately exited the room following the activity. R24 was seated in her wheelchair inside her room. R24's eyes were closed and head was dropped down in a chin to chest position. No staff were observed to offer assistance with repositioning. -At 10:55 a.m. R24 remained seated in her wheelchair inside her room, R24's eyes were closed and head was dropped down in a chin to chest position. No staff were observed to offer assistance with repositioning. -At 10:55 a.m. R24 remained seated in her wheelchair. NA-C entered R24's room and attempted to wake R24. R24's eyes were closed and chin was resting on her chest. NA-C offered R24 a shower which she decloned. NA-C immediately left R24's room and did not offer or assist R24 with repositioning. -At 11:07a.a.m. R24 remained seated in her wheelchair. NA-C and RN-A dentered R24's room -At 11:07a.a.m. R24 remained seated in her wheelchair. NA-C and RN-A chertered R24's room			245313	B. WING		04/:	29/2016
GOLDEN LIVINGCENTER - MEADOW LANE BENSON, MN 56215 (M) ID PHEFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATIONY OR LSC IDENTIFYING INFORMATION) ID PAGE PROVIDERS PLAN OF CORRECTIVE (EACH DEFICIENCY) MUST BE PRECEDED BY PLUL REGULATIONY OR LSC IDENTIFYING INFORMATION) PRECE PROVIDERS PLAN OF CORRECTIVE (EACH DEFICIENCY) COMMENTER (EACH DEFICIENCY) F 282 F 282 Continued From page 16 wheelchair in the activity corom. R24 was seated in her wheelchair with her eyes closed. NA-A positioned the wheelchair with her eyes closed. NA-A positioned the wheelchair inside between her boom and did not offer assistance with repositioning at this time. F 282 - A1 10:39 a.m. R24 remained seated in her wheelchair inside her room. Registered nurse (RN)- A was observed to enter R24's bod. RN-A did not offer or assist R24 with repositioning. A 10:55 a.m. R24 remained seated in her wheelchair inside her orom. R24's bed. RN-A did not chest position. No staff were observed to offer assistance with repositioning. A 10:55 a.m. R24 remained seated in her wheelchair. NA-C entered R24's room and attempted to wake R24. R24's room and attempted to wake R24. R24's room and attempted to wake R24. R24's room and did not offer or assist R24 with repositioning. A 10:55 a.m	NAME OF F	PROVIDER OR SUPPLIER					
Pričejki TAG (EACH OERICENCY MUST BE PRECEDB DY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRĚFIX TAG (EACH CORRECTIVE ACTION SHOLD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 16 wheelchair in the activity proom. R24 was seated in her wheelchair and listened to the news which was read by the activity director. F 282 -At 10:16 a.m. NA-A wheeled R24 to her room following the activity. R24 was seated in the wheelchair between her bed and the wall inside of the room. NA-A stated the bath aid would be coming to get R24 shortly for a showr. NA-A immediately exited the room and did not offer assistance with repositioning at this time. -At 10:39 a.m. R24 remained seated in her wheelchair inside of the room. Registered nurse (RN)- A was observed to enter R24's room, removed a mechanical lift from her room which was stationed at the end of R24's bed. RN-A did not offer or assist R24 with repositioning. -At 10:55 a.m. R24 remained seated in her wheelchair inside her room. Rej4's eyes were closed and head was dropped down in a chin to chest position. No staff were observed to offer assistance with repositioning. -At 10:58 a.m. NA-C entered R24's room and attempted to wake R24. R24's eyes were closed and chin was resting on her chest. NA-C offered R24 a shower which she declined. NA-C immediately left R24's room and did not offer or assist R24 with repositioning. -At 11:07 a.a.m. R24 remained seated in her wheelchair. NA-C and RN-A entered R24's room	GOLDEN	LIVINGCENTER - ME	EADOW LANE				
 wheelchair in the activity room. R24 was seated in her wheelchair and listened to the news which was read by the activity director. -At 10:16 a.m. NA-A wheeled R24 to her room following the activity. R24 was seated in the wheelchair with her eyes closed. NA-A positioned the wheelchair between her bed and the wall inside of the room. NA-A stated the bath aid would be coming to get R24 shortly for a shower. NA-A-immediately exited the room and did not offer assistance with repositioning at this time. -At 10:39 a.m. R24 remained seated in her wheelchair inside her room. Registered nurse (RN)- A was observed to enter R24's room, removed a mechanical lift from her room which was stationed at the end of R24's bed. RN-A did not offer or assist R24 with repositioning. -At 10:55 a.m. R24 remained seated in her wheelchair inside her room. R24's eyes were closed and head was dropped down in a chin to chest position. No staff were observed to offer assistance with repositioning. -At 10:58 a.m. NA-C entered R24's room and attempted to wake R24. R24. R24's eyes were closed and chin was resting on her chest. NA-C offered R24 a shower which she declined. NA-C immediately left R24's room and did not offer or assist R24 with repositioning. -At 11:07 a.a.m. R24 remained seated in her wheelchair. NA-C and RN-A entered R24's room 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
shower room in her wheelchair and assisted R24 to stand with a mechanical lift. NA-C removed R24's incontinent brief which was soiled with a	F 282	wheelchair in the activity was read by the activity wheelchair with her the wheelchair with her the wheelchair with her the wheelchair betw inside of the room. would be coming to NA-A immediately e offer assistance wit -At 10:39 a.m. R24 wheelchair inside h (RN)- A was observ removed a mechan was stationed at the not offer or assist F -At 10:55 a.m. R24 wheelchair inside h closed and head was chest position. No s assistance with rep -At 10:58 a.m. NA-0 attempted to wake and chin was restin R24 a shower whici immediately left R2 assist R24 with rep -At 11:07 aam. R2 wheelchair. NA-C a and offered a show shower room in her to stand with a med	ctivity room. R24 was seated nd listened to the news which tivity director. A wheeled R24 to her room y. R24 was seated in the eyes closed. NA-A positioned ween her bed and the wall NA-A stated the bath aid oget R24 shortly for a shower. exited the room and did not h repositioning at this time. remained seated in her er room. Registered nurse ved to enter R24's room, nical lift from her room which e end of R24's bed. RN-A did R24 with repositioning. remained seated in her er room. R24's eyes were as dropped down in a chin to staff were observed to offer ositioning. C entered R24's room and R24. R24's eyes were closed g on her chest. NA-C offered h she declined. NA-C 4's room and did not offer or ositioning.	F 282			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/:	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - MI	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	moderate amount of observed on R24's area measured app (cm) long, 1 cm wice border which was re- could not be visuali thick whitish matter ulcer was pink and the open area on R- confirmed R24's ind soiled. NA-C confirm with repositioning p R24 had not been re- 11:07 a.m. a total o On 4/27/16, at 8:07 unable to turn herse assistance to turn a hours in a sitting ar- staff needed to anti severe cognitive im was aware R24 had for at least 3 month recent changes to F last few months oth mattress. On 4/27/16, at 11:0 been really busy with had not been able to away. NA-C stated including reposition due to not enough s with another bath. N not enough staff in were assisted with	of urine. An open area was right side coccyx. The open proximately 2.5 centimeters de, had an irregular shaped ed and raised. The wound bed ized as it was covered with a r. The skin surrounding the blanchable. RN-A confirmed 824's right coccyx and continent brief was moderately med she had not assisted R24	F 282			

