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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OG11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **01/04/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 02/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5324

On January 4, 2017, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 2, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of December 28,2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 4, 2017, as of December 28, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 28, 2016. In addition, this Department recommended to the CMS Region V Office the following action related to the remedies recommended in our letters of October 12, 2016 and December 12, 2016:

• Civil money penalty for the deficiency cited at F157, be imposed. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016, be rescinded. (42 CFR 488.417 (b))

In our letters of October 12, 2016 and December 12, 2016, we advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 30, 2016, due to denial of payment for new admissions. Since the facility attained substantial compliance on December 28, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is also rescinded.

Refer to the CMS2567b for this visit.

Effective December 28, 2016 the facility is certified for 76 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245324

February 27, 2017

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

Dear Ms. Jenkins:

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 December 28, 2016 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

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

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

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 6, 2017

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number H5324057, H5324058, H5324059, S5324026, H5324054

Dear Ms. Jenkins:

On October 12, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 17, 2016. (42 CFR 488.422)

On October 12, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F157. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016. (42 CFR 488.417 (b))

Also, in our letter of October 12, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 30, 2016.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on September 30, 2016 and a standard survey completed on October 6, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 2, 2016, the Minnesota Department of Health's, Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on September 30, 2016 and a standard survey completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we determined that your

facility had not corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on September 30, 2016 and standard survey completed October 6, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, on December 12, 2016, the Department recommended to the CMS Region V Office the following action related to the remedies recommended in our letters of October 12, 2016 and December 12, 2016:

- Civil money penalty for the deficiency cited at F157, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016, remain in effect. (42 CFR 488.417 (b))

On January 4, 2017, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 28, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 4, 2017, as of December 28, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 28, 2016.

In addition, this Department recommended to the CMS Region V Office the following action related to the remedies recommended in our letters of October 12, 2016 and December 12, 2016:

- Civil money penalty for the deficiency cited at F157, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016, be rescinded. (42 CFR 488.417 (b))

In our letters of October 12, 2016 and December 12, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 30, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 28, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is also rescinded.

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

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

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

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

Enclosure(s)

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245324	A. Building B. Wing	1/4/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/28/2016	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/28/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR / TITLE	DATE
STATE AGENCY [X]	GL/mm	01/12/2017	34086	01/04/2017
CMS RO [ ]			TITLE	

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00169 Y1	A. Building B. Wing Y2	1/4/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 01/04/2016	ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. 1 LSC	Correction Completed 01/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	01/12/2017	34086	01/04/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OG11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**

2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **12/02/16** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Jane Teipel, HFE NEII — 12/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/09/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5324

On December 2, 2016, the Minnesota Department of Health's Office of Health Facility Complaints andLicensing and Certification Program completed a Post Certification Revisit (PCR) and on November 29,2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to anabbreviated standard survey, completed on September 30, 2016 and a standard survey completed on October 6, 2016. We presumed, based on your plan of correction, that the facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our abbreviated standard survy. However the facility has not achieved substantial compliance with deficiencies issued pursuant to the standard survey, completed on October 6, 2016. The deficiencies not corrected are as follows:

-F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
-F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

As a result of the revisit findings, the Category 1 remedy of State monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of October 12, 2016:

Civil money penalty for deficiency cited at F157, remain in effect. (42 CFR 488.430 through 488.444)
Civil money penalty for deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA) effective December 30, 2016, remain in effect. (42 CFR 488.417 (b))

If DPNA goes into effect. The facility is subject to a two year loss of NATCEP, begining December30, 2106.

Refer to the CMS 2567bs for the results of this revisit. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5694 3658

December 12, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number H5324057, H5324058, H5324059, S5324026, H5324054

Dear Ms. Jenkins:

On October 12, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 17, 2016. (42 CFR 488.422)

On October 12, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for deficiency cited at F157. (42 CFR 488.430 through 488.444)

- Civil money penalty for deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on September 30, 2016 and a standard survey completed on October 6, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 2, 2016, the Minnesota Department of Health's Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit (PCR) and on November 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on September 30, 2016 and a standard survey completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey. However, your

facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 6, 2016. The deficiencies not corrected are as follows:

F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of State monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of October 12, 2016:

- Civil money penalty for deficiency cited at F157, remain in effect. (42 CFR 488.430 through 488.444)

- Civil money penalty for deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016, remain in effect. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of October 12, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 30, 2016.

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

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

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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 12/1/16 to 12/2/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 10/6/16. During this visit the following regulations were not corrected.	{F 000}	F000 Golden Living Care Center Bloomington objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Golden Living Care Center Bloomington MN have caused "actual harm" or substandard quality of care.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor the skin of 2 of 5 residents (R19, R46) who were reviewed for non-pressure related skin conditions. Findings include: R46 was observed walking in the facility with a walker on 12/1/16, at 9:12 a.m. R46 asked the surveyor, "Do you know where the yoga activity is being held?" Bruising was observed on the top of his left hand that went from the top of the hand down the slide to the later (pinky) finger as the surveyor conversed with the resident. Bruising was also observed on the top of R46's right hand that extended toward the thumb. Later that day at at 11:42 a.m. R47 was unable to recall how he	{F 309}	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	

POC accepted LS Santto 12/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Lintgens | TITLE: Executive Director | (X6) DATE: 12-16-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 309}	Continued From page 1 sustained the bruises. R47 looked at his hands and stated, "Oh these are just old scratches," and began picking at his hands. R46's care plan dated 7/21/16, indicated he was at risk for complications related to (r/t) anticoagulant (blood thinner) medication. Interventions included observing for signs and symptoms of bleeding and bruising. R46 also had a self-care deficits r/t forgetfulness and the need for assistance with activities of daily living (ADL's). R46's Weekly Skin Reviews from 10/4/16 to 11/29/16, indicated skin was intact, and no bruising or discolorations were noted. Licensed practical nurse (LPN)-B had performed all weekly skin checks. Progress notes for R46 from 10/3/16 to 11/30/16, lacked any documentation r/t skin issues. During an interview on 12/2/16, at 9:26 a.m. nursing assistant (NA)-A verified she was providing care for R46 that day, and was familiar with the resident. NA-A explained R46 required one staff to assist him with ADL's. NA-A explained that following a resident's bath, the nurse performed a skin inspection. NA-A stated she had given R46 a full bed bath that day, and she checks the resident's skin every time she gave the resident a bath. She stated she had not noticed any bruising that day but said, "If I did see bruising, I would tell the nurse right away." On 12/2/16, at 9:33 a.m. the director of nursing (DON) and registered nurse (RN)-A observed R46's hands with the surveyor. The DON verified R46 had bruising on his hands. RN-A left to talk to the staff working with R46. The DON explained when skin issues were noted, staff were to inform the nurse "and then I start an incident report."	{F 309}	F309 • R46 and R19 have had a comprehensive skin assessment in which all current skin alterations have been documented. • All residents receiving care at facility have the potential to be affected • Facility will implement "Stop and Watch" for staff to communicate changes in skin condition to licensed nursing staff. Nursing assistants, licensed nurses and non-licensed staff members have been educated on the use of the "Stop and Watch" notification forms. DNS or designee will facilitate a daily care huddle with certified nursing assistants to allow for additional opportunities to report changes in skin condition. DNS or designee will maintain a log of attendance and issues discussed at the care huddles. DNS or designee will visually audit the accuracy of five (5) skin assessments per week to ensure all new skin conditions are accurately captured. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 12/28/16	

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{F 309}	Continued From page 2 The DON verified the bruising on R46's hand should have been reported to him and been noted on the skin assessment sheet. The DON stated, "I will start and incident report now." At approximately 9:50 a.m. both the DON and RN-A stated they had talked to the staff on R46's unit who had stated the bruises on R46's hands were not actually bruises, just darker pigmentation. In a follow-up interview with R46 at 10:00 a.m. the resident was then asked about his hands. R46 was unable to articulate why his hands were dark in color and stated, "Those are scratches for the dogs and cats at home." R46 proceeded to roll up the right sleeve of his shirt and two additional oblong purplish/red bruises were seen on his forearm. Additionally, a bright pink area with a shallow indented area (as if a scab had been removed) was observed by the top of his elbow area. R19 was observed on 12/1/16, at 10:22 a.m. while in an activity. A reddish/purple area approximately the size of a quarter was observed on the top of R19's left hand. R19 was unable to explain how she sustained the skin issue to the surveyor and DON when asked. R19's care plan dated 10/19/16, indicated she was at risk for complications r/t anticoagulant medication. Interventions was to observe for signs and symptoms of bleeding and bruising. R19 indicated she was at risk for falls r/t a history of falls and diagnosis of Alzheimer's dementia. R19's Weekly Skin Review from 10/14/16 to 11/25/16, indicated the resident's skin was intact. Progress from 10/1/16 to 11/30/16, lacked	{F 309}		

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{F 309}	Continued From page 3 documentation of any skin issues. R19's hand was observed by the DON and surveyor at 10:14 a.m. The DON verified the bruising to R19's left hand and stated, "I will have to look at her skin sheets." When asked if it should have been noted on the skin sheet, the DON explained it should only have been noted on the assessment if the injury was present prior to the resident's bath day. On 12/1/16, at 10:46 a.m. LPN-C stated that although she had administered R19's medications that day, she had not noticed any bruising on her hand. On 12/1/16, at 10:31 a.m. both the DON and RN-A explained R19 was prescribed blood thinners and aspirin (known to contribute to bruising). Both verified that R19 had a bruise to the top of her hand, which would have been picked up on her next skin assessment day. In a follow-up interview at 10:59 a.m. the DON verified R19 required staffs' assistance with ADL's and "yes the bruise should have been noted before her next skin assessment day and reported so an incident report could be started." At 11:14 a.m. NA-B stated she was providing care for R19 that day as well as on the previous day. NA-B verified she noticed the bruise to the top of R19's hand "today and yesterday" and said she had reported it to LPN-B "yesterday." LPN-B was not available for an interview. The facility's undated Skin Integrity Guideline policy indicated under monitor compliance "Patient/resident will be evaluated/observed for risk of skin breakdown and existing areas	{F 309}		

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{F 309}	Continued From page 4 including but not limited to burising. Residents will be observed by the nursing assistance daily for reddened/open areas and reported to the licensed nurse and documented."	{F 309}	F431 • All refrigerated medications in the affected refrigerator have been destroyed and replaced. The TCU refrigerator has been removed from the facility. All medications have been moved to a single centrally located refrigerator on the long term care unit. • All residents with refrigerated medications have the potential to be affected. • All staff members who handle or administer medications will be re-educated on proper storage of refrigerated medications. DNS or designee will monitor the medication and food refrigerator temperatures no less than once (1) daily and maintain a log of these temperatures. DNS or designee will audit these logs five (5) times a week. DNS or designee will audit the refrigerator five (5) days week to ensure that medications and food are stored in the correct refrigerator. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 12/28/16	
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	{F 431}		

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{F 431}	Continued From page 5	{F 431}		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to maintain proper temperature for 1 of 2 medication refrigerators. This had the potential to affect 3 of 3 residents (R59, R161, R165) whose medications were stored for use as well as residents who may have received influenza vaccination or tuberculin skin testing (for tuberculosis screening).

