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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P5PC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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 **12/14/2015** (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 **175** (L18)

13.Total Certified Beds **175** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 12/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 12/29/2015 (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
08/01/1969
(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: **00** (L30)

VOLUNTARY
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.
00450
(L31)

30. REMARKS
Posted 12/30/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245105
December 29, 2015

Ms. Diane Willette, Administrator
Golden Livingcenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

Dear Ms. Willette:

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 2, 2015 the above facility is certified for or recommended for:

175 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

December 24, 2015

Ms. Diane Willette, Administrator
Golden Livingcenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

RE: Project Number S5105027

Dear Ms. Willette:

On November 30, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 22, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 30, 2015, 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 22, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on September 22, 2015, that included an investigation of complaints numbered H5105118, H5105119, and lack of verification of substantial compliance with the Life Safety Code (LSC) health deficiencies at the time of our November 30, 2015 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 21, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2015, as of December 2, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 30, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December

22, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 22, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 22, 2015, is to be rescinded.

In our letter of November 30, 2015, 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 22, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 2, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Minnesota Department of Health

Certified Mail # 7011 0470 0000 5262 2403

November 30, 2015

Ms Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

RE: Project Number H5105118, H5105119 & S5105026

Dear Ms. Willette:

On September 28, 2015 and November 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey completed September 22, 2015 and a standard survey completed, completed on October 23, 2015. The surveys found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 16, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on September 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our abbreviated standard survey, completed on September 22, 2015.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the October 23, 2015 standard survey have not yet been verified. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 22, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 22, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 22, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Lake Ridge is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 22, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the November 16, 2015 revisit is enclosed.

APPEAL RIGHTS

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

Jan.Suzuki@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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 22, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245105	A. Building B. Wing	12/14/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/02/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/02/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	12/24/2015	16022	12/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245105	A. Building B. Wing 01 - MAIN BUILDING 01	12/21/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	12/02/2015	ID Prefix Reg. # NFPA 101 LSC K0050	12/02/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By SR/KJ	Date: 12/24/2015	Signature of Surveyor: 12/24/2015	Date: 12/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/21/2015		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: P5PC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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 **10/23/2015** (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 **175** (L18)

13.Total Certified Beds **175** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 12/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(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.
00450
(L31)

30. REMARKS
Posted 12/21/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7235
November 9, 2015

Ms. Diane Willette, Administrator
Golden Livingcenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

RE: Project Number S5105027

Dear Ms. Willette:

On October 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 2, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 22, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

golden
living centers

November 25, 2015

RE: Project Number S5105027
Golden Living-Lake Ridge

Susanne Reuss, Unit Supervisor
MDH
P.O. Box 64900
St. Paul, MN 55164-0900

Dear Ms Reuss,

A standard survey was completed at our facility on October 23, 2015. I have enclosed a copy of the statement of deficiencies with our plan of correction. If you have any questions regarding this information please direct them to Diane Willette at the numbers listed below.

Sincerely,

Diane Willette

Diane Willette, Executive Director
Direct Phone: 651-486-2407
email: diane.willette@goldenliving.com

POCA letter dated 12/4/2015. KJ

Golden Living Lake Ridge
2727 North Victoria
Roseville, MN 55113
651-483-5431

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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.	F 000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and it also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to make prompt efforts to resolve grievances for 2 of 2 residents (R129, R245) ✓ whose family members (FMK, FMJ) verbalized grievances as an advocate for the residents. Findings include: R129 was admitted to the facility on 03/20/15. Although the quarterly Minimum Data Set (MDS) assessment, dated 09/22/15, identified the resident's Brief Interview for Mental Status (BIMS) score as 15, indicative of an intact cognition; the plan of care dated 04/03/15, indicated R129 had impaired cognition due to Wernicke's	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Willett | TITLE: Executive Director | (X6) DATE: 11-25-15

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
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 166	Continued From page 1 encephalopathy and confusion. The plan of care, dated 04/03/15, directed staff that R129 required assistance with all transfers. The physical functioning plan of care, dated 04/03/15 revealed R129 had a physical deficit related to self-care impairment due to limited range of motion in bilateral hands, contractures and lower extremity weakness. The plan directed staff to provide assistance of 1 to 2 staff for toileting, dressing, eating, transfers, and personal hygiene. R129 used a wheelchair for mobility. The toileting plan of care directed staff to check and change R129 every 2 hours and as needed. During an interview on 10/22/15, at 4:30 p.m. FMK stated that on 04/22/15 an aide changed R129's incontinent brief and put the soiled, wet pants back on R129. FMK also explained that this aide did not know how to connect R129's gastric tube feeding and did not ask for help from the nurse. FMK stated these concerns were brought up to management. FMK stated that after being persistent with concerns regarding this aide's lack of assisting R129, the aide was finally removed from providing R129's cares. FMK addressed another example of lack of care that occurred on 05/02/15 when R129 spilled some water on her clothing during breakfast. R129 asked staff to take her to the bathroom to change her clothing and staff refused to help her. FMK indicated that these examples were common occurrences and felt that the issues were not followed up on. FMK stated it was "very disheartening to see [R129] in soiled clothing." FMK added, she could not understand why health care workers would not do their jobs to provide proper care to these vulnerable adults who were dependent on them for their daily cares. FMK said it was very	F 166	F 166 -R129 and R245 grievances related to care has been completed and followed up on regarding care concern. -All residents with a grievance have the potential to be affected. The process and guidelines for resident grievances has been reviewed and education provided to leadership team members. -Weekly audits of resident grievance will be conducted and findings reported to QA&A to ensure that guidelines are followed. -Director Social Services/designee is the responsible party. RECEIVED DEC 01 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 166	Continued From page 2 frustrating when these types of concerns are brought to the attention of management, and no follow-up is done. FMK also reported that another resident was observed to sit in BM soiled clothing for over 2 hours without being changed and brought this concern to the management. To date FMK had not seen changes made to improve the care. R245 was admitted on 05/14/15. The quarterly MDS, dated 08/13/15, identified R245 had severely impaired cognition and short/long term memory problems. The plan of care, dated 05/14/15, directed staff to anticipate R245's needs due to impaired communication related to aphasia, impaired cognition and language barrier. The plan identified R245 was dependent on staff for all activities of daily living including toileting, dressing, eating, oral hygiene and personal hygiene. The resident used a mechanical device with assist of 1 to 2 staff for transferring needs. R245 used a wheelchair propelled by staff for mobility. The plan further directed staff to toilet and reposition R245 every 2 hours and as needed. During an interview with family member (FMJ) on 10/22/15, at 4:40 p.m. FMJ indicated she had brought repeated concerns to management related to R245's lack of timely care and lack of staff assisting R245 when her clothing becomes soiled. FMJ added that she visited R245 at least one to two times per day to help R245 with cares and did not feel that management had followed up on her concerns. FMJ stated, "[R245] is neglected because they [staff] don't check her	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 166	Continued From page 3 every 2 hours as her care plan says and she is wet/dirty for 6 hours or longer." FMJ continued to voice frustration about R245's wellbeing and explained, R245 had a stroke and was dependent on staff for daily cares. R245 did not speak English, but did speak some Russian. FMJ further explained that she noticed when staff did not clean