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		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From pa had not repositioner On 4/27/16, at 11:1 ⁻ unable to turn herse repositioning every her left side at all du hip. RN-A stated the had been there for improved and worse few months. RN-A located on a bony p On 04/28/2016, at 9 nursing (DON) conf directed facility staf based on assessed hours. The DON star reposition R24 time requested to the DO provided by the DO Upon review of the Care Plan dated 4/- interdisciplinary car provision of care ar maintain the highes and psychological v Based on observati review the facility fa 2 of 4 residents (R24) rev urinary incontinence Findings include:	age 18 ad R24 since prior to breakfast. 1 a.m. RN-A stated R24 was elf in bed, required 2 hours and could not be on ue to an abscess on R24's left e ulcer on R24's right coccyx quite a while and had ened multiple times in the past confirmed R24's ulcer was brominence (coccyx). 9:04 a.m. the director of firmed R24's care plan if to assist R24 to reposition d need, which was every 2 ated she would expect staff to ely. A copy of the grid was ON and a copy was not N. facily policy, Interdisciplinary 1/16 identified the re plan guided the facility in the nd services to attain or st practible physical, mental well being of each resident. ion, interview and document ailed to follow a plan of care for 24, R30) reviewed for activities ary incontinence and 1 of 4 riewed for pressure ulcers and e.	F 282	DEFICIENCY)		
	R30's care plan dat	ted 4/27/16 identified R30 was				

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STATEMEN	OF DEFICIENCIES	KANNERS KANNERS	()		ONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245313	B. WING			04	/29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		2209	ET ADDRESS, CITY, STATE, ZIP CODE UTAH AVENUE SON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 282	occasionally incontineed of blade to improve bladder than 2 episodes of and less than 2 epi per week. The care was on a schedule staff to assist him v offered toileting eve indicated staff were symptoms of urina odors. On 4/25/16, at 5:07 overwhelming sme filled R30's room. T and coming from F On 4/26/16, at 1:58 and R30's entire re concentrated urine -04/26/16, 2:27 p.m position. -3:02 p.m. nursing R30's room and pla on bedroom counter room. -04/26/16, 3:25 p.r room when license opened R30's bedr was still asleep FM immediately entere R30's room, peeke down the hallway tr -04/26/2016 4:32 p asleep in the same	 tinent of bowel and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day, isodes of bowel incontinence e plan further identified R30 d toileting program, required 2 with toileting, and was to be ery 2 hours. The care plan e to report any signs or rry tract infection including 7 p.m. there was an ell of concentrated urine which The smell was heavy in the air R30's body. 8 p.m. R30 was in bed asleep for smelled strong of the same assistant (NA-A) entered aced clean towels and gowns er next to sink and left the m. FM-C was outside R30's for practical nurse (LPN-A) room door and told FM-C R30 has not provided with a snack and left the room. p.m. NA-D and NA-F passed and continued to walk owards nursing station. p.m. R30 remained in bed 	F 2	82			

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		AND HUMAN SERVICES				FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING _			04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	and stated she just confirmed R30's bri it. On 4/27/16, at 7:08 seated in his wheel hallway. R30's room urine and other bod On 4/27/16, at 1:05 smelled sickening v On 4/26/16, at 9:42 stated there was may had to go to the bat call light and they w she had to physical and told them, "R30 FM-A stated R30's of urine. FM-A state change R30 during smelled so strong of On 4/27/16, at 1:11 always incontinent of She stated R30 cor and urine and was of incontinent cares. S R30's urine odor by and stated she felt getting some spray, smelled of urine, ar very strong. NA-A s R30 hadn't been to minutes yesterday of and stated they wor	 changed R30's brief and ief had both urine and stool in a.m. R30 was in his room lohair looking out towards in and body smelled of strong dy odor. b.m. R30's room and body with urine and stool. c.a.m. family member (FM-A) any times R30 had told her he throom, she tuned on R30's vaited for over an hour until lly go and find a staff person 0 had to use the bathroom." entire hallway always smelled ed she has asked staff to a family visit because he of urine. p.m. NA-A stated R30 was of both bowel and bladder. Insistently leaked both stool dependent on staff for She stated she controlled y changing him every 2 hours, they probably should look into 5. NA-A stated R30 always ind stated R30's urine smelled stated she was unaware that ileted for 2 hours and 40 during continuous observation, uld have to work on that. She are plan and stated R30 	F 28	82			

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		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245313	B. WING _		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	On 4/27/16, at 2:00 be changed every 2 it is R30's pattern to brief every time he R30 always smelled was so thick and st was aware of R30's stinky problem." NA assistance with inco urine every day. Sh on time every day. Sh on time every day be enough staff. She stated the facil control his odor and game and get on to aware that R30 sm done. On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake and She stated staff we benefit from more t there just wasn't tim bath a week becaus On 4/28/16, at 11:1 continuous observa responsible for the resided. LPN-A stat a load for just those the DON and ED an to adequately care west side. LPN-A stat	age 21 9 p.m. NA-B stated R30 should 2 hours at the least. She stated o have stool and urine in his was changed. NA-B stated d of urine because R30's urine trong. She stated leadership s odor and had called it "R30's A-B stated R30 required total ontinence care and smelled of the stated R30 was not toileted because their just wasn't lity hasn't tried anything to d they need to step up their op of it. She stated everyone is elled and nothing has been 0 a.m. NA-C stated R30 got 1 d she felt it was not enough to odor. NA-C stated R30 always trine odor because he had nd his urine was so strong. The aware that R30 would than one shower a week, but ne to give R30 more than 1 se she was the only bath aide. 9 a.m. LPN-A stated during ation she and NA-A were entire west side where R30 ted she felt it was too heavy of a 2 and had went to went to nd told them they needed help for all of the residents on the tated R30 wasn't toileted for 2 tes because of the lack of staff	F 28			

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		AND HUMAN SERVICES				FORM	06/09/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING			04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	interview FM-A stat to go to the bathroot take him when he s was upset. FM-A st smelled of urine an also complained ab R30's cares and gr because the facility On 4/28/16, at 4:29 resident was identif that resident's care with odor control in R30's care plan wh toiled every 2 hours on staff for incontin Upon review of the Managment/Bladde 6/9/15 identified a s with toileting times avoid UTI and skin morale, dignity, and function as possible plan for each reside resident's schedule Upon review of the Care Plan dated 4/ interdisciplinary car provision of care ar maintain the highes and psychological w	 p.m. during follow-up ed R30 had to wait, and wait om. FM-A stated they just don't says he has to go and FM-A ated most of the time R30 d other family members have bout his odor. FM-A stated coming weren't getting done was short staffed. p.m. DON stated If any "ied with urine odor problems, plan would be individualized terventions. DON confirmed ich included R30 was to be s, and was totally dependnet ent cares. facility policy, Incontinence er Function Guidelines dated schedule would be developed specific to each resident to problems and to improve d to restor or maintain bladder e. The policy indicated the care ent would include each determined include each determin	F 3				6/8/16
	and psychological v 483.25(a)(3) ADL C	well being of each resident. CARE PROVIDED FOR	F 3	312			6/8/16

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MU			FORM MB NO.	06/09/2016 APPROVED 0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245313	B. WING	à		04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	daily living receives maintain good nutri and oral hygiene. This REQUIREMEN by: Based on observat review the facility fa incontinence cares R30) reviewed for u Findings include:	NT is not met as evidenced tion, interview and document iled to provide timely for 2 of 4 residents (R24, urinary incontinence.	F			cated n inary elated al bath re	
	(MDS) dated 3/1/16 cognitive impairment included: dementia, disorders. The MDS extensive assistance (ADL's,) and was fr and bladder. The M toileting plan. Review of R24's unit Assessment (CAA) was totally incontine CAA identified R24 check and change of repositioning. Review of R24's cat identified R24 was of staff were to offer to	arterly Minimum Data Set 6, identified R24 had severe nt and had diagnoses which 6 diabetes and other skin 6 identified R24 required 20 for all activities of daily living requently incontinent of bowel IDS identified R24 had no nary incontinence Care Area dated 12/9/15, identified R24 ent of bowel and bladder. The required staff assistance to every 2 hours with re plan revised 2/19/16, on a toileting program where bileting with repositioning. arterly bowel and bladder			 reviewed and updated as indicated to address toileting and turning and repositioning schedule. 2. Staff received education on the importance of adhering to the turning and repositioning schedule and toileting schedule to ensure all residents have been provided timely incontinence cares per individualized plan of care. Toileting and repositioning schedules are completed upon admission, quarterly, and prn with change in conditions. 3. Nursing staff have been re-educated regarding ensuring residents receive timely incontinence cares. Toileting and repositioning audits to be completed weekly by DNS/designee. Any negative findings at the time of the audit will be addressed immediately. Audits from the prior week are reviewed with 		