Findings include:

On 12/1/16, at 10:00 a.m. refrigerator temperatures were observed in the locked 300 transitional care unit (TCU) medication refrigerator. Licensed practical nurse (LPN)-A verified the temperature registered 20 degrees Fahrenheit (F). LPN-A stated she was unsure what the proper temperature should have been, but said, "Look at the temperature logs it has the temps [proper temperatures] on the top." A Drug Records, Label/Store drugs & Biological temperature log indicated the temperature for refrigerator should have been between 36-46 degrees. LPN-A explained she had received related training on checking refrigerator temperatures. The temperatures were now to be taken by staff on all three shifts, not just by the night staff as previous. Items observed inside the medication refrigerator included residents' personal food items. In the bottom drawer of the refrigerator were residents' medications and house stock medications. A broken carbonated beverage container was frozen into an approximate inch-thick pool of frozen brown

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{F 431}	Continued From page 6 liquid, which had not been cleaned. LPN-A stated she did not know how long the exploded beverage had been in the refrigerator, but said, "It's the responsibility of the kitchen to keep the refrigerator clean." The most recent Drug Records, Label/Store drugs & Biological log sheet revealed on 11/30/16, no temperature was recorded on the day shift, 36 degrees was recorded on the evening shift, and 37 degrees was recorded on the night shift. However, on 12/1/16, at 10:00 a.m. LPN-A verified the temperature measured 20 degrees. The temperature log for the month of 11/16 indicated 15 of 30 days the temperature was out of range between 28-35 degrees. There was no documentation to show the dial had been re-adjusted and temperatures re-measured when out of range. The director of nursing (DON) verified the 12/16 log had not been clipped to the refrigerator as of 12/1/16. On the same day at 11:20 a.m. the DON and registered nurse (RN)-A observed and verified the refrigerator temperature registered 18 degrees, and the frozen carbonated beverage and medications remained in the refrigerator. The DON explained the staff should not have been storing individual resident or stock medications in the refrigerator, however, food storage temperatures were not consistent with those posted on the refrigerator door (i.e. not greater than 41 degrees). The surveyor suggested testing the temperature with a different thermometer. The DON placed a new thermometer in the refrigerator. RN-A stated, "I don't think the staff know how to read the thermometer correctly." When the second thermometer was checked at 12:30 p.m. the	{F 431}		

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{F 431}	Continued From page 7 DON verified it read 20 degrees. The DON stated "It's too cold and I took out the medication and placed them in the 200 unit refrigerator." Later that day the DON stated he had discarded the frozen medications. On 12/1/16, at 1:45 p.m. the dining service manager stated emphatically it was not the dietary staffs' responsibility to clean the locked nursing refrigerators. At 1:49 p.m. the DON stated he did not know how long the frozen carbonated beverage had been in the refrigerator, but it was the dietary staffs' responsibility to keep the refrigerators clean. The 300 TCU locked refrigerator contained the following medications on 12/1/16: 1) R161's Prevnar 13 (pneumococcal) 1 injection syringe 0.5 milliliter (ml) 2) R165's (2) Aspart Novolog 100 unit injectable pens and (7) Lantus injectable pens (five in an unopened box) both insulin to control blood sugar 3) R59's Toujeo insulin (4) injectable pens and (1) Novolog injectable pen. In addition, house stock medication stored for resident and/or staff use included a. Fluzone quad injection (influenza vaccine) 1 vial with opened date 11/18/16, and b. tuberculin purified protein aplisol 1 opened/undated vial. R161's immunization record was reviewed on 12/2/16, at approximately 9:15 a.m. R161 received an injection of Prevnar 13 on 11/28/16, by licensed practical nurse (LPN)-B. R161's medication administration record (MAR) for the month of 11/16, indicated he received the medication vaccine Fluzone on 11/9/16, when night shift temperature logs revealed the	{F 431}		

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{F 431}	Continued From page 8 temperature registered below acceptable range (i.e. frozen) on the night shift. R165's physician's orders dated 12/1/16, and indicated orders for Lantus injector pen 52 units at bedtime. Although Novalog was stored for use, R165 did not have a current physician's order for the medication. R165's MAR for the month of 11/16, indicated the resident had received tuberculosis skin testing on 11/22/16, but the previous five day's temperature log showed the temperature was out of range between 32 and 35 degrees five times on the night shift. R59's physician's orders dated 12/1/16, included Aspart (Novolog) injections of 13 units with meals, sliding scale Novolog if blood sugar results were greater than 150 and Toujeo injection of 60 units every morning. R59's MAR for the month of 11/16, indicated she had received sliding scale Novolog on 88 out of occasions. The facility's 1/6/15, Storage of Medications policy directed staff to ensure refrigerated medications were "between 36 degrees Fahrenheit (°F) to 46°F" and would be "kept in a refrigerator with a thermometer to allow temperature monitoring."	{F 431}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245324 (Y1)	A. Building B. Wing (Y2)	12/2/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 11/11/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 11/11/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 11/11/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** GL/mm	**DATE** 12/12/2016	**SIGNATURE OF SURVEYOR** 33937	**DATE** 12/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245324	A. Building 01 - MAIN BUILDING 01 B. Wing	11/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 10/08/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 12/12/2016	SIGNATURE OF SURVEYOR 35482	DATE 11/29/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/5/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5694 3658

December 12, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

Re: Enclosed Reinspection Results - Project Number H5324057, H5324058, H5324059

Dear Ms. Jenkins:

On December 2, 2016 survey staff of the Minnesota Department of Health, Office of Health Facility Complaints completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 30, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

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

Enclosure(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00169	A. BUILDING: _____ B. WING _____	R 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A state licensing follow up survey was conducted on 12/1/16 to 12/2/16 to follow up on licensing orders issued on a survey on 10/6/16. The licensing orders were found corrected.	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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	00169	A. BUILDING: _____ B. WING _____	R 12/02/2016

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{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	{2 830}		

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{2 830}	Continued From page 2 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor the skin of 2 of 5 residents (R19, R46) who were reviewed for non-pressure related skin conditions. Findings include: R46 was observed walking in the facility with a walker on 12/1/16, at 9:12 a.m. R46 asked the surveyor, "Do you know where the yoga activity is being held?" Bruising was observed on the top of his left hand that went from the top of the hand down the slide to the later (pinky) finger as the surveyor conversed with the resident. Bruising was also observed on the top of R46's right hand that extended toward the thumb. Later that day at at 11:42 a.m. R47 was unable to recall how he sustained the bruises. R47 looked at his hands and stated, "Oh these are just old scratches," and began picking at his hands. R46's care plan dated 7/21/16, indicated he was at risk for complications related to (r/t) anticoagulant (blood thinner) medication. Interventions included observing for signs and symptoms of bleeding and bruising. R46 also had a self-care deficits r/t forgetfulness and the need for assistance with activities of daily living (ADL's). R46's Weekly Skin Reviews from 10/4/16 to 11/29/16, indicated skin was intact, and no bruising or discolorations were noted. Licensed practical nurse (LPN)-B had performed	{2 830}		

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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{2 830}	Continued From page 3	{2 830}		

all weekly skin checks. Progress notes for R46 from 10/3/16 to 11/30/16, lacked any documentation r/t skin issues.

During an interview on 12/2/16, at 9:26 a.m. nursing assistant (NA)-A verified she was providing care for R46 that day, and was familiar with the resident. NA-A explained R46 required one staff to assist him with ADL's. NA-A explained that following a resident's bath, the nurse performed a skin inspection. NA-A stated she had given R46 a full bed bath that day, and she checks the resident's skin every time she gave the resident a bath. She stated she had not noticed any bruising that day but said, "If I did see bruising, I would tell the nurse right away."

On 12/2/16, at 9:33 a.m. the director of nursing (DON) and registered nurse (RN)-A observed R46's hands with the surveyor. The DON verified R46 had bruising on his hands. RN-A left to talk to the staff working with R46. The DON explained when skin issues were noted, staff were to inform the nurse "and then I start an incident report." The DON verified the bruising on R46's hand should have been reported to him and been noted on the skin assessment sheet. The DON stated, "I will start and incident report now."

At approximately 9:50 a.m. both the DON and RN-A stated they had talked to the staff on R46's unit who had stated the bruises on R46's hands were not actually bruises, just darker pigmentation.

In a follow-up interview with R46 at 10:00 a.m. the resident was then asked about his hands. R46 was unable to articulate why his hands were dark in color and stated, "Those are scratches for the dogs and cats at home." R46 proceeded to roll up

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{2 830}	Continued From page 4	{2 830}		

the right sleeve of his shirt and two additional oblong purplish/red bruises were seen on his forearm. Additionally, a bright pink area with a shallow indented area (as if a scab had been removed) was observed by the top of his elbow area.

R19 was observed on 12/1/16, at 10:22 a.m. while in an activity. A reddish/purple area approximately the size of a quarter was observed on the top of R19's left hand. R19 was unable to explain how she sustained the skin issue to the surveyor and DON when asked.

R19's care plan dated 10/19/16, indicated she was at risk for complications r/t anticoagulant medication. Interventions was to observe for signs and symptoms of bleeding and bruising. R19 indicated she was at risk for falls r/t a history of falls and diagnosis of Alzheimer's dementia. R19's Weekly Skin Review from 10/14/16 to 11/25/16, indicated the resident's skin was intact. Progress from 10/1/16 to 11/30/16, lacked documentation of any skin issues.

R19's hand was observed by the DON and surveyor at 10:14 a.m. The DON verified the bruising to R19's left hand and stated, "I will have to look at her skin sheets." When asked if it should have been noted on the skin sheet, the DON explained it should only have been noted on the assessment if the injury was present prior to the resident's bath day.

On 12/1/16, at 10:46 a.m. LPN-C stated that although she had administered R19's medications that day, she had not noticed any bruising on her hand.

On 12/1/16, at 10:31 a.m. both the DON and

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{2 830}	Continued From page 5 RN-A explained R19 was prescribed blood thinners and aspirin (known to contribute to bruising). Both verified that R19 had a bruise to the top of her hand, which would have been picked up on her next skin assessment day. In a follow-up interview at 10:59 a.m. the DON verified R19 required staffs' assistance with ADL's and "yes the bruise should have been noted before her next skin assessment day and reported so an incident report could be started." At 11:14 a.m. NA-B stated she was providing care for R19 that day as well as on the previous day. NA-B verified she noticed the bruise to the top of R19's hand "today and yesterday" and said she had reported it to LPN-B "yesterday." LPN-B was not available for an interview. The facility's undated Skin Integrity Guideline policy indicated under monitor compliance "Patient/resident will be evaluated/observed for risk of skin breakdown and existing areas including but not limited to burising. Residents will be observed by the nursing assistance daily for reddened/open areas and reported to the licensed nurse and documented."	{2 830}		
{21610}	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document	{21610}		

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{21610}	Continued From page 6	{21610}		

review, the facility failed to maintain proper temperature for 1 of 2 medication refrigerators. This had the potential to affect 3 of 3 residents (R59, R161, R165) whose medications were stored for use as well as residents who may have received influenza vaccination or tuberculin skin testing (for tuberculosis screening).

Findings include:

On 12/1/16, at 10:00 a.m. refrigerator temperatures were observed in the locked 300 transitional care unit (TCU) medication refrigerator. Licensed practical nurse (LPN)-A verified the temperature registered 20 degrees Fahrenheit (F). LPN-A stated she was unsure what the proper temperature should have been, but said, "Look at the temperature logs it has the temps [proper temperatures] on the top." A Drug Records, Label/Store drugs & Biological temperature log indicated the temperature for refrigerator should have been between 36-46 degrees. LPN-A explained she had received related training on checking refrigerator temperatures. The temperatures were now to be taken by staff on all three shifts, not just by the night staff as previous. Items observed inside the medication refrigerator included residents' personal food items. In the bottom drawer of the refrigerator were residents' medications and house stock medications. A broken carbonated beverage container was frozen into an approximate inch-thick pool of frozen brown liquid, which had not been cleaned. LPN-A stated she did not know how long the exploded beverage had been in the refrigerator, but said, "It's the responsibility of the kitchen to keep the refrigerator clean."