Facility ID: 00930

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
AND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		245313	B. WING _		04/	29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 312	review dated 3/1/16 frequently incontine incontinent of bower required extensive mobility, transfers a identified R24 require positioning, and c incontinence pad e identified R24 had a scratch mark; a line usually covered wit her left buttock and revealed current int pressure mattress The note identified breakdown based of measure risk for de 14. On 4/26/16, during 1:44 p.m. to 4:40 p. bed on her right sid assisted to toilet du Although staff was entered the room o 4:40 p.m. the direct observed to enter th On 4/27/16, during 8:33 a.m. to 11:07 a seated in her whee assisted to repositio observation. Althour room following brea 10:16 a.m. R24 wa the shower room at At that time R24's to with a moderate an	5, identified R24 was ent of bladder and totally el. The note revealed R24 assist of 1 staff for bed and toileting. The note ired staff assistance with checking and changing the very 2 hours. The note an area of excoriation (A ear break in the skin surface, h blood or serous crusts) on in the "fold." The note reventions of an alternating and treatment per MD order. R24 was at high risk for skin on a Braden score (tool to eveloping pressure ulcers) of continuous observations from .m., R24 was observed lying in le without being offered, or rring the entire observation. near the room, no staff r offered assist to toilet. At tor of nursing (DON) was he room and close the door. continuous observations from a.m., R24 was observed lchair without being offered, or on during the entire gh R24 was returned to her akfast and a group activity at s not toileted until brought to	F 31	 2 management team to identify ar concerns and need for further at 4. Results will be reviewed at Que ladentified areas of concern will be addressed and needed changes discussed and implemented. 	ctions. API. e	

Facility ID: 00930

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DER/SUPPLIER/CLIA FICATION NUMBER: 245313 ANE DEFICIENCIES RECEDED BY FULL 'ING INFORMATION) ng assistant (NA)-C ed R24 with toileting		ING STRE 2209 BEN X	ONSTRUCTION EET ADDRESS, CITY, STATE, ZIP CODE UTAH AVENUE ISON, MN 56215 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	04/	E SURVEY PLETED 29/2016 (X5) COMPLETION DATE
ANE DEFICIENCIES RECEDED BY FULL 'ING INFORMATION) ng assistant (NA)-C	ID PREFI) TAG	STRE 2209 BEN	UTAH AVENUE ISON, MN 56215 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	DN D BE	(X5) COMPLETION
DEFICIENCIES RECEDED BY FULL 'ING INFORMATION) ng assistant (NA)-C	PREFI) TAG	2209 BEN ×	UTAH AVENUE ISON, MN 56215 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
DEFICIENCIES RECEDED BY FULL 'ING INFORMATION) ng assistant (NA)-C	PREFI) TAG	BEN	ISON, MN 56215 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETIO
RECEDED BY FULL 'ING INFORMATION) ng assistant (NA)-C	PREFI) TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETIO
	F 3	12			
y due to an issue ed she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The et staff to complete					
	A stated R24 was and required staff tion at least every 2 sition. NA-A stated 4's needs due to NA-A stated she re on her coccyx for not aware of any of care within the n air alternating confirmed she had since prior to -C stated she had residents baths and 4's shower right any residents cares, not completed timely y due to an issue ed she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The tt staff to complete	A stated R24 was and required staff tion at least every 2 sition. NA-A stated 4's needs due to NA-A stated she re on her coccyx for not aware of any of care within the n air alternating confirmed she had since prior to A-C stated she had residents baths and 4's shower right any residents cares, not completed timely y due to an issue ed she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The t staff to complete hicy, Incontinence n Guidelines dated	A stated R24 with toileting A stated R24 was and required staff tion at least every 2 sition. NA-A stated 4's needs due to NA-A stated she re on her coccyx for not aware of any of care within the n air alternating a confirmed she had since prior to A-C stated she had residents baths and 4's shower right any residents cares, not completed timely y due to an issue ed she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The tt staff to complete hicy, Incontinence n Guidelines dated	A stated R24 with toileting A stated R24 was and required staff tion at least every 2 sition. NA-A stated 4's needs due to NA-A stated she re on her coccyx for not aware of any of care within the n air alternating confirmed she had since prior to -C stated she had residents baths and 4's shower right any residents cares, not completed timely y due to an issue ad she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The t staff to complete licy, Incontinence n Guidelines dated	ed R24 with toileting A stated R24 was and required staff tion at least every 2 sition. NA-A stated 4's needs due to NA-A stated she re on her coccyx for not aware of any of care within the air alternating confirmed she had since prior to -C stated she had residents baths and 4's shower right any residents cares, not completed timely y due to an issue ad she felt there was to ensure residents ing timely. the director of 4's care plan R24 to check and repositioning based s every 2 hours. The tt staff to complete licy, Incontinence n Guidelines dated

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		AND HUMAN SERVICES				FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING	i		04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	with toileting times avoid UTI and skin morale, dignity, and function as possible plan for each reside resident's schedule R30's quarterly min 3/22/16, identified F impairment and req with all activities of further identified R3 of bowel and bladde toileting program. R30's annual bowe dated 12/24/15, ide incontinent of bowe checked for incontin hours, and was to r incontinent episode R30's care plan dat occasionally inconti incontinent of bladde to improve bladder than 2 episodes of and less than 2 epis per week. The care was on a scheduled staff to assist him w offered toileting ever indicated staff were symptoms of urinar odors. On 4/25/16, at 5:07 overwhelming smel	specific to each resident to problems and to improve d to restor or maintain bladder e. The policy indicated the care ent would include each a. imum data set (MDS), dated R30 had severe cognitive quired extensive assistance daily living (ADLs). The MDS 30 was frequently incontinent er and was not on a scheduled I and bladder assessment entified R30 was frequently el and bladder and was to be nence and changed every 2 receive good pericare after es. ted 4/27/16, identified R30 was inent of bowels and frequently der. R30's care plan goal was incontinence and have less urinary incontinence per day sodes of bowel incontinence e plan further identified R30 d toileting program, required 2 with toileting, and was to be ery 2 hours. The care plan e to report any signs or by tract infection including	F	312			

Facility ID: 00930

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		AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245313	B. WING		04/:	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa and coming from R	-	F 312			
	On 4/26/16, at 1:58 and R30's entire roo of concentrated urin assistant (NA)-A en clean towels and go the sink and left the outside R30's room (LPN)-A opened R3 family member (FM FM-C and LPN-A le R30's room and pro snack and left the r NA-F passed R30's continued to walk d nursing station. At 4 room and stated sh confirmed R30's bri it. During continuou toileted for 2 hours On 4/27/16, at 7:08 seated in his wheel smelled strongly of 1:05 p.m. R30's roo overwhelming smel On 4/26/16, at 9:42 many times R30 tol bathroom, she tune waited for over an h physically go and fin them, "[R30] had to stated R30's entire urine. FM-A stated sh	a p.m. R30 was in bed asleep om continued to smell strongly ne. At 3:02 p.m. nursing netered R30's room and placed owns on the counter next to a room. At 3:25 p.m. FM-C was a when licensed practical nurse 30's bedroom door and told 1)-C R30 was still asleep. aft. NA-A immediately entered ovided R30's roommate with a room. At 4:03 p.m. NA-D and a room, peeked in and lown the hallway toward the 4:40 p.m. NA-A exited R30's ne just changed R30's brief and ief had both urine and stool in as observation, R30 was not				