The most recent Drug Records, Label/Store

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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{21610}	Continued From page 7	{21610}		

drugs & Biological log sheet revealed on 11/30/16, no temperature was recorded on the day shift, 36 degrees was recorded on the evening shift, and 37 degrees was recorded on the night shift. However, on 12/1/16, at 10:00 a.m. LPN-A verified the temperature measured 20 degrees. The temperature log for the month of 11/16 indicated 15 of 30 days the temperature was out of range between 28-35 degrees. There was no documentation to show the dial had been re-adjusted and temperatures re-measured when out of range. The director of nursing (DON) verified the 12/16 log had not been clipped to the refrigerator as of 12/1/16.

On the same day at 11:20 a.m. the DON and registered nurse (RN)-A observed and verified the refrigerator temperature registered 18 degrees, and the frozen carbonated beverage and medications remained in the refrigerator. The DON explained the staff should not have been storing individual resident or stock medications in the refrigerator, however, food storage temperatures were not consistent with those posted on the refrigerator door (i.e. not greater than 41 degrees). The surveyor suggested testing the temperature with a different thermometer. The DON placed a new thermometer in the refrigerator. RN-A stated, "I don't think the staff know how to read the thermometer correctly." When the second thermometer was checked at 12:30 p.m. the DON verified it read 20 degrees. The DON stated "It's too cold and I took out the medication and placed them in the 200 unit refrigerator." Later that day the DON stated he had discarded the frozen medications.

On 12/1/16, at 1:45 p.m. the dining service manager stated emphatically it was not the

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{21610}	Continued From page 8	{21610}		

dietary staffs' responsibility to clean the locked nursing refrigerators. At 1:49 p.m. the DON stated he did not know how long the frozen carbonated beverage had been in the refrigerator, but it was the dietary staffs' responsibility to keep the refrigerators clean.

The 300 TCU locked refrigerator contained the following medications on 12/1/16:
1) R161's Prevnar 13 (pneumococcal) 1 injection syringe 0.5 milliliter (ml)
2) R165's (2) Aspart Novolog 100 unit injectable pens and (7) Lantus injectable pens (five in an unopened box) both insulin to control blood sugar
3) R59's Toujeo insulin (4) injectable pens and (1) Novolog injectable pen.
In addition, house stock medication stored for resident and/or staff use included
a. Fluzone quad injection (influenza vaccine) 1 vial with opened date 11/18/16, and
b. tuberculin purified protein aplisol 1 opened/undated vial.

R161's immunization record was reviewed on 12/2/16, at approximately 9:15 a.m. R161 received an injection of Prevnar 13 on 11/28/16, by licensed practical nurse (LPN)-B. R161's medication administration record (MAR) for the month of 11/16, indicated he received the medication vaccine Fluzone on 11/9/16, when night shift temperature logs revealed the temperature registered below acceptable range (i.e. frozen) on the night shift.

R165's physician's orders dated 12/1/16, and indicated orders for Lantus injector pen 52 units at bedtime. Although Novalog was stored for use, R165 did not have a current physician's order for the medication. R165's MAR for the month of 11/16, indicated the resident had received

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{21610}	Continued From page 9 tuberculosis skin testing on 11/22/16, but the previous five day's temperature log showed the temperature was out of range between 32 and 35 degrees five times on the night shift. R59's physician's orders dated 12/1/16, included Aspart (Novolog) injections of 13 units with meals, sliding scale Novolog if blood sugar results were greater than 150 and Toujeo injection of 60 units every morning. R59's MAR for the month of 11/16, indicated she had received sliding scale Novolog on 88 out of occasions. The facility's 1/6/15, Storage of Medications policy directed staff to ensure refrigerated medications were "between 36 degrees Fahrenheit (°F) to 46°F" and would be "kept in a refrigerator with a thermometer to allow temperature monitoring."	{21610}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00169 Y1	A. Building B. Wing Y2	12/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20302	Correction	ID Prefix	20555	Correction	ID Prefix	20900	Correction
Reg. #	MN State Statute 144.6503	Completed	Reg. #	MN Rule 4658.0405 Subp. 1	Completed	Reg. #	MN Rule 4658.0525 Subp. 3	Completed
LSC		12/02/2016	LSC		12/02/2016	LSC		12/02/2016
ID Prefix	21426	Correction	ID Prefix	21915	Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN St. Statute 144.651 Subd. 27	Completed	Reg. #		Completed
LSC		12/02/2016	LSC		12/02/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
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LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	12/12/2016	33937	12/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2016

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

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

OHFC

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245324 Y1	A. Building B. Wing Y2	12/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	10/31/2016	LSC	10/31/2016	LSC	10/31/2016
ID Prefix F0333	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(m)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LK/mm	12/12/2016	29249	12/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/30/2016

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00169 Y1	A. Building B. Wing Y2	12/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265	Correction	ID Prefix 20900	Correction	ID Prefix 21545	Correction
Reg. # MN Rule 4658.0085	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.1320 A.B.C	Completed
LSC	10/31/2016	LSC	10/31/2016	LSC	10/31/2016
ID Prefix 21850	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144.651 Subd. 14	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LK/mm	12/12/2016	29249	12/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/30/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OG11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **10/06/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 11/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5324

On October 12, 2016, we informed you that the following enforcement remedy was being imposed:

State Monitoring effective October 17, 2016. (42 CFR 488.422)

On October 12, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies being imposed:

- Civil money penalty for deficiency cited at F157. (42 CFR 488.430 through 488.444)
- Civil money penalty for deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions (MDPNA), effective December 30, 2016. (42 CFR 488.417 (b))

If MDPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning December 30, 2016.

This was based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey completed on September 30, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On October 6, 2016, the Minnesota Departments of Health and Public Safety completed a standard survey to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiency to be widespread deficiencies thatconstituted no actual harm with potential for more than minimal harm that was not immediate Jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required. As a result, that the facility continues to be found not in substantial compliance, the Category 1 remedy of state monitoring will remain in effect.

In addition, we are recommending to the CMS Region V Office the following actions related to the remedies in our letter of October 12, 2016, for imposition:

- Civil money penalty for deficiency cited at F157. remain in effect (42 CFR 488.430 through 488.444)
- Civil money penalty for deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December30, 2016, remain in effect. (42 CFR 488.417 (b))

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7016 0640 0003 5694 9926

October 24, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number H5324057, H5324058, H5324059, S5324026, H5324054

Dear Ms. Jenkins:

On October 12, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 17, 2016. (42 CFR 488.422)

On October 12, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies being imposed:

- Civil money penalty for deficiency cited at F157. (42 CFR 488.430 through 488.444)
- Civil money penalty for deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016. (42 CFR 488.417 (b))

Also, as we notified you in our letter of October 12, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 30, 2016.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on September 30, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On October 6, 2016, the Minnesota Departments of Health and Public Safety completed a standard survey to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiency to be widespread deficiencies that

constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result, that the facility continues to be found not in substantial compliance, the Category 1 remedy of state monitoring will remain in effect.

In addition, we are recommending to the CMS Region V Office the following actions related to the remedies in our letter of October 12, 2016, for imposition:

- Civil money penalty for deficiency cited at F157, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 30, 2016, remain in effect. (42 CFR 488.417 (b))

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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

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

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed for H5324054 at the time of the standard recertification survey and was not substantiated.	F 000	F000 Golden Living Care Center Bloomington objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Golden Living Care Center Bloomington MN have caused "actual harm" or substandard quality of care. This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	POC accepted as plan 11/8/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Hutchens | TITLE: Executive Director | (X6) DATE: 11-4-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plan approaches to minimize the risk for pressure ulcer development for 1 of 1 resident (R29) reviewed and who had existing pressure ulcers. Findings include: R29's 7/12/16, care plan for pressure ulcer risk indicated goals to heal existing pressure ulcer, and remain free from further breakdown. Interventions included, "provide pressure reduction/relieving mattress...Turning and repositioning schedule per assessment," however, no assessment to determine R29's repositioning schedule was available in the resident's record. R29's Comprehensive Skin Assessment indicated a score of 15, indicating the resident was at high risk for pressure ulcer development. The assessment indicated that after two hours of prolonged pressure, the resident's skin was "red, blanches with gentle pressure." Also checked was "Resident is able to make significant changes in positioning independently. Tissue tolerance is deferred. Will reassess if resident is not longer independent with changes in position. On 10/6/16, at 12:25 p.m. following the dressing change, RN-A explained R29 used her call light to request help and added, "I will check on her some times." R29 preferred lying on her right side, and did not have a repositioning schedule. RN-A said, "She will request when she needs to	F 279	F279 • R2's care plan has been reviewed and revised by the interdisciplinary team. Care plan was reviewed and updated. • All residents receiving care at facility have the potential to be affected • All current residents with pressure ulcers or a history of pressure ulcers have had their care plan reviewed and updated as necessary. All new residents will be reviewed during clinical standup meeting after admission to develop a comprehensive pressure ulcer plan of care. All current residents with pressure ulcers are being reviewed at the weekly IDT pressure ulcer meeting. DNS or designee will audit five (5) random residents' charts weekly for completeness of pressure injury plan of care, interventions and nursing assistant care sheet accuracy. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 11/11/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 move and she does also move herself." R29's Minimum Data Set (MDS) dated 7/24/16, indicated the resident was admitted to the facility with an unhealed stage IV pressure ulcer (full thickness loss with exposed bone, tendon or muscle) to the coccyx, and was at high risk for pressure ulcer development. The MDS also indicated R29 had a range of motion impairment on one side, and was dependent on two staff for repositioning in bed. RN-C was interviewed regarding R29's pressure ulcer on 10/6/16, at 1:34. RN-C stated she was responsible for providing wound care for the resident, but the MDS nurse was responsible for care planning interventions. RN-C explained R29 was "always on her right side--I have never seen her lying on her back." RN-C also stated R29's care plan needed revision, to indicate the need for staffs' assistance with routine repositioning, rather that relying on the resident to call for help when she had pain. RN-D was interviewed on 10/6/16, at 1:59 p.m. and explained she was responsible for completing the MDS assessments. RN-D explained that the resident did not have scheduled repositioning, "because she can turn herself without out staff assist." The nurse also said it was a "general understanding" residents were to be repositioned every two hours. NA-D stated on 10/6/16, at 2:12 p.m. regarding R29, "I will turn her whenever she puts the call light on. She only likes to lay down on her right side. Unless she requests, I do not move or reposition her."	F 279		

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	245324	A. BUILDING _____ B. WING _____	10/06/2016

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F 279	Continued From page 3 Following the interviews with staff, R29 stated on 10/6/16, at 2:18 p.m. "I cannot reposition myself. I can roll over for them, but they need to put pillow under me." She explained she could assist by holding the grab bar for a short while, but said, "I cannot put the pillow under myself when I roll over." NA-E stated on 10/6/16, at 2:22 p.m. regarding R29's cares, "When she is wet she can put the call light on and then I will assist her. When I sometimes pass by her room I will say 'hi' to her and if she has concerns she will let me know." The facility's undated Skin Integrity Guidelines policy read, "The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified...Indicate [repositioning] frequency in the individualized plan of care."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services were provided to assess and monitor 1	F 309		