Facility ID: 00930

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION). 0938-039 TE SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245313	B. WING _			/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOLDEI	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	On 4/27/16, at 1:11 always incontinent of She stated R30 cor- urine and was depe- incontinence cares. R30's urine odor by and stated she felt getting some spray, smelled of urine. N/ that R30 hadn't bee- minutes on 4/26/16 they would have to R30's care plan was On 4/27/16, at 2:00 be changed "at leas was R30's pattern t brief every time he R30 always smelled was so "thick and s referred to it as "R3 stated R30 required incontinence care a She stated R30 was there just wasn't en On 4/28/16, at 9:29 shower a week and control R30's urine smelled of strong u poor liquid intake an She stated staff we benefit from more ti there just wasn't tim bath a week becaus On 4/28/16, at 11:15	p.m. NA-A stated R30 was of both bowel and bladder. asistently leaked stool and andent on staff for She stated she controlled changing him every 2 hours, they probably should look into NA-A stated R30 always A-A stated she was unaware in toileted for 2 hours and 40 . yesterday NA-A further said work on that. NA-A confirmed is to toilet every 2 hours. p.m. NA-B stated R30 should st" every 2 hours. She stated it o have stool and urine in his was changed. NA-B stated d of urine because his urine trong." NA-B stated staff 0's stinky problem." NA-B d total assistance with nd smelled of urine every day. is not toileted on time because	F 31	2		

Facility ID: 00930

If continuation sheet Page 29 of 54

	-	AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245313	B. WING		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - ME	EADOW LANE		209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	where R30 resided. too heavy a load for went to the director executive director (needed help to ade residents on the we wasn't toileted for 2 because of the lack On 4/28/16, at 4:06 interview FM-A stat go to the bathroom, take him when he s she was upset. FM- smelled of urine an also complained ab R30's cares and gro because the facility On 4/28/16, at 4:29 expected the facility all times with no ex- unaware of any res problems. She state identified, the reside individualized with o DON confirmed R3 toileted every 2 hou registered nurse as to join the interview confirmed R30 was incontinence care. aware of R30's urin Upon review of the Management/Blado 6/9/15, it identified a	. LPN-A stated she felt it was r just the 2 of them. LPN-A of nursing (DON) and ED) and told them they equately care for all of the est side. LPN-A stated R30 hours and 40 minutes of staff on the west side. p.m. during a follow-up red R30 had to wait and wait to . FM-A stated staff just don't says he has to go. FM-A stated -A stated most of the time R30 d other family members have bout his odor. FM-A stated ooming weren't getting done was short staffed. p.m. DON stated she y to be clean and odor free at ceptions. She stated she was idents with urine odor ed If odor problems were ents care plan would be odor control interventions. 0's care plan was to be urs. The DON called in the essesment coordinator (RNAC) . The RNAC and DON a totally dependent on staff for The RNAC stated she was	F 312			

Facility ID: 00930

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		245313	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - M	EADOW LANE	2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 312	improve morale, di bladder function as	gnity, and restore or maintain possible. The policy indicated ach resident would include	F 31	2		
F 314 SS=G	483.25(c) TREATM		F 31	4	6/8/16	
	who enters the fac does not develop p individual's clinical they were unavoid pressure sores rec	y must ensure that a resident ility without pressure sores pressure sores unless the condition demonstrates that able; and a resident having veives necessary treatment and e healing, prevent infection and from developing.				
	by: Based on observa review, the facility to comprehensive assulter ulcer development to promote healing of further pressure (R24) with a currer R24 sustained actu- care of pressure ul repositioning and la Findings include: R24's quarterly Mir 3/1/16, identified R impairment and ha	NT is not met as evidenced tion, interview and document failed to conduct a sessment related to pressure , and implement interventions and prevent the development ulcers for 1 of 2 residents at unstagable pressure ulcer. Jul harm due to inappropriate cers due to lack of timely ack of on-going assessment.		 Resident R24 skin plan of care has been reassessed. Care plan has been reviewed and is receiving skin care per the assessment. All residents identified needing assistance with repositioning are receiv care per care plan with weekly UDA reviews. Every resident has a weekly s review completed and skin alteration issues identified are addressed, physic notified and a plan is individualized per each resident need. Re-educated all staff on skin integrity guidelines, identification, assessment, proper notification to the MD and how to 	kin an	

Event ID:NH3C11

Facility ID: 00930

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		& MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED	
		245313	B. WING			29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
GOLDE	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 314	for all activities of c identified R24 had bed and chair, and repositioning progra had no skin problem Review of R24's pr Assessment (CAA) was at risk for skin mobility and inconti- repositioning progra CAA also identified concerns related to disorder in which fl skin, not generally However, the CAA pressure ulcers. R24's care plan rev was on a turning at hours in wheelchai R24's care plan list pressure relieving to complete weekly assessments per fa On 4/26/16, during 1:44 p.m. to 4:40 p bed on her right sic assisted to repositi observation (a tota -At 1:44 p.m. R24 v right side with an a R24's eyes were cl	daily living (ADL's.) The MDS a pressure relieving device in was on a turn and am. The MDS identified R24 ms. ressure ulcer Care Area) dated 12/9/15, identified R24 breakdown related to limited inence and required a turn and am of every two hours. The R24 had a history of skin o a bullous disorder (skin uid filled blisters occur on the seen on bony prominences.) did not identify any current vised 2/19/16, identified R24 nd positioning program every 2 r and staff was to refer to for further repositioning needs. ted various interventions of a mattress (added 2/19/16) and v skin checks and skin	F 314	 Policies on skin care guideline with all nursing staff. Random risk for pressure ulcer audit an repositioning audits to be comp DNS/designee. 4. Results will be reviewed at 	audits of at d pleted by		

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STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245313	B. WING _		04/29/2016		
	PROVIDER OR SUPPLIER	EADOW LANE	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		IOULD BE	(X5) COMPLETIO DATE	
F 314	 At 2:32 p.m. R24 r right side in bed, ar chest. No staff wer At 3:02 p.m. R24 r right side in bed, ey assistant (NA)-A wa down the hall in fro enter R24's room. I assistance. At 3:34 p.m. R24 r right side in bed, ey passing out snacks hallway. NA-A walk NA-A did not stop of -At 4:03 p.m. NA-D hallway past R24's R24's room. NA-D enter R24's room. At 4:32 p.m. R24 r her right side, eyes observed to offer a At 4:40 p.m. R24 r her right side, eyes nursing (DON) was room at this time a On 4/27/16, during 8:33 a.m. to 11:07 seated in her whee assisted to repositi observation (a tota At 8:33 a.m. R24 n 	remained lying, tilted on her rms were crossed over her e observed to offer assistance. remained lying, tilted on her yes were closed. Nursing as observed to walk up and nt of R24's room, but did not No staff were observed to offer remained lying, tilted on her yes were closed. NA-A was a to various residents on R24's ted past R24's room, however, or enter R24's room. and NA-F walked down the room and briefly looked into and NA-F did not stop, talk or remained lying in bed, tilted on a were closed. No staff were ssistance or enter R24's room. remained lying in bed, tilted on a were closed. The director of s observed to enter R24's	F 3				