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F 309	Continued From page 4 of 1 resident (R132) reviewed for non-pressure related skin conditions. Findings include: R132 was interviewed on 10/3/16, at 3:36 p.m. Multiple bruises were observed on the resident's left forearm. The resident reported she sustained the bruises while hospitalized, prior to her admission to the facility on 9/26/16. A bruise was present on the left anticubital space, one to the left hand near her thumb, one to the left inner forearm and one to the left outer upper forearm, all with intact skin. R132 explained one was from a blood draw, two were from intravenous therapy (IV) and one was a tuberculin test. In addition, she said bruises on her right arm were from blood draws prior to her admission to the facility. During a review of R132's medical record on 10/6/16, at 9:57 a.m. there was no documented evidence of the presence of bruising or an assessment and monitoring. R132's 9/16, physician's orders revealed the resident's medications included both aspirin, Prednisone (known to contribute to bruising potential). A hospital history form dated 9/22/16, revealed the resident would continue on deep venous thrombosis prophylaxis and would utilize Sequential Compression Devices, both to minimize the risk for blood clot development. These interventions, however, were not noted on the the resident's hospital discharge orders. The facility's Clinical Health Status document completed on 9/26/16, was blank for the skin assessment. There was a note on the sheet that read, "N/A" (not applicable). A Comprehensive Skin Assessment dated 9/27/16, noted R132 had	F 309	F309 • R132 Discharged from the facility as of 10/25/16. • All residents receiving care at facility have the potential to be affected • All licensed nursing staff have been educated on policy and procedure for skin assessments and documentation. All admitting residents will have as skin assessment completed within twenty four (24) hours. All residents will have a skin assessment no less than one (1) time every seven (7) days. DNS or designee will audit all new admissions for a complete skin assessment. DNS or designee will audit five (5) resident charts weekly for evidence resident have had a skin assessment within the last seven (7) days. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 11/11/16	

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F 309	Continued From page 5 poor skin turgor, and tissue tolerance observation was noted as "normal skin color" and staff was to reposition the resident every two hours. A Braden Scale skin testing score was 13, indicating the resident was at high risk for pressure ulcer development. Progress notes at the time of R132's admission did not reflect a skin assessment of problems. A 9/28/16, care plan did not mention the presence of bruising or measures to minimize the risk for potential bruising and for healing of current bruising. Notes did indicated on 10/4/16, the resident was being tapered off the medication Prednisone. On 10/5/16, at 8:43 a.m. the education nurse explained that short term residents did not have their skin checked by the nurse weekly. Nursing assistant (NA)-C stated, "The nurse does a weekly skin assessment on every resident on their bath day." In addition, any new skin problems were reported to the nurse. However, there was no evidence of the weekly skin checks in R132's record. Registered nurse (RN)-B stated on 10/6/16, at 9:39 a.m. she had reviewed R132's medical record and did not find skin documentation in the Clinical Health Assessment. She had also investigated the condition of R132 arms and stated, "Those bruises should have been documented on the clinical health record and in the progress notes." RN-B confirmed the R132 had been admitted with the bruises and they had not been sustained after her admission to the facility. RN-B also confirmed there was no other documentation in the residents records or monitoring that was being performed and documented.	F 309		

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F 309	Continued From page 6 On 10/5/16, at 9:34 a.m. the director of nursing (DON) stated the blue Clinical Health Status form in the medical records under the assessments section of the paper chart should have contained documentation related to residents' skin. Nurses were expected to complete a skin assessment on each newly admitted resident within 24 hours of admission. Any bruises or skin issues were to be recorded on the document. After admission, skin issues were to be documented on an incident report, which was then logged. The DON also confirmed that all residents including short term stay residents should have been having their skin condition assessed weekly, and the nurse's statement was incorrect. The DON stated on 10/6/16, at 10:42 a.m. that the skin assessment should have been completed for R132 and stated, "That is an opportunity for us."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary care to minimize the risk for pressure ulcer	F 314		

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F 314	Continued From page 7 development for 1 of 1 resident (R29) reviewed and who had existing pressure ulcers. Findings include: R29 was observed on 10/4/16, at 2:36 p.m. while lying on her right side. On 10/5/16, at 8:00 a.m. R29 was again observed while in bed and was lying on her right side. Continuous observations were conducted on 10/6/16, at 9:23 a.m. R29 was assisted back to bed and was again positioned on her right side with pillow support behind her back, by nursing assist (NA)-M. NA-M stated at 10:09 a.m. she was familiar with R29's cares, and said the resident let her know when she needed something. R29 remained on her right side watching television and/or with her eyes closed until 11:30 when without repositioning the resident, certified occupational therapy assistant (COTA)-A placed a splint on the resident's left arm. At 11:42 registered nurse (RN)-A checked R29's blood sugar and vital signs, but did not reposition the resident. NA-A gave the resident her meal tray at 12:03 p.m. and explained "I gave her her tray and moved her upper body." NA-A said the resident wanted to move a little bit upright, although the resident remained on her right side. R29 explained on 10/6/16, at 12:20 p.m. that she was off the pressure ulcer area, which was on her coccyx. She also stated she usually laid on her right side, as she had hip pain following surgery on her left side. R29 rated her pain at the time of the interview at a five out of 10 (10 being the worst pain) and she used her call light when she needed help from staff.	F 314	F314 • R29's care plan has been reviewed and updated. • All residents at risk of developing a pressure ulcer have the potential to be affected. • All new residents at risk for developing a pressure ulcer will be reviewed during clinical standup meeting after admission to develop a comprehensive pressure ulcer plan of care. DNS or designee will review all new admission assessments within twenty four (24) hours and implement a plan of care and interventions as necessary. DNS or designee will audit five (5) random residents' charts weekly for completeness of pressure injury plan of care, interventions and nursing assistant care sheet accuracy. IDT wound care team will meet on a weekly basis to evaluate and update the plan of care for all at risk residents to ensure all appropriate preventative interventions are in place. The interdisciplinary wound team will consist of nursing and one (1) or more of the following as clinically indicated, social services, Dietary, Physical Therapy, Occupational Therapy or Recreational Therapy. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results.	

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F 314	Continued From page 8 On 10/6/16, at 12:25 p.m. R29 was moved briefly moved to perform pressure ulcer by RN-A and licensed practical nurse (LPN)-D. Following the dressing change, R29 requested pain medication for left hip pain. RN-A explained R29 used her call light to request help, and additionally RN-A said "I will check on her some times." R29 preferred lying on her right side, and did not have a repositioning schedule. RN-A said, "She will request when she needs to move and she does also move herself." R29's Minimum Data Set (MDS) dated 7/24/16, indicated the resident was admitted to the facility with an unhealed stage IV pressure ulcer (full thickness loss with exposed bone, tendon or muscle) to the coccyx, and was at high risk for pressure ulcer development. The MDS also indicated R29 had a range of motion impairment on one side, and was dependent on two staff for repositioning in bed. RN-C was interviewed regarding R29's pressure ulcer on 10/6/16, at 1:34. RN-C stated she was responsible for providing wound care for the resident, but the MDS nurse was responsible for care planning interventions. RN-C explained R29 was "always on her right side--I have never seen her lying on her back." RN-C also stated R29's care plan needed revision, to indicate the need for staffs' assistance with routine repositioning, rather that relying on the resident to call for help when she had pain. RN-D was interviewed on 10/6/16, at 1:59 p.m. and explained she was responsible for completing the MDS assessments. RN-D explained that the resident did not have scheduled repositioning, "because she can turn	F 314	• Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 11/11/16	

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F 314	Continued From page 9 herself without out staff assist." The nurse also said it was a "general understanding" residents were to be repositioned every two hours. NA-D stated on 10/6/16, at 2:12 p.m. regarding R29, "I will turn her whenever she puts the call light on. She only likes to lay down on her right side. Unless she requests, I do not move or reposition her." Following the interviews with staff, R29 stated on 10/6/16, at 2:18 p.m. "I cannot reposition myself. I can roll over for them, but they need to put pillow under me." She explained she could assist by holding the grab bar for a short while, but said, "I cannot put the pillow under myself when I roll over." NA-E stated on 10/6/16, at 2:22 p.m. regarding R29's cares, "When she is wet she can put the call light on and then I will assist her. When I sometimes pass by her room I will say 'hi' to her and if she has concerns she will let me know." R29's 7/12/16, care plan for pressure ulcer risk indicated goals to heal existing pressure ulcer, and remain free from further breakdown. Interventions included, "provide pressure reduction/relieving mattress...Turning and repositioning schedule per assessment," however, no assessment to determine R29's repositioning schedule was available in the resident's record. R29's Comprehensive Skin Assessment indicated a score of 15, indicating the resident was at high risk for pressure ulcer development. The assessment indicated that after two hours of prolonged pressure, the resident's skin was "red, blanches with gentle pressure." Also checked was "Resident is able to	F 314		

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F 314	Continued From page 10 make significant changes in positioning independently. Tissue tolerance is deferred. Will reassess if resident is not longer independent with changes in position. The facility's undated Skin Integrity Guidelines policy read, "Living Center develops a routine schedule to review patients/residents with wounds or at risk on a weekly basis and will document findings. The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified...Reposition every two hours, or as needed and tolerated, taking into consideration the patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care."	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	F356 • The staffing information for the cited dates has been compiled and is now being stored per state and federal requirement. • This had the potential to affect all residents, family and the public. • Management staff has been educated on regulations regarding posting of staffing hours. DNS or designee will maintain and update the mandated staffing information on a daily basis, including weekends. This information will be posted in an easily accessible location for all residents and members of the public. DNS or designee will audit on a weekly basis that the required staffing information has been posted and retained. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 11/11/16	

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F 356	Continued From page 11 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post the accurate required information for nursing hours and resident census on a daily basis at the beginning of each shift. This had the potential to affect all residents, family and the public. Findings include: During initial tour observation on 10/3/16 at 11:46 a.m. It was noted by the reception desk the facility census posting titled "Hours Report of Nursing Staff Directly Responsible for Resident Care" had been dated 9/30/16 and resident census was 60.The total Nursing assistant hour indicated 30. At 12:45 p.m., it was noted the facility census posting had been replaced with current daily posting dated 10/3/16 and with census of 58 residents. The total hours of nursing assistant indicated 45. During interview on 10/5/16, at 12:23 p.m., the staffing coordinator,Confirmed stating "Usually	F 356		

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F 356	Continued From page 12 manager of the day (MOM) Supposed to post the correct census posting on weekends, I noticed the Friday census posting was there until Monday, I replaced with the current posting for that day. " During interview on 10/5/16, at 1:48 p.m., The Director of nursing (DON) stated "I am not aware of the incorrect posting but, we have system in place, the business office manager and the staffing coordinator are responsible to post the right census. I do not know how they do it on weekends" The facility policy "Titled Nursing Staff Hours" dated 8/14/14, read, "Nursing staff posting will be posted in accordance with state and federal regulations in all facilities...The following information shall be posted on a daily basis at the beginning of the each shift. Center/current location, Current date ,Total number and actual hour worked by licensed and unlicensed staff "	F 356		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F431 • All refrigerated medications in the affected refrigerators have been destroyed and replaced and a new refrigerator purchased. • All residents with refrigerated medications have the potential to be affected. • All staff members who handle or administer medications will be educated on proper storage of refrigerated medications. All staff members will be educated on how to adjust the temperature on medication refrigerators. DNS or designee will monitor refrigerator temperatures on a daily basis and maintain a log of these temperatures. DNS or designee will audit these logs five (5) times a week. Audits will continue for no less than three (3) months. Audit results will be discussed at monthly QAPI meeting. Frequency of audits will be adjusted as needed based upon these results. • Executive Director and Director of Nursing Services are responsible for compliance. • Dates of completion 11/11/16	

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F 431	Continued From page 13 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper temperatures for 2 of 2 medication refrigerators. This had the potential to affect 18 of 58 residents (R60, R1, R36, R81, R126, R78, R96, R58, R74, R50, R76, R84, R34, R59, R137, R138, R139, R140) whose medications were stored for use in the refrigerators. Findings include: On 10/5/16, at 12:39 p.m. licensed practical nurse (LPN)-C verified the temperature in the 100-200 medication refrigerator was 32 degrees. LPN-C stated the night nurse usually checked the temperature and the reason it was not	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 consistently recorded was because the facility had lost some regular nurses. LPN-C verified on the October temperature log 10/1, 10/2, 10/3 and 10/4 the log was blank and on the September log 18 days the temperature log was left blank on 9/1, 9/2, 9/3, 9/4, 9/7, 9/8, 9/9, 9/10, 9/11, 9/16, 9/17, 9/20, 9/21, 9/25, 9/26, 9/27, 9/28, and 9/29/16. The September temperature log for the 100/200 refrigerator had the following temperatures documented for 9/16: 9/5, 27 degrees, 9/6, 28 degrees, 9/12, 28 degrees, 9/13, -30 degrees, 9/14, -30 degrees, 9/15, -30 degrees, 9/18, -30 degrees, 9/19, -30 degrees, 9/22, 28 degrees, 9/23, 28 degrees, 9/24, 26 degrees, and 9/30, 35 degrees Fahrenheit (F). The following day on 10/6/16, at 8:10 a.m. the assistant director of nursing services (ADNS) verified in the 100/200 medication refrigerator the temperature was 32 degrees. The thermometer was located on the middle shelf in the middle. The ADNS stated, "Maybe the thermometer is faulty. I will get another thermometer from the kitchen." The ADNS verified the following medications were stored in the 100/200 refrigerator: 14 Pneumovax vaccines, 13 Prevnar vaccine syringes unlabeled, 1 opened Tubersol multi use vial dated 9/13/16, 1/4 full, 1 opened Tubersol multi use vial dated 9/30/16, 1/2 full; 1 opened Tubersol multi use vial dated 9/28/16, 3/4 full; 1 unopened Tubersol multi use vial dated 8/21/16; R36's 5 Lantus pens unopened all dated 8/25/16, R81's Lantoprost eye drops unopened dated 10/2/16, 8 unopened influenza vaccine vials, 30 pre-filled influenza vaccine ordered 8/24/16, (instructions sent with vaccine indicated influenza vaccines should have been stored at	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 431	Continued From page 15 35.6-46 degrees Fahrenheit). In addition, the refrigerator contained R126's Humulin 70/30 4 unopened pens dated 8/16/16, R96's 1 bottle of Gabapentin 1/4 full dated 8/24/16, labeled refrigerate, R96's second bottle of Gabapentin 1/4 full dated 8/24/16, R96's bottle of Pantoprazole 3/4 full dated 9/9/16, R96's bottle of Gabapentin full bottle dated 9/16/16, 10 pneumovaccines, 23 syringes with no date; R76's 4 Lantus pens unopened dated 8/18/16, R126's 2 unopened Novolog flex pens dated 9/27/16, R126's 1 Humulin pen dated 8/15/16, R126's 3 unopened Novolog flex pen dated 9/9/16, R126's Novolog pen dated 8/26/16, R126's Levemir insulin dated 9/27/16, R126's 2 Lantus pens dated 8/26/16, R126's Levemir insulin dated 9/27/16, R126's 2 Lantus pens dated 8/26/16; R58's 1 unopened vial of cathflo, acti inj vase dated 5/25/16, 1 unopened vial of Novolog labeled e kit (emergency kit) dated 10/3/16, R74's 1 Victoza insulin pen unopened dated 9/29/16, R50's 2 Lantus pens unopened dated 10/3/16, R76's 2 Novolog pens unopened dated 9/24/16, R78's 2 Lantus pens unopened dated 10/2/16, R74's 3 Humalog kwik pens unopened dated 9/29/16, 1 Levemir insulin e-kit unopened dated 8/26/16, R140's Novolog unopened pen dated 9-30-16, 1 Novolog pen e-kit unopened dated 8/28/16, e-kit 1 bag of grenades (antibiotics) with green label stated "refrigerate upon arrival," R84 's 7 grenades of Nafcillin (antibiotic) upon admission; 1 stock bottle of acidophilus opened dated 6/13/16, 6 of 60 capsules left; 1 bottle of stock acidophilus opened dated 3/1/16, 1/2 full, 1 bottle of stock acidophilus opened undated, expired 10/16, 9 of 60 capsules left, and R34's Prilosec liquid 1 bottle dated 8/16/16, 1/4 full. The ADNS also verified the emergency kit was on a shelf in the 100/200 medication refrigerator and	F 431		

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F 431	Continued From page 16 that there was a list which listed the medications inside of the kit. On 10/6/16, at 8:01 a.m. licensed practical nurse (LPN)-D verified the transitional care unit (TCU) medication refrigerator temperature was 35 degrees. LPN-D verified the medications in the refrigerator were R60's Novolog (insulin) pen dated 9/28/16, on the label, R1's Lantus pen dated 9/16/16, 2 bottles of acidophilus house stock 1 opened dated 11/23/15, 2/3 full, and 1 opened dated 7/29/15, 1/2 full; house stock Tubersol vaccine vial opened dated 9/10/16, 1/3 full; R59's Levemir pen dated 7/15/16, R59's Toujeo insulin pen dated 7/26/16, R59's Levemir pen dated 8/19/16, R59's Levemir pen dated 7/15/16, R59's Novolog pen dated 8/19/16, R137's Novolog pen dated 9/28/16, R139's Humulin 70/30 pen dated 9/13/16, R138's Lantus pen dated 9/13/16, and a Novolog pen unopened, undated, unidentified, and unlabeled. LPN-D stated the refrigerator temperature "should be between 30 and 40 degrees and the night shift checks the temperature." LPN-D stated insulins and injectable medications for the residents were kept in the TCU medication refrigerator. LPN-D verified the temperatures on the 10/16 TCU medication room refrigerator log were 10/1, 31 degrees, 10/2, 28 degrees, 10/3, 30 degrees, and 10/4, 31 degrees. The 9/16 TCU Refrigerator Temperature Log indicated 23 blanks and the following temperatures documented for: 10/3, 18 degrees, 10/4 39 degrees, 10/8 25 degrees, 10/9, 25 degrees, 10/11, 30 degrees, 10/20, 20 degrees, 10/22, 23 degrees. The August 2016 TCU Refrigerator Temperature Log indicated 16 blanks and the following	F 431		

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F 431	Continued From page 17 temperatures documented for: 8/1, 20 degrees, 8/3, 20 degrees, 8/4, 20 degrees, 8/5, 12 degrees, 8/7, 10 degrees, 8/8, 18 degrees, 8/11, 20 degrees, 8/12, 12 degrees, 8/15, 8 degrees, 8/19 14 degrees, 8/20, 18 degrees, 8/25, 18 degrees, 8/26, 26 degrees, 8/29, 24 degrees, and 8/30, 24 degrees. On 10/6/16, at 8:31 a.m. LPN-D who worked on 100 and 200 halls stated she did not know the proper temperature ranges for the medication refrigerators. At 9:02 a.m. the ADNS stated, "Medications should be stored at 36 to 46 degrees." The ADNS stated the medication refrigerator temperatures were supposed to be checked by the nurses on the 10:00 p.m. to 6:00 a.m. shift, but was not being done. The ADNS stated, "The night nurses and the nurses needed to be educated." At 1:21 p.m. the ADNS explained she had put another thermometer from the kitchen in the 100/200 medication refrigerator this morning and had checked it 30 minutes later and the temperature read 32 degrees. Since the refrigerator was still too cold, she had adjusted the dial of the refrigerator and planned to recheck the temperature later. The ADNS stated she had sent an email to the consulting pharmacist (CP) and so far the CP had instructed her to dispose of the insulins from the refrigerators. The ADNS also stated, "I don't think the nurses understand about the parameters" for the temperatures for the medication storage...I have already made the documentation to educate the nurses on and am going to bring to QAPI [the quality committee]." The ADNS further stated the facility had made "immediate correction and had the sheet of	F 431		

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F 431	Continued From page 18 paper" regarding nursing education, and the nurses were being educated effective immediately and monitoring of temperatures by the ADNS and the director of nursing was being performed. R60's physician orders included orders for: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 20 units subcutaneously one time a day for type diabetes ordered 9/28/16 and an order for Tuberculin PPD Solution 5 unit/0.1 ml Inject 5 unit intradermally one time a day for 2nd Step Mantoux until 10/12/16, ordered 9/28/16. R1's physician orders included orders for: Gabapentin Capsule Give 100 mg by mouth two times a day for Type 2 Diabetes with complication ordered 9/6/16, and an order for Insulin Glargine Solution Pen-Injector 100 unit/ml Inject 25 unit subcutaneously at bedtime for Type 2 diabetes with complication Inject 25 units subcutaneous at bedtime ordered 9/6/16. R36's physician orders included orders for: Insulin Glargine Solution 100 unit/ml Inject 10 unit subcutaneously two times a day for Type 2 diabetes Inject 10 units subcutaneous 2 times daily at 8 am and 8 pm ordered 8/25/16, and an order for Novolin R Solution 100 unit/ml (Insulin Regular Human) Inject as per sliding scale ordered 8/25/16. R81's physician orders included orders for: Xalatan Solution 0.005% (Latanoprost) Instill 1 drop in both eyes at bedtime related glaucoma Give 1 drop in both eyes at bedtime ordered 12/3/15.	F 431		

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F 431	Continued From page 19 R126's physician orders included: Gabapentin Capsule 300 mg Give 2 capsule by mouth three times a day ordered 9/27/16, Insulin Aspart Solution 100 unit/ml Inject as per sliding scale ordered 8/15/16, Levemir FlexTouch Solution Pen-injector 100 unit/ml (Insulin detemir) Inject 40 unit subcutaneously one time a day ordered 9/27/16, Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 6 unit subcutaneously in the evening meal related to type 2 diabetes mellitus with meals ordered 9/4/16, and Tuberculin PPD Solution 5 UNIT/0.1 ML Inject 5 unit intradermally one time a day for 2nd Step Mantoux until 10/04/16 ordered 9/27/16. R78's physician orders included: Gabapentin Capsule Give 100 mg by mouth two times a day related to POLYNEUROPATHY IN DIABETES ordered 2/11/15, and an order for Insulin Glargine Solution Pen-injector 100 unit/ml Inject 27 unit subcutaneously two times a day ordered 8/16/16. R96's physician orders included: Gabapentin Solution 250 mg/5ml Give 500 mg via PEG-Tube in the morning every Sun, Tue, Thur for nerve pain ordered 9/16/16, Gabapentin Solution 250 mg/5ml mg Give 600 mg via PEG-Tube at bedtime for nerve pain ordered 9/16/16, and an order for Protonix Solution Reconstituted (Pantoprazole Sodium) Give 40 mg via G-Tube one time a day for TDD ordered 8/24/16. R58's physician orders included: 16 French catheter, Bottle Normal Saline, and irrigation kit (incontinence) ordered 7/29/16. R74's physician orders included: Insulin Glargine Solution Inject 36 unit subcutaneously at bedtime related to type 2 diabetes mellitus ordered	F 431		