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245313	B. WING _			/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 314	assisted R24 to a ta room. NA-A procee her breakfast. R24 wheelchair until 9:0 to a group activity. -At 9:22 a.m. R24 re wheelchair in the act in her wheelchair ar was read by the act -At 10:16 a.m. NA-A following the activity wheelchair with her the wheelchair betw inside of the room. would be coming to NA-A immediately e offer assistance wit -At 10:39 a.m. R24 wheelchair inside he (RN)-A was observe removed a mechan was stationed at the not offer or assist R -At 10:55 a.m. R24 wheelchair inside he closed and head was chest position. No s assistance with rep -At 10:58 a.m. NA-C attempted to wake	to the dining room and able in the front of the dining ded to assist R24 with eating remained seated in the 3 a.m. when staff wheeled her emained seated in the stivity room. R24 was seated nd listened to the news which ivity director. A wheeled R24 to her room 7. R24 was seated in the eyes closed. NA-A positioned yeen her bed and the wall NA-A stated the bath aide get R24 shortly for a shower. exited the room and did not h repositioning at this time. remained seated in her er room. Registered nurse ed to enter R24's room, ical lift from her room which e end of R24's bed. RN-A did 24 with repositioning. remained seated in her er room. R24's eyes were as dropped down in a chin to taff were observed to offer ositioning. C entered R24's room and R24. R24's eyes were closed. a shower which she declined.	F 3			

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ID PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED
		245313	B. WING			/29/2016
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (2209 UTAH AVENUE	CODE	
OLDEN	LIVINGCENTER - ME	EADOW LANE		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa	ge 34	F 3	14		
	-At 11:07 aam. R24 remained seated in her wheelchair. NA-C and RN-A entered R24's room and offered a shower. NA-C wheeled R24 to the shower room in her wheelchair and assisted R24 to stand with a mechanical lift. NA-C removed R24's incontinent brief which was soiled with a moderate amount of urine. An open area was observed on R24's right side of coccyx. The open area measured approximately 2.5 centimeters (cm) long, 1 cm wide, had an irregular shaped border which was red and raised. The wound bed could not be visualized as it was covered with a thick whitish matter. The skin surrounding the ulcer was pink and blanchable. RN-A confirmed the open area on R24's right coccyx and confirmed R24's incontinent brief was moderately soiled. NA-C confirmed she had not assisted R24 with repositioning prior to the shower.					
	assistance to turn a hours in a sitting an staff needed to anti severe cognitive im was aware R24 had least 3 months. NA recent changes to F	elf in bed and required staff and reposition at least every 2 id lying position. NA-A stated cipate R24's needs due to pairment. NA-A stated she d the sore on her coccyx for at -A was not aware of any R24's plan of care within the ier than an air alternating				
	been really busy with had not been able t away. NA-C stated including reposition due to not enough s	9 a.m. NA-C stated she had th various residents baths and o start R24's shower right she felt many residents cares, ing, were not completed timely staff. NA-C stated she felt gh staff in the facility to ensure				

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		<u>0938-039</u> E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:				СОМ	IPLETED
		245313	B. WING			04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	LIVINGCENTER - M	EADOW LANE	2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 35	F 3	14			
		isted with repositioning timely.					
		0 a.m. NA-A confirmed she d R24 since prior to breakfast.					
	unable to turn hers repositioning every her left side at all d hip. RN-A stated th had been there for	2 hours and could not be on ue to an abscess on R24's left e ulcer on R24's right coccyx quite a while and had					
	few months. RN-A located on a bony p indicated the curren ulcer were 2.5 cent	ened multiple times in the past confirmed R24's ulcer was prominence (coccyx). RN-A nt measurements of R24's timeters (cm) long and 0.7 cm Id be determined due to					
	slough tissue (non- or brown tissue; us and mucinous in te to the base of the v throughout the wou	viable yellow, tan, gray, green ually moist, can be soft, stringy xture. Slough may be adherent vound or present in clumps ind bed) present on the wound ed R24 was at risk for					
		e ulcers due to pressure,					
	interview, R24's pe was also the medic medical director (N	26 p.m. during a phone rsonal physician, confirmed he cal director for the facility. The ID) confirmed R24's open area was a pressure ulcer (a					
	tissue usually over result of pressure, with shear and/or f	ne skin and/or underlying a bony prominence, as a or pressure in combination riction). MD stated he was was directly on R24's right					
	coccyx or more on aware R24 had rec	the sacrum. MD stated he was surrent open areas on her d he would expect R24 to be					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	· · /	TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COI	MPLETED
		245313	B. WING _		04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 314	hours. MD stated F go over 2 hours an policy for reposition he had visualized F and had at that time pressure ulcer. MD condition had overa months and now re stated he had conce good about re-asse changes in condition concerns with nurs and high staff turn MD stated he felt to management in the with clinical assess On 04/28/2016, at the	sitioned routinely, every 2 824's repositioning should not d stated the facility had a ning residents. MD confirmed 824's pressure ulcer in March e identified the open area as a stated he felt R24's medical all changed in the last 3 equired more assistance. MD erns nursing was not very essing residents needs when on occurred. MD stated he had ing communication, leadership over rate within the last year. hat staff lacked RN e facility and lacked training	F 31	4		
	diagnosed R24's or The DON stated sh ulcer was a pressu (surface material, s external factors sur friction). The DON not use the Reside (RAI) to identify pri facility grid as a gui expected the facility assessments on we R24's care plan dir to reposition based every 2 hours. The staff to reposition F	haware R24's MD had boccyx sore as a pressure ulcer. he did not feel R24's coccyx re ulcer, but an "erosion," such as skin, broken down by ch as moisture, pressure and stated the facility nurses did nt Assessment Instrument essure ulcers but did use a ideline. The DON stated she y RNs to complete weekly bunds. The DON confirmed ected facility staff to assist R24 on assessed need, which was DON stated she would expect 824 timely. A copy of the grid he DON and a copy was not N.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245313	B. WING _		04	/29/2016
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 314	completed R24's sl coccyx ulcer. RN-A have slough type tis surrounding skin w measurements of F cm x 0.9 cm, not al the wound bed not she felt R24's ulcer R24's weekly woun to 4/21/16, revealed -On 3/16/16, identif on the coccyx whic 2/18/16, was pink, assessment identifi leaving open to air, (drying topical crea mattress and a whe -On 3/23/16, identif measured 4 cm x 1 tissue in the wound identified current in Calmoseptine crea -On 3/30/16, reveal measured 2.5 cm x tissue in the wound defined. -On 4/21/16, reveal measured 2.5 cm x tissue in the wound defined. The asses interventions of pre	kin assessment to the right stated the ulcer continued to ssue on the wound bed, as pink and defined. The R24's coccyx ulcer were 2.5 oble to measure depth due to being visible. RN-A indicated was healing. d assessments from 3/16/16, d the following: fied R24 had a "other wound" h had been identified on had defined margins. The ied current interventions of application of Calmoseptine m,) a pressure redistribution eelchair cushion. fied R24 coccyx ulcer cm and had 100% slough l bed. The assessment terventions application of m after each incontinence. led R24's coccyx ulcer a 0.7 cm had 100% slough l bed, wound margins were sment identified current ssure redistribution mattress, , specific turn/reposition	F 3			

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		AND HUMAN SERVICES				FORM	: 06/09/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY IPLETED
		245313	B. WING	à		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - MI	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	The assessments I wound and any sta- lacked causative fa assessment/analys R24's weekly skin r 4/27/16, revealed th -On 12/22/15, skin buttock cheek was applied. -On 2/1/16, continu sacrum with no sigu -On 2/2/16, continu the sacrum with no infection. -On 2/16/16, had a sacrum. -On 3/1/16, had a continued to be ope -On 3/8/16, had a which was covered foam dressing, des exuding chronic an secondary healing every 72 hours and R24's sore was pre -On 3/6/16, had a buttocks. -On 3/11/16, had a	acked identification of type of ging. The assessments also actors, and an is of R24's ulcer. reviews from 12/22/15, to he following: was intact, though right red and Calmoseptine was red to have a open sore on the ns or symptoms of infection. red to have an open sore on signs or symptoms of a pre-existing open area on the pre-existing open area which en on the buttocks. small open sore on buttocks with Mepiplex (is an all-in-one igned for a wide range of d acute wounds as well as wounds,) bandage, changed I prn. The skin review revealed	F	314	4		

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(XO) MU	וחוד		1	0938-0391 SURVEY
-	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION		PLETED
		245313	B. WING			04/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE		
					BENSON, MN 56215		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			<u>н</u>				
F 314	Continued From pa	ge 39	F 3	314			
		0	_				
		ued to have an open area on					
		neasured 3 cm in diameter, as pink and the area was					
	pre-existing.	as plink and the area was					
	-On 3/23/16 contin	ued to have a pre-existing					
		ittocks which measured 4 cm					
	x 1 cm, skin around						
		ued to have a pre-existing					
		occyx which measured 2.5 cm ow and had slough covering					
	the wound bed.	ow and had slough covening					
		re-existing open area on the					
		sured 2.5 cm x 0.7 cm, had					
	slough tissue cover	ing the would bed.					
	-On 4/14/16, had a	pre-existing sore on the					
	buttocks.						
	-On 4/20/16, lacked	d any documentation of R24's					
	ulcer on the coccyx	<i>,</i>					
		pre-existing open area which 0.9 cm 1.0 cm and the skin					
		ify the location of the open					
	area.						
	R24's clinical record	d lacked documentation of a					
		und assessment completed for					
		nich developed on 12/22/15.					
	R24's physician pro	gress notes from 2/18/16, to					
	3/10/16, revealed th						
		ind D04 had a gradual darling					
		ied R24 had a gradual decline status and in her function. The					

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PRINTED: 06/09/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245313	B. WING			04/:	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	-On 3/10/16, reveal for a concern regard that was not healing a pressure sore on note identified the p cm x 2.0 cm and ha devitalized tissue th usually black, brown appear scab like,) or revealed the current bandage which nurs wound too wet. R24's tissue tolerant measures tissue tol determine appropria dated 3/29/16, reve sitting, however, do not completed. R24's TTT dated 4/ skin was red and bl R24 was to be repoilying position, howe sitting TTT was cont Review of R24's sig transcribed date of written note indicati cream'' to coccyx en healed, continue wo physician orders als document wound st (electronic medical	 R24 had any skin concerns. ed R24 was seen in the facility ding open sore on buttocks g. The note identified R24 had the right side gluteal fold. The pressure sore measured 4.5 ad a layer of eschar (dead or nat is hard or soft in texture; n, or tan in color, and may over the top. The note further t treatment was a Mepiplex sing felt was keeping the nce test (TTT, a test which lerance for sitting and lying to ate repositioning schedule) ealed no assessment for cumentation of lying TTT was 4/16, revealed at lying R24's anched. The TTT revealed very 2 hours in a ever, no documentation for npleted. gned physician orders with a 4/14/16, revealed a hand ng R24 was to have "Butt rosion BID (twice daily) until pund pack as ordered. R24's so revealed an order to tatus weekly in UDA record would assessment,) as surements and a description 	F 3	114			

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	-	AND HUMAN SERVICES			FORM	06/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING		04 /;	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 41	F 314			
		rsing progress notes from 6, revealed the following:				
		a sore on the buttocks which treatment of cleansing and plex boarder.				
		re conference had been held The note identified R24's skin ion.				
	area. The note reverse characteristics: coc appeared as an ope Left buttocks meas with no drainage. Lo red area Right inn The note revealed a Calmoseptine was revealed R24 was r	ccyx measured 2 cm x 1 cm, en blister without drainage. ured 2 cm round open area eft lower buttock 1 cm round her buttock was 1 cm red area. all areas were blanchable and applied. The note further repositioned and toileted every ay on her side to offload				
	identified R24 had a scratch mark, a line usually covered with her left buttock and revealed current int alternating mattress The note identified breakdown based of	terly bowel and bladder review an area of excoriation (a ear break in the skin surface, h blood or serous crusts) on l in the "fold." The note terventions of an pressure s and treatment per MD order. R24 was at high risk for skin on a Braden score (tool to eveloping pressure ulcers) of				
		erly tissue tolerance review open areas on the buttocks				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245313	B. WING		04	/29/2016	
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 314	which were blanch excoriation. The not for pressure ulcers non-pressure skin need for assist with periods, bladder ar incontinence. The staff to anticipate h repositioning every wheelchair. The not ulcer interventions mattress on bed ar in the wheelchair. -On 3/3/16, reveale wound was change soiled. The note did characteristics of F -On 3/10/16, cocc cm and had a deep blanchable, had a f the dressing. The r recommended to le apply Calmoseptim -On 3/23/16, reveal been held with R24 R24 had skin conc were identified as e -On 4/5/16, had a buttocks which me cm. was without sig The note lacked ar location of the wou -On 4/7/16, sore o	able and R24 was prone to be identified R24 was at risk related to a history of concerns, limited mobility, n mobility, sitting for long nd occasional bowel note identified R24 required ther needs, required 2 hours in bed and in be identified current pressure included pressure relieving nd a pressure relieving cushion ed R24's dressing on buttocks ad due to the bandage was d not reveal any further R24's pressure ulcer. by wound measured 2 cm x 1 o red wound bed, area was foul odor and drainage covered note revealed R24's MD eave the dressing off and to e. led R24's care conference had d's family. The note revealed erns of the buttocks which excoriation. pre-existing wound on the asured 2.8 cm x 0.8 cm x 0.2 gns or symptoms of infection. by further characteristics or	F3				

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	<i>I</i> PLETED
		245313	B. WING			04	/29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE			ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 314		ge 43 ation of the wound.	F 3	814			
	-On 4/10/16, contir	nued to have open an area on ed areas on hips and buttocks					
	"watched." The not looked the same. A	"areas" currently being e revealed R24's coccyx nother later note revealed ocks measured 4 cm x 2.5 cm, t odor.					
	remained red. The repositioned every area. Another later	cks sore continued and note revealed R24 was 2 hours to take pressure off of note revealed MD assessed ordered "Butt Cream" to until healed.					
	measured 2.5 cm x	ed R24's coccyx ulcer 1 cm. The note did not naracteristics of R24's					
	kept clean and left	ed R24's coccyx had been open to air, was kept off of her oned every 2 hours.					
	copy of a facility for appointment, which by a Nurse Practitic examined R24's uld	survey the ED provided a m titled Problem sheet, Future revealed R24 had been seen oner (NP) at that time. The NP cer and had indicated the ulcer prominence and was an sure ulcer.					
	interview on 4/28/1	was left with MD requesting an 6, at 4:00 p.m. and on 4/29/16, D did not return the phone call					

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		& MEDICAID SERVICES	r			0. 0938-039
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245313	B. WING _		04	/29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314	Continued From pa during survey.	ge 44	F 3 ⁻	14		
	Clinical Services Sk revealed a facility p comprehensive app conditions, decreas formation by identify implementing appro- promote healing of The policy directed optimal care to pror wounds by routine a documentation, imp and monitoring of c interventions. The protocols for identify though 4. The polic	proach for monitoring skin ing pressure ulcer, wound ying residents at risk, opriate interventions and to wounds. nursing staff to provide note healing of identified assessments, monitoring, olementation of interventions, ompliance with assessed policy also revealed treatment ied pressure ulcers stage 1 y did not identify treatment gable or suspected deep				
	Resident Assessme Manual version 3.0 upon the facilities n assessments, R24's defined as an unsta bed cannot be visual slough or eschar.) I identified, clinical st reverse staging or b document healing a characterize what is the ulcer begins to require an ulcer to o highest stage until I staging should be b	ng Term Care Facility ent Instrument (RAI) User's dated October 2014, based ursing and physician s pressure ulcer would be agable pressure ulcer (wound alized due to the presence of n addition, the manual andards do not support backstaging as a way to us it does not accurately s physiologically occurring as heal. Clinical standards continue to be staged at healed. In addition, ulcer based on the ulcers deepest e damage that is visible or				