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F 431	Continued From page 20 4/25/16, Insulin Glargine Solution Inject 36 unit subcutaneously one time a day ordered 4/25/16, Insulin Lispro (Human) Solution Inject 15 unit subcutaneously before meals ordered 3/13/16, and an order for Victoza Solution Pen-injector 18 mg/3ml (Liraglutide) Inject 1.2 mg subcutaneously one time a day ordered 10/24/15. R50's physician orders included: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 15 unit subcutaneously in the evening for diabetes ordered 6/23/16,and an order for Lantus SoloStar Solution Pen-Injector 100 unit/ml (Insulin Glargine) Inject 22 unit subcutaneously in the morning related to type 2 diabetes mellitus ordered 2/24/16. R76's physician orders included: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 20 unit subcutaneously two times a day related to type 2 diabetes mellitus ordered 8/17/16, and an order for Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 8 unit subcutaneously three times a day ordered 6/22/16. R84's physician orders included: Nafcillin Sodium Solution Reconstituted 2 grams--use 2 gram intravenously four times a day for joint infection until 10/6/16, ordered 9/1/16. The facility's 5/12, Storage of Medications policy indicated "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff member lawfully authorized to administer medications." Medication storage was	F 431		

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F 431	Continued From page 21 to be monitored by the consultant pharmacist or pharmacy designee, and "corrective action taken if problems are identified...Temperature A. Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopoeia guidelines for temperature ranges...Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees C [Centigrade] (36 degrees F and 8 degrees C (46 degrees F) with a thermometer to allow temperature monitoring...The Facility should maintain a temperature log in the storage area to record temperatures at least once a day. F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines...Infusion Therapy Storage and Labeling...The Facility should assure infusion products are stored at the appropriate temperature in a medication--only refrigerator or freezer or in a designated area of a medication or biological--only refrigerator or freezer. "	F 431		

F53240 27

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

APPROVED Thm & Linhoff
By Tom Linhoff at 9:38 am, Nov 08, 2016

PRINTED: 10/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	245324	B. WING	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on October 11, 2016. At the time of this survey, Golden Livingcenter-Bloomington was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	F000 Golden Living Care Center Bloomington objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Golden Living Care Center Bloomington MN have caused "actual harm" or substandard quality of care. This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	

RECEIVED
NOV - 8 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul Smithson	Executive Direct	11-4-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	**9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter-Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. In 1999, an addition was constructed and was determined to be Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000	RECEIVED NOV 07 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the facilities electrical wiring per the National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1. This deficient practice could affect all patients, staff and visitors. Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1. FINDINGS INCLUDE: On the facility tour between 9:30 am to 12:30 pm on 10/11/2016 observations and staff interview revealed the following: 1.) A microwave was plugged into a power strip in the Staff Break Room. The power strip was being used as a source of fixed wiring. 2.) An air conditioning unit was plugged into a power strip in the Laundry Folding Room.The power strip was being used as a source of fixed wiring. These deficient practices were verified by the Facility Maintenance Director.	K 147	K147 • Power strips have been removed from the cited microwave and air conditioning unit. The cited microwave and air conditioning unit have been plugged into a fixed wiring outlet. Maintenance director has audited the building for the presence of further K-147 deficiencies. • Maintenance Director is responsible for compliance. • Date of completion October 8th, 2016	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 1520 0002 9402 2587

October 24, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5324026, H5324054

Dear Ms. Jenkins:

The above facility was surveyed on October 5, 2016 through October 5, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5324054. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at the phone number or email address detailed above.

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

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

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

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

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00169	A. BUILDING: _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 3, 4, 5 and 6, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED NOV 07 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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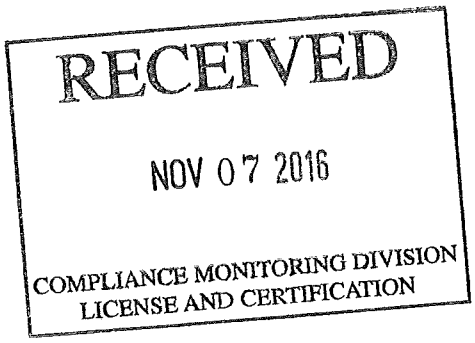
2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900 A complaint investigation was completed for H5324054 at the time of the standard recertification survey and was not substantiated. 	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease or related disorders as required. Findings include: During a review of the facility's Alzheimer's training program, evidence was lacking to show consumers had been provided a written or electronic description of the facility's Alzheimer's training program (categories of employees trained, frequency of training and the basic topics covered). At the time of the survey, the facility had numerous residents with primary diagnoses of Alzheimer's disease or other dementia.	2 302		

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2 302	Continued From page 3 When interviewed on 10/5/16, at 3:22 p.m. the interim director of nursing (IDON) stated written or electronic information provided to consumers was unavailable. The IDON further stated the assistant director of nursing services was aware of this requirement, and was working on it. A policy related to Alzheimer's training was requested from the facility but was not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. Appropriate staff could be informed/educated regarding the requirement and their responsibility to ensure it is met. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 302		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.	2 555		

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2 555	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plan approaches to minimize the risk for pressure ulcer development for 1 of 1 resident (R29) reviewed and who had existing pressure ulcers. Findings include: R29's 7/12/16, care plan for pressure ulcer risk indicated goals to heal existing pressure ulcer, and remain free from further breakdown. Interventions included, "provide pressure reduction/relieving mattress...Turning and repositioning schedule per assessment," however, no assessment to determine R29's repositioning schedule was available in the resident's record. R29's Comprehensive Skin Assessment indicated a score of 15, indicating the resident was at high risk for pressure ulcer development. The assessment indicated that after two hours of prolonged pressure, the resident's skin was "red, blanches with gentle pressure." Also checked was "Resident is able to make significant changes in positioning independently. Tissue tolerance is deferred. Will reassess if resident is not longer independent with changes in position. On 10/6/16, at 12:25 p.m. following the dressing change, RN-A explained R29 used her call light to request help and added, "I will check on her some times." R29 preferred lying on her right side, and did not have a repositioning schedule. RN-A said, "She will request when she needs to move and she does also move herself." R29's Minimum Data Set (MDS) dated 7/24/16,	2 555		

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2 555	Continued From page 5 indicated the resident was admitted to the facility with an unhealed stage IV pressure ulcer (full thickness loss with exposed bone, tendon or muscle) to the coccyx, and was at high risk for pressure ulcer development. The MDS also indicated R29 had a range of motion impairment on one side, and was dependent on two staff for repositioning in bed. RN-C was interviewed regarding R29's pressure ulcer on 10/6/16, at 1:34. RN-C stated she was responsible for providing wound care for the resident, but the MDS nurse was responsible for care planning interventions. RN-C explained R29 was "always on her right side--I have never seen her lying on her back." RN-C also stated R29's care plan needed revision, to indicate the need for staffs' assistance with routine repositioning, rather that relying on the resident to call for help when she had pain. RN-D was interviewed on 10/6/16, at 1:59 p.m. and explained she was responsible for completing the MDS assessments. RN-D explained that the resident did not have scheduled repositioning, "because she can turn herself without out staff assist." The nurse also said it was a "general understanding" residents were to be repositioned every two hours. NA-D stated on 10/6/16, at 2:12 p.m. regarding R29, "I will turn her whenever she puts the call light on. She only likes to lay down on her right side. Unless she requests, I do not move or reposition her." Following the interviews with staff, R29 stated on 10/6/16, at 2:18 p.m. "I cannot reposition myself. I can roll over for them, but they need to put pillow under me." She explained she could assist by	2 555		

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2 555	Continued From page 6 holding the grab bar for a short while, but said, "I cannot put the pillow under myself when I roll over." NA-E stated on 10/6/16, at 2:22 p.m. regarding R29's cares, "When she is wet she can put the call light on and then I will assist her. When I sometimes pass by her room I will say 'hi' to her and if she has concerns she will let me know." The facility's undated Skin Integrity Guidelines policy read, "The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified...Indicate [repositioning] frequency in the individualized plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing or nurse managers could review resident care plans to determine appropriate interventions are noted. Appropriate staff could be trained and audits conducted and brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

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2 830	Continued From page 7 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services were provided to assess and monitor 1 of 1 resident (R132) reviewed for non-pressure related skin conditions. Findings include: R132 was interviewed on 10/3/16, at 3:36 p.m. Multiple bruises were observed on the resident's left forearm. The resident reported she sustained the bruises while hospitalized, prior to her admission to the facility on 9/26/16. A bruise was present on the left anticubital space, one to the left hand near her thumb, one to the left inner forearm and one to the left outer upper forearm, all with intact skin. R132 explained one was from a blood draw, two were from intravenous therapy (IV) and one was a tuberculin test. In addition, she said bruises on her right arm were from blood draws prior to her admission to the facility. During a review of R132's medical record on 10/6/16, at 9:57 a.m. there was no documented evidence of the presence of bruising or an assessment and monitoring. R132's 9/16, physician's orders revealed the resident's medications included both aspirin, Prednisone (known to contribute to bruising potential). A hospital history form dated 9/22/16, revealed the resident would continue on deep venous	2 830		

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2 830	Continued From page 8 thrombosis prophylaxis and would utilize Sequential Compression Devices, both to minimize the risk for blood clot development. These interventions, however, were not noted on the the resident's hospital discharge orders. The facility's Clinical Health Status document completed on 9/26/16, was blank for the skin assessment. There was a note on the sheet that read, "N/A" (not applicable). A Comprehensive Skin Assessment dated 9/27/16, noted R132 had poor skin turgor, and tissue tolerance observation was noted as "normal skin color" and staff was to reposition the resident every two hours. A Braden Scale skin testing score was 13, indicating the resident was at high risk for pressure ulcer development. Progress notes at the time of R132's admission did not reflect a skin assessment of problems. A 9/28/16, care plan did not mention the presence of bruising or measures to minimize the risk for potential bruising and for healing of current bruising. Notes did indicated on 10/4/16, the resident was being tapered off the medication Prednisone. On 10/5/16, at 8:43 a.m. the education nurse explained that short term residents did not have their skin checked by the nurse weekly. Nursing assistant (NA)-C stated, "The nurse does a weekly skin assessment on every resident on their bath day." In addition, any new skin problems were reported to the nurse. However, there was no evidence of the weekly skin checks in R132's record. Registered nurse (RN)-B stated on 10/6/16, at 9:39 a.m. she had reviewed R132's medical record and did not find skin documentation in the Clinical Health Assessment. She had also	2 830		

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2 830	Continued From page 9 investigated the condition of R132 arms and stated, "Those bruises should have been documented on the clinical health record and in the progress notes." RN-B confirmed the R132 had been admitted with the bruises and they had not been sustained after her admission to the facility. RN-B also confirmed there was no other documentation in the residents records or monitoring that was being performed and documented. On 10/5/16, at 9:34 a.m. the director of nursing (DON) stated the blue Clinical Health Status form in the medical records under the assessments section of the paper chart should have contained documentation related to residents' skin. Nurses were expected to complete a skin assessment on each newly admitted resident within 24 hours of admission. Any bruises or skin issues were to be recorded on the document. After admission, skin issues were to be documented on an incident report, which was then logged. The DON also confirmed that all residents including short term stay residents should have been having their skin condition assessed weekly, and the nurse's statement was incorrect. The DON stated on 10/6/16, at 10:42 a.m. that the skin assessment should have been completed for R132 and stated, "That is an opportunity for us." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies regarding skin monitoring are current and staff are educated as appropriate. Audits could be conducted and brought the to quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 900	Continued From page 10	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary care to minimize the risk for pressure ulcer development for 1 of 1 resident (R29) reviewed and who had existing pressure ulcers. Findings include: R29 was observed on 10/4/16, at 2:36 p.m. while lying on her right side. On 10/5/16, at 8:00 a.m. R29 was again observed while in bed and was lying on her right side. Continuous observations were conducted on 10/6/16, at 9:23 a.m. R29 was assisted back to bed and was again positioned on her right side with pillow support behind her back,	2 900		