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		0938-039 SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	COM	PLETED
		245313	B. WING		04/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 314	Continued From pa	ge 45	F 314	L L		
F 353	classified at the hig	e ulcer should continue to be her numerical stage. ENT 24-HR NURSING STAFF	F 353	3		6/8/16
	PER CARE PLANS					0,0,10
	provide nursing and maintain the highes and psychosocial w	ve sufficient nursing staff to I related services to attain or it practicable physical, mental, rell-being of each resident, as lent assessments and care.				
	numbers of each of personnel on a 24-h	ovide services by sufficient the following types of nour basis to provide nursing in accordance with resident				
		d under paragraph (c) of this Irses and other nursing				
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of				
	by: Based on observat review the facility fa staffing was availab life and quality of ca practice had the por residing in the facili	NT is not met as evidenced ion, interview, and document illed to ensure sufficient facility ble to meet resident quality of are needs. This deficient tential to affect all 47 residents ty. Because of the deficient caused actual harm to R24.		1. Schedule sufficient staff to mer resident needs to ensure adequat coverage. Staff survey was comp identify areas of staff concerns an for delivering quality of care to res Results of survey were reviewed b ED/DNS and additional NAR staff	e leted to d needs idents. by	

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		& MEDICAID SERVICES	[0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	E SURVEY IPLETED
		245313	B. WING _		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 353	Continued From pa	age 46	F 3	53		
	repositioning for pro- prevention due to in R24 was harmed, s R24 and R30 did m hygiene as directed insufficient staffing. R66 did not have h honored as directed due to insufficient s R5 and R30 were m manner as directed due to insufficient s R28's annual MDS had intact cognition assistance with toil bed mobility and oc On 4/28/16, at 3:25 staff assistance with tried to space out h staff would be less certified nursing as able to walk with he staffed. She was on physical therapist w work week. On 4/26/16, at 9:16 stated she felt her met due to staffing 4/28/16, at 4:06 p.r	ot receive timely personal d by the care plan due to , see F312 and F282. er preference for waking times d by the patient bill of rights staffing, see F241. not treated in a dignified d by the patient bill of rights		 Address ongoing s making changes as n resident needs. Ensu utilizing cordless phor to increase communic to best meet resident management educatie to nursing staff. DNS needs at clinical starts staffing as needed. Resident interview tool to be completed w DNS/designee to iden related sufficient staff educated staff on brin concerns to them so t addressed. Additional resources have been nursing staff. Any neg time of the audit will b immediately. Audits f are reviewed with man identify areas of concernations. Results will be revier Identified areas of con- addressed and needed discussed and implentified 	eeded based on ire floor staff is nes and 2 way radios cation between staff needs. Time on was also provided will review staffing up and adjust v and observation weekly by ntify issues/concerns . ED and DNS have riging staffing they can be al time management presented to the gative findings at the re addressed rom the prior week nagement team to erns and need for ewed at QAPI. neern will be ad changes will be	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		NG	`´co	MPLETED
		245313	B. WING	·····	04	/29/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 353	bathroom and staff when he would ask R30 was left sitting to a mechanical lift received assistance a staff member to a stated R30 routinel his body. FM-A state R30's wife if they co due to worry over F had asked facility s times a week, to as odor. FM-A stated F routinely met. FM-A completed timely du was unaware if R30 showers to assist w On 4/27/16, at 8:56 pattern for staffing and then 3 NA's for stated the 4th NA w ago and the facility On 4/28/16, at 11:4 assists R18 to get u almost daily R18 w NA-B stated she ha room a few weeks with urine. NA-B sta saturated with urine stated on a routine it to the dining room residents with eatin the weekends she 12-14 hours due to most dependent res	age 47 would not want to take him FM-A stated most recently on the toilet while hooked up for 20 minutes before he/she e. FM-A stated she had to find assist R30 off the toilet. FM-A y had a strong odor of urine on ted she was routinely asked by ould move somewhere else R30's care. FM-A stated she taff to assist with showers 3 sist with managing the foul R30's toileting needs were not A stated R30's cares were not ue to staffing shortages and D had received increased with the foul urine body odor. 6 a.m. NA-A stated the usual was 4 NA's on until 10:00 a.m. the rest of the shift. NA-A vas brought in about 2 weeks had a bath aid to do baths. 6 a.m. NA-B stated she up on the days she works and ould be saturated with urine. ad brought the DON into R18's ago due R18 being saturated ated R18 continued to be e at the start of her shift. NA-B basis the NA's could not make n until 9:00-9:30 a.m. to assist ing breakfast. NA-B stated on would get frozen into staying short staffing. NA-B stated sidents will go 3-4 hours for routine basis due to short	F 3	53		

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		245313	B. WING _		04	04/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE	04/29/2010		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE		BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
F 353	would only be 2 NA evening shift. NA-E recently on 4/26/16 On 4/29/16, at 8:46 basis R60 would be beginning of her sh routinely short staff a night over into da the weekdays. NA- dependent resident checked and chang stated she had rep done time due to st recently as last wee it out." On 4/29/16, at 9:00 stated staffing leve facility. RN- A state thin and would rout weekends she wou hour shifts. RN-A s DON a few weeks lacking quality. RN- responded that the the amount of staff RN-A stated the NA about resident care which most recently On 4/29/16, at 12:0 (ED) stated she did not getting done du they had added a th weeks to help as m a.m. to help with m confirmed this was	's working on a day and stated this occurred most	F 35	53			

Facility ID: 00930

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IDENTIFICATION NUMBER: 245313 EADOW LANE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 49 ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	A. BUILDING B. WING PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION JLD BE	29/2016 COMPLETION DATE
EADOW LANE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 49 ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	ID PREFIX TAG	2209 UTAH AVENUE BENSON, MN 56215 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION JLD BE	(X5) COMPLETIOI
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 49 ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	PREFIX TAG	2209 UTAH AVENUE BENSON, MN 56215 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLETIO
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 49 ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	PREFIX TAG	BENSON, MN 56215 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLETIO
Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 49 ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETIO
ad been working on staffing oved significantly. The ED ttempts at hiring additional hours for licensed and staff. The ED stated staff	F 35	53		
t in a staff member being shift which could last up to a 16 and the DON did not respond ften staff call-ins were replaced g staff. D5 p.m. the DON stated R30 ere not completed due to staff ns for surveyors on 4/26/16, DON confirmed the master ng term care and board and cility. The DON stated she ndom audits of cares. This the facility and observing and the evening shifts. The erns. The DON stated she int from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short rning, however this was not a d shift. The DON stated the erns were as follows, 3 NA's on the stated				
	and the DON did not respond ften staff call-ins were replaced g staff. 05 p.m. the DON stated R30 ere not completed due to staff hs for surveyors on 4/26/16, 00N confirmed the master ing term care and board and cility. The DON stated she ndom audits of cares. This the facility and observing and the evening shifts. The erns. The DON stated she nt from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short ming, however this was not a d shift. The DON stated the rns were as follows, 3 NA's on .m. to 2:00 p.m., 3 NA's on the 's from 2:00 p.m., and 2 NA's om 10:00 p.m. to 6:00 a.m.	and the DON did not respond ften staff call-ins were replaced g staff. D5 p.m. the DON stated R30 ere not completed due to staff hs for surveyors on 4/26/16, DON confirmed the master ing term care and board and cility. The DON stated she ndom audits of cares. This the facility and observing and the evening shifts. The erns. The DON stated she int from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short ming, however this was not a d shift. The DON stated the rns were as follows, 3 NA's on m. to 2:00 p.m., 3 NA's on the 's from 2:00 p.m., and 2 NA's om 10:00 p.m. to 6:00 a.m. taffing schedule for licensed rsing staff from 2/14/16, to he facility did not consistently umbers identified by the DON. hsistencies were identified:	and the DON did not respond ften staff call-ins were replaced g staff. 35 p.m. the DON stated R30 ere not completed due to staff is for surveyors on 4/26/16, DON confirmed the master ing term care and board and cility. The DON stated she ndom audits of cares. This the facility and observing and the evening shifts. The erms. The DON stated she nt from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short ming, however this was not a d shift. The DON stated the rns were as follows, 3 NA's on .m. to 2:00 p.m., 3 NA's on the 's from 2:00 p.m., and 2 NA's om 10:00 p.m. to 6:00 a.m. taffing schedule for licensed sing staff from 2/14/16, to he facility did not consistently umbers identified by the DON. issistencies were identified:	and the DON did not respond ften staff call-ins were replaced g staff. D5 p.m. the DON stated R30 ere not completed due to staff is for surveyors on 4/26/16, iON confirmed the master ng term care and board and cility. The DON stated she ndom audits of cares. This the facility and observing and the evening shifts. The prms. The DON stated she nt from a NA about cares not a month ago. The DON stated 6:00 a.m. to 10:00 a.m. (short ming, however this was not a d shift. The DON stated the rns were as follows, 3 NA's on .m. to 2:00 p.m., and 2 NA's om 10:00 p.m. to 6:00 a.m. taffing schedule for licensed sing staff from 2/14/16, to he facility did not consistently umbers identified by the DON. isstencies were identified:

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY IPLETED
		245313	B. WING		04/29/2016	
	PROVIDER OR SUPPLIER	EADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 353 F 441 SS=E	identified by the EL days - day shift lac The evening shift of identified by the EL days - evening shift The night shift did identified by the EL days - the night shift On 4/29/16, at 12:1 (AD) stated they re- residents since 2/2 times from R28, R3 incontinent due to A policy/procedure none was provided 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control P safe, sanitary and to help prevent the of disease and infe (a) Infection Contro The facility must es Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to in (b) Preventing Spre	D and DON for 46 out of 60 ked 1-2 aides lid not have the staffing levels D and DON for for 48 out of 60 t lacked 1-2 aides not have the staffing levels D and DON for 28 out of 60 ift lacked 1 aide 10 p.m. the activity director received 3 complaints from 19/16, related to long call wait 37, R5. R5 reported being the long wait. for staffing was requested, l. N CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and development and transmission action. D Program stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.	F 35			6/8/16

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		AND HUMAN SERVICES			FO	ED: 06/09/2016 RM APPROVED NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED		
		245313	B. WING	i		04/29/2016		
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOW LANE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF 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 51 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. 		F	441				
	by: Based on observative review, the facility f handwashing technic personal cares for observed. In additive for 1 of 1 resident (Findings include: R65's admission M 4/15/16, identified F included dementia diabetes and arthrith had both short termic problems. Further, incontinent of urine	NT is not met as evidenced tion, interview and document ailed to ensure proper inques were followed during 1 of 3 residents (R65) on, the facility failed to ensure as properly sanitized after use R65). inimum Data Set (MDS) dated R65 had diagnoses which with behavioral disturbance, tis. The MDS identified R65 of and long term memory the MDS identified R65 was and required extensive sfers and toileting activities.			 NA H has been individually re-educated regarding proper hand hygiene technique. Improper hand hygiene could adversely affect all residents. During plan of correction staff meeti staff were re-educated regarding proper hand hygiene and proper infection cont practices. Hand washing audits completed weet by each department and followed up by ED/DNS/Designee. Any negative findings at the time of the audit will be addressed immediately. Audits from the prior week are reviewed with management team to identify areas of 	r rol kly		

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/29/2016		
		245313	B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 441	 4:20 p.m., nursing observed to assist to the wheelchair. A disposable gloves of mechanical standir bed to the toilet. Nowas soiled with urind disposable gloves. hands, NA-H applie and proceeded to a with wet wipes. W disposable gloves, R65's clean incontigrabbed the mechangloved hands, and the sling when remeremove the soiled of hands until after R6 wheelchair. At 4:18 mechanical lift into the soiled utility rook handwashing. During interview or confirmed cares we confirmed she had and sanitized her hands after person further cares. NA-P product was soiled personal cares. NA-P 	age 52 on 4/26/16, from 4:03 p.m. to assistant (NA)-H was R65 to transfer from the toilet At 4:03 p.m., NA-H applied on both hands and utilized a ng lift to transfer R65 from the A-H removed R65's brief which he, then removed the At 4:10 p.m., without sanitizing ed fresh disposable gloves, cleanse R65's perineal area ithout removing the soiled NA-H continued to pull up nence product and pants, anical lift handles with both touched the plastic buckles of oved from R65. NA-H did not disposable gloves and wash 55 was transferred to the a p.m., NA-H pushed the the hallway, delivered trash to om and then performed A 4/26/16, at 4:20 p.m. NA-H ere completed for R65, and not removed the soiled gloves ands prior to operating the sling. NA-H reported she off the gloves and washed her al cares before continuing 4 confirmed R65's incontinence with urine and required a the off the gloves and washed her al cares before continuing 4 confirmed R65's incontinence with urine and required a the off the gloves and washed her al care before continuing a confirmed R65's incontinence	F 44	1 concerns and need for further act 4. Results will be reviewed at QA Identified areas of concern will be addressed and needed changes discussed and implemented.	PI.		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2016 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245313	B. WING			04/29/2016				
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN LIVINGCENTER - MEADOW LANE			2209 UTAH AVENUE BENSON, MN 56215							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 441	registered nurse as indicated staff are e wash hands after p touching anything e the mechanical lifts sanitizing cloths be During interview on director of nursing (expected to follow t hygiene guidelines. received the educat thereafter. The facility's Hand Policy dated 8/14, o hygiene after remov The facility's Cleani Resident Care Item 8/14, indicated reus	4/28/16, at 3:20 p.m., sessment coordinator (RNAC) expected to take off gloves and roviding perineal cares before else. Further, the RNAC stated should be cleaned with tween each resident use. 4/28/16, at 3:22 p.m., the DON) confirmed staff was he handwashing and hand The DON verified all staff tion upon hire and every year Hygiene and Handwashing lirected staff to perform hand	F 4	141						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV												
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391					
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION (X3 BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED					
		245313	B. WING			04/	28/2016					
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-						
GOLDEN	LIVINGCENTER - MI	EADOW LANE	2209 UTAH AVENUE BENSON, MN 56215									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION) T		(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	КC	000								
	FIRE SAFETY											
	Minnesota Departm Fire Marshal Divisio Golden Living Cent in substantial comp for participation in N Subpart 483.70(a), 2000 edition of Nat Association (NFPA) Code (LSC), Chapt Golden Living Cent building with a partic constructed at 3 dif building was constr facility and was det construction. In 197 built that was detern connect the SNF/N which was determin construction. Becau	Survey was conducted by the nent Of Public Safety, State on. At the time of this survey, er - Meadow Lane was found diance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety er 19 Existing Health Care. er - Meadow Lane is a 1 story al basement. The building was ferent times. The original ucted in 1958, it is an NF2 ermined to be of Type V(000) 70, the SNF/NF facility was mined to be of Type II(222) 76 an addition was added to F building to the NF2 building ned to be of Type II(000) use the original building and et the construction types										
LABORATOR	surveyed as one but The building is fully facility has a fire all detection in the cor corridors that is mo department notifica licensed capacity o the time of the surv	sprinklered throughout. The arm system with smoke ridors and spaces open to the nitored for automatic fire tion. The facility has a f 62 and had a census of 47 at	NATURE		TITLE		(X6) DATE					
	ically Signed				····		05/13/2016					

Electronically Signed

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.

PRINTED: 06/10/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE								
		& MEDICAID SERVICES	1				0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION D1 - MAIN BUILDING 01		E SURVEY PLETED	
		245313	B. WING			04/28/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN LIVINGCENTER - MEADOW LANE					209 UTAH AVENUE ENSON, MN 56215			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
K 000	Continued From pa	ge 1	K 0	000				
	The requirement at MET.	42 CFR, Subpart 483.70(a) is						

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