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2 900	Continued From page 11 by nursing assist (NA)-M. NA-M stated at 10:09 a.m. she was familiar with R29's cares, and said the resident let her know when she needed something. R29 remained on her right side watching television and/or with her eyes closed until 11:30 when without repositioning the resident, certified occupational therapy assistant (COTA)-A placed a splint on the resident's left arm. At 11:42 registered nurse (RN)-A checked R29's blood sugar and vital signs, but did not reposition the resident. NA-A gave the resident her meal tray at 12:03 p.m. and explained "I gave her her tray and moved her upper body." NA-A said the resident wanted to move a little bit upright, although the resident remained on her right side. R29 explained on 10/6/16, at 12:20 p.m. that she was off the pressure ulcer area, which was on her coccyx. She also stated she usually laid on her right side, as she had hip pain following surgery on her left side. R29 rated her pain at the time of the interview at a five out of 10 (10 being the worst pain) and she used her call light when she needed help from staff. On 10/6/16, at 12:25 p.m. R29 was moved briefly moved to perform pressure ulcer by RN-A and licensed practical nurse (LPN)-D. Following the dressing change, R29 requested pain medication for left hip pain. RN-A explained R29 used her call light to request help, and additionally RN-A said "I will check on her some times." R29 preferred lying on her right side, and did not have a repositioning schedule. RN-A said, "She will request when she needs to move and she does also move herself." R29's Minimum Data Set (MDS) dated 7/24/16, indicated the resident was admitted to the facility	2 900		

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2 900	Continued From page 12 with an unhealed stage IV pressure ulcer (full thickness loss with exposed bone, tendon or muscle) to the coccyx, and was at high risk for pressure ulcer development. The MDS also indicated R29 had a range of motion impairment on one side, and was dependent on two staff for repositioning in bed. RN-C was interviewed regarding R29's pressure ulcer on 10/6/16, at 1:34. RN-C stated she was responsible for providing wound care for the resident, but the MDS nurse was responsible for care planning interventions. RN-C explained R29 was "always on her right side--I have never seen her lying on her back." RN-C also stated R29's care plan needed revision, to indicate the need for staffs' assistance with routine repositioning, rather that relying on the resident to call for help when she had pain. RN-D was interviewed on 10/6/16, at 1:59 p.m. and explained she was responsible for completing the MDS assessments. RN-D explained that the resident did not have scheduled repositioning, "because she can turn herself without out staff assist." The nurse also said it was a "general understanding" residents were to be repositioned every two hours. NA-D stated on 10/6/16, at 2:12 p.m. regarding R29, "I will turn her whenever she puts the call light on. She only likes to lay down on her right side. Unless she requests, I do not move or reposition her." Following the interviews with staff, R29 stated on 10/6/16, at 2:18 p.m. "I cannot reposition myself. I can roll over for them, but they need to put pillow under me." She explained she could assist by holding the grab bar for a short while, but said, "I	2 900		

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2 900	Continued From page 13 cannot put the pillow under myself when I roll over." NA-E stated on 10/6/16, at 2:22 p.m. regarding R29's cares, "When she is wet she can put the call light on and then I will assist her. When I sometimes pass by her room I will say 'hi' to her and if she has concerns she will let me know." R29's 7/12/16, care plan for pressure ulcer risk indicated goals to heal existing pressure ulcer, and remain free from further breakdown. Interventions included, "provide pressure reduction/relieving mattress...Turning and repositioning schedule per assessment," however, no assessment to determine R29's repositioning schedule was available in the resident's record. R29's Comprehensive Skin Assessment indicated a score of 15, indicating the resident was at high risk for pressure ulcer development. The assessment indicated that after two hours of prolonged pressure, the resident's skin was "red, blanches with gentle pressure." Also checked was "Resident is able to make significant changes in positioning independently. Tissue tolerance is deferred. Will reassess if resident is not longer independent with changes in position. The facility's undated Skin Integrity Guidelines policy read, "Living Center develops a routine schedule to review patients/residents with wounds or at risk on a weekly basis and will document findings. The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified...Reposition every two hours, or as needed and tolerated, taking into consideration the patient/resident tolerance and choice, tissue	2 900		

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2 900	Continued From page 14 tolerance, current condition of skin. Indicate frequency in the individualized plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure appropriate staff are re-educated on related facility policies. Individualized assessments could be implemented for persons with pressure ulcer risk. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 of 6 employees (E1, E2, E3, E4, E5, E6) and 5 of 5 residents (R48, R135, R29, R133, R96) received tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. Findings include: During an employee record review on 10/04/16, at 8:40 a.m. E-1, whose date of hire (DOH) was 7/20/16, had no date recorded on the tuberculosis screening tool for healthcare workers (HCWs). There was a record of a tuberculin test with a note dated 10/31/12, from the nurse practitioner (NP) that read, "Your TB test indicated no exposure to TB." E-2 whose DOH was 9/27/16, had a negative chest X-ray in the record dated 9/20/16. There was no evidence of a tuberculosis screening tool for healthcare workers. E-3 whose DOH was 9/6/16, had no tuberculin screening or test results in the employee's file. E-4 whose DOH was 6/28/16, had a first step administered on 6/21/16, with risk factors noted on the tuberculin screening tool. This test was noted negative with 0 mm on 6/23/16, although there was no second step test administered. E-5 whose DOH was 7/14/16, had a "Negative PPD" recorded by a NP on 4/14/16, there was a statement of "no noted symptoms of TB" in the NP narrative. There was no evidence of a second step TST test provided by the facility. E-6 whose DOH was 7/8/16, had no tuberculin	21426		

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21426	Continued From page 16 test results on file according to the housekeeping director and a first step TST and history and risk tool was completed on 10/4/16. R48 was admitted 2/19/15. A first step TST was administered 2/19/15, it was read to be zero millimeters (mm) on 2/20/15. The second step TST was administered on 2/26/16. Although the electronic medical record (EMR) indicated the results were negative, no millimeters of induration were measured and/or recorded. R135 was admitted 9/29/16. There was no evidence of a history or risk screening. The first step TST was administered on 9/29/16, and read as negative (0 mm) on an unknown date. R29 was admitted, 9/9/16. There was no evidence of a history or risk screening. The first step TST date given is unclear. According to the EMR, education was provided to the resident on 9/9/16. There is a date noted on the medication sheet for 9/11/16, although it was unclear if this was the date test was read or what the results of the test revealed. There was no date for the day the injection was administered or read in the immunization report provided. The second step TST was provided on 9/24/16, it was read on an unknown date with 0 mm (negative). A staff's signature was recorded on the medication sheet on 9/26/16, although the results of the test were not recorded. R133 was admitted on 9/28/16. There was no evidence of a history or risk screening. The first step TST was administered on 9/2/16, and read with negative results on an unknown date. There was no evidence of induration having been measured. R96 was admitted on 3/31/16. There was no evidence of a history or risk screening. The first step TST was administered 9/7/16, and read on 9/13/16, however, a measurement was not	21426		

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21426	Continued From page 17 indicated. A second step TST was administered 9/18/16, and read on 9/20/16. There was no evidence of induration having been measured on the medication sheets although the immunization record states "step 2 TB 2 Step Mantoux Skin Test (Step 1) 9/10/2016 Negative (0 mm)." During an interview with the business office manager on 10/5/16, at 3:00 p.m. she stated that she thought the educator for the building had been tracking the TST and test results. As she reviewed the employee TST records she stated, "None of them are up to date" and said she would discuss the situation with the DON. On 10/5/16, at 2:26 p.m. the DON stated the policy read they should have been documenting the induration for the mm and that a negative response was not enough. He stated, "We have some work we can do in this area." The facility's 8/10/15, Tuberculosis, Screening Employees and New Hires indicated, "All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment...The Employee Health Coordinator (or designee) will accept documented verification of two-step TST or BAMT results within the preceding 12 months...Each newly hired employee will be screened for TB (tuberculosis) infection and disease after an employment offer has been [made but] prior to the employee's duty assignment." The TB Screening Tool for Nursing Home, used by the facility indicated that a single TB blood test for tuberculosis or a two-step TST is used. This tool also noted, the induration measurement of the test results was to be documented.	21426		

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21426	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The infection control nurse with the director of nursing could re-educate staff on facility policies related to TB screening and prevention. Audits of both newly hired staff and residents could be conducted to ensure compliance and the results could be brought the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper temperatures for 2 of 2 medication refrigerators. This had the potential to affect 18 of 58 residents (R60, R1, R36, R81, R126, R78, R96, R58, R74, R50, R76, R84, R34, R59, R137, R138, R139, R140) whose medications were stored for use in the refrigerators. Findings include: On 10/5/16, at 12:39 p.m. licensed practical nurse (LPN)-C verified the temperature in the 100-200 medication refrigerator was 32 degrees. LPN-C stated the night nurse usually checked the temperature and the reason it was not	21610		

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21610	Continued From page 19 consistently recorded was because the facility had lost some regular nurses. LPN-C verified on the October temperature log 10/1, 10/2, 10/3 and 10/4 the log was blank and on the September log 18 days the temperature log was left blank on 9/1, 9/2, 9/3, 9/4, 9/7, 9/8, 9/9, 9/10, 9/11, 9/16, 9/17, 9/20, 9/21, 9/25, 9/26, 9/27, 9/28, and 9/29/16. The September temperature log for the 100/200 refrigerator had the following temperatures documented for 9/16: 9/5, 27 degrees, 9/6, 28 degrees, 9/12, 28 degrees, 9/13, -30 degrees, 9/14, -30 degrees, 9/15, -30 degrees, 9/18, -30 degrees, 9/19, -30 degrees, 9/22, 28 degrees, 9/23, 28 degrees, 9/24, 26 degrees, and 9/30, 35 degrees Fahrenheit (F). The following day on 10/6/16, at 8:10 a.m. the assistant director of nursing services (ADNS) verified in the 100/200 medication refrigerator the temperature was 32 degrees. The thermometer was located on the middle shelf in the middle. The ADNS stated, "Maybe the thermometer is faulty. I will get another thermometer from the kitchen." The ADNS verified the following medications were stored in the 100/200 refrigerator: 14 Pneumovax vaccines, 13 Prevnar vaccine syringes unlabeled, 1 opened Tubersol multi use vial dated 9/13/16, 1/4 full, 1 opened Tubersol multi use vial dated 9/30/16, 1/2 full; 1 opened Tubersol multi use vial dated 9/28/16, 3/4 full; 1 unopened Tubersol multi use vial dated 8/21/16; R36's 5 Lantus pens unopened all dated 8/25/16, R81's Lantoprost eye drops unopened dated 10/2/16, 8 unopened influenza vaccine vials, 30 pre-filled influenza vaccine ordered 8/24/16, (instructions sent with vaccine indicated influenza vaccines should have been stored at 35.6-46 degrees Fahrenheit). In addition, the	21610		

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21610	Continued From page 20 refrigerator contained R126's Humulin 70/30 4 unopened pens dated 8/16/16, R96's 1 bottle of Gabapentin 1/4 full dated 8/24/16, labeled refrigerate, R96's second bottle of Gabapentin 1/4 full dated 8/24/16, R96's bottle of Pantoprazole 3/4 full dated 9/9/16, R96's bottle of Gabapentin full bottle dated 9/16/16, 10 pneumovaccines, 23 syringes with no date; R76's 4 Lantus pens unopened dated 8/18/16, R126's 2 unopened Novolog flex pens dated 9/27/16, R126's 1 Humalin pen.dated 8/15/16, R126's 3 unopened Novolog flex pen dated 9/9/16, R126's Novolog pen dated 8/26/16, R126's Levemir insulin dated 9/27/16, R126's 2 Lantus pens dated 8/26/16, R126's Levemir insulin dated 9/27/16, R126's 2 Lantus pens dated 8/26/16; R58's 1 unopened vial of cathflo, acti inj vase dated 5/25/16, 1 unopened vial of Novolog labeled e kit (emergency kit) dated 10/3/16, R74's 1 Victoza insulin pen unopened dated 9/29/16, R50's 2 Lantus pens unopened dated 10/3/16, R76's 2 Novolog pens unopened dated 9/24/16, R78's 2 Lantus pens unopened dated 10/2/16, R74's 3 Humalog kwik pens unopened dated 9/29/16, 1 Levemir insulin e-kit unopened dated 8/26/16, R140's Novolog unopened pen dated 9-30-16, 1 Novolog pen e-kit unopened dated 8/28/16, e-kit 1 bag of grenades (antibiotics) with green label stated "refrigerate upon arrival," R84 's 7 grenades of Nafcillin (antibiotic) upon admission; 1 stock bottle of acidophilus opened dated 6/13/16, 6 of 60 capsules left; 1 bottle of stock acidophilus opened dated 3/1/16, 1/2 full, 1 bottle of stock acidophilus opened undated, expired 10/16, 9 of 60 capsules left, and R34's Prilosec liquid 1 bottle dated 8/16/16, 1/4 full. The ADNS also verified the emergency kit was on a shelf in the 100/200 medication refrigerator and that there was a list which listed the medications inside of the kit.	21610		

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21610	Continued From page 21 On 10/6/16, at 8:01 a.m. licensed practical nurse (LPN)-D verified the transitional care unit (TCU) medication refrigerator temperature was 35 degrees. LPN-D verified the medications in the refrigerator were R60's Novolog (insulin) pen dated 9/28/16, on the label, R1's Lantus pen dated 9/16/16, 2 bottles of acidophilus house stock 1 opened dated 11/23/15, 2/3 full, and 1 opened dated 7/29/15, 1/2 full; house stock Tubersol vaccine vial opened dated 9/10/16, 1/3 full; R59's Levemir pen dated 7/15/16, R59's Toujeo insulin pen dated 7/26/16, R59's Levemir pen dated 8/19/16, R59's Levemir pen dated 7/15/16, R59's Novolog pen dated 8/19/16, R137's Novolog pen dated 9/28/16, R139's Humalin 70/30 pen dated 9/13/16, R138's Lantus pen dated 9/13/16, and a Novolog pen unopened, undated, unidentified, and unlabeled. LPN-D stated the refrigerator temperature "should be between 30 and 40 degrees and the night shift checks the temperature." LPN-D stated insulins and injectable medications for the residents were kept in the TCU medication refrigerator. LPN-D verified the temperatures on the 10/16 TCU medication room refrigerator log were 10/1, 31 degrees, 10/2, 28 degrees, 10/3, 30 degrees, and 10/4, 31 degrees. The 9/16 TCU Refrigerator Temperature Log indicated 23 blanks and the following temperatures documented for: 10/3, 18 degrees, 10/4 39 degrees, 10/8 25 degrees, 10/9, 25 degrees, 10/11, 30 degrees, 10/20, 20 degrees, 10/22, 23 degrees. The August 2016 TCU Refrigerator Temperature Log indicated 16 blanks and the following temperatures documented for: 8/1, 20 degrees, 8/3, 20 degrees, 8/4, 20 degrees, 8/5, 12 degrees, 8/7, 10 degrees, 8/8, 18 degrees, 8/11,	21610		

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21610	Continued From page 22 20 degrees, 8/12, 12 degrees, 8/15, 8 degrees, 8/19 14 degrees, 8/20, 18 degrees, 8/25, 18 degrees, 8/26, 26 degrees, 8/29, 24 degrees, and 8/30, 24 degrees. On 10/6/16, at 8:31 a.m. LPN-D who worked on 100 and 200 halls stated she did not know the proper temperature ranges for the medication refrigerators. At 9:02 a.m. the ADNS stated, "Medications should be stored at 36 to 46 degrees." The ADNS stated the medication refrigerator temperatures were supposed to be checked by the nurses on the 10:00 p.m. to 6:00 a.m. shift, but was not being done. The ADNS stated, "The night nurses and the nurses needed to be educated." At 1:21 p.m. the ADNS explained she had put another thermometer from the kitchen in the 100/200 medication refrigerator this morning and had checked it 30 minutes later and the temperature read 32 degrees. Since the refrigerator was still too cold, she had adjusted the dial of the refrigerator and planned to recheck the temperature later. The ADNS stated she had sent an email to the consulting pharmacist (CP) and so far the CP had instructed her to dispose of the insulins from the refrigerators. The ADNS also stated, "I don't think the nurses understand about the parameters" for the temperatures for the medication storage...I have already made the documentation to educate the nurses on and am going to bring to QAPI [the quality committee]." The ADNS further stated the facility had made "immediate correction and had the sheet of paper" regarding nursing education, and the nurses were being educated effective immediately and monitoring of temperatures by the ADNS and the director of nursing was being	21610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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21610	Continued From page 23 performed. R60's physician orders included orders for: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 20 units subcutaneously one time a day for type diabetes ordered 9/28/16 and an order for Tuberculin PPD Solution 5 unit/0.1 ml Inject 5 unit intradermally one time a day for 2nd Step Mantoux until 10/12/16, ordered 9/28/16. R1's physician orders included orders for: Gabapentin Capsule Give 100 mg by mouth two times a day for Type 2 Diabetes with complication ordered 9/6/16, and an order for Insulin Glargine Solution Pen-Injector 100 unit/ml Inject 25 unit subcutaneously at bedtime for Type 2 diabetes with complication Inject 25 units subcutaneous at bedtime ordered 9/6/16. R36's physician orders included orders for: Insulin Glargine Solution 100 unit/ml Inject 10 unit subcutaneously two times a day for Type 2 diabetes Inject 10 units subcutaneous 2 times daily at 8 am and 8 pm ordered 8/25/16, and an order for Novolin R Solution 100 unit/ml (Insulin Regular Human) Inject as per sliding scale ordered 8/25/16. R81's physician orders included orders for: Xalatan Solution 0.005% (Latanoprost) Instill 1 drop in both eyes at bedtime related glaucoma Give 1 drop in both eyes at bedtime ordered 12/3/15. R126's physician orders included: Gabapentin Capsule 300 mg Give 2 capsule by mouth three times a day ordered 9/27/16, Insulin Aspart Solution 100 unit/ml Inject as per sliding scale ordered 8/15/16, Levemir FlexTouch Solution	21610		

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21610	Continued From page 24 Pen-injector 100 unit/ml (Insulin detemir) Inject 40 unit subcutaneously one time a day ordered 9/27/16, Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 6 unit subcutaneously in the evening meal related to type 2 diabetes mellitus with meals ordered 9/4/16, and Tuberculin PPD Solution 5 UNIT/0.1 ML Inject 5 unit intradermally one time a day for 2nd Step Mantoux until 10/04/16 ordered 9/27/16. R78's physician orders included: Gabapentin Capsule Give 100 mg by mouth two times a day related to POLYNEUROPATHY IN DIABETES ordered 2/11/15, and an order for Insulin Glargine Solution Pen-injector 100 unit/ml Inject 27 unit subcutaneously two times a day ordered 8/16/16. R96's physician orders included: Gabapentin Solution 250 mg/5ml Give 500 mg via PEG-Tube in the morning every Sun, Tue, Thur for nerve pain ordered 9/16/16, Gabapentin Solution 250 mg/5ml mg Give 600 mg via PEG-Tube at bedtime for nerve pain ordered 9/16/16, and an order for Protonix Solution Reconstituted (Pantoprazole Sodium) Give 40 mg via G-Tube one time a day for TDD ordered 8/24/16. R58's physician orders included: 16 French catheter, Bottle Normal Saline, and irrigation kit (incontinence) ordered 7/29/16. R74's physician orders included: Insulin Glargine Solution Inject 36 unit subcutaneously at bedtime related to type 2 diabetes mellitus ordered 4/25/16, Insulin Glargine Solution Inject 36 unit subcutaneously one time a day ordered 4/25/16, Insulin Lispro (Human) Solution Inject 15 unit subcutaneously before meals ordered 3/13/16, and an order for Victoza Solution Pen-injector 18 mg/3ml (Liraglutide) Inject 1.2 mg	21610		

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21610	Continued From page 25 subcutaneously one time a day ordered 10/24/15. R50's physician orders included: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 15 unit subcutaneously in the evening for diabetes ordered 6/23/16,and an order for Lantus SoloStar Solution Pen-Injector 100 unit/ml (Insulin Glargine) Inject 22 unit subcutaneously in the morning related to type 2 diabetes mellitus ordered 2/24/16. R76's physician orders included: Lantus SoloStar Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 20 unit subcutaneously two times a day related to type 2 diabetes mellitus ordered 8/17/16, and an order for Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 8 unit subcutaneously three times a day ordered 6/22/16. R84's physician orders included: Nafcillin Sodium Solution Reconstituted 2 grams--use 2 gram intravenously four times a day for joint infection until 10/6/16, ordered 9/1/16. The facility's 5/12, Storage of Medications policy indicated "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff member lawfully authorized to administer medications." Medication storage was to be monitored by the consultant pharmacist or pharmacy designee, and "corrective action taken if problems are identified...Temperature A. Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopoeia guidelines for temperature ranges...Medications requiring	21610		

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21610	Continued From page 26 refrigeration are kept in a refrigerator at temperatures between 2 degrees C [Centigrade] (36 degrees F and 8 degrees C (46 degrees F) with a thermometer to allow temperature monitoring...The Facility should maintain a temperature log in the storage area to record temperatures at least once a day. F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines...Infusion Therapy Storage and Labeling...The Facility should assure infusion products are stored at the appropriate temperature in a medication--only refrigerator or freezer or in a designated area of a medication or biological--only refrigerator or freezer. " SUGGESTED METHOD OF CORRECTION: The director of nursing and pharmacist could ensure thermometers reflect accurate readings in medication refrigerators. The pharmacist could direct staff as to appropriate medication storage temperatures. The staff could be re-educated and return demonstrations could be expected of appropriate staff. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Seven (7) days.	21610		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or	21915		

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21915	Continued From page 27 visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 58 resident families who resided in the facility. Findings include: On 10/5/16, at 1:30 p.m. licensed social worker (LSW)-A verified the facility did not have an existing family council. LSW-A stated the last family council meeting was on 3/24/15, and no one had attended. LSW-A stated no further attempts had been made to encourage the formation of a family council. The facility's Family Council policy dated 2/4/16, indicated a family council would be formed to provide families with mutual support, receive information and education. This would be in order to allow families to offer suggestions about the facilities policies and procedures affecting resident care, treatment and quality of life. SUGGESTED METHOD OF CORRECTION: The administrator with the LSW could send letters, post information, and talk to family representatives to encourage them to develop a family council. Continued attempts should be made at least annually should representatives	21915		

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21915	Continued From page 28 decline to develop a council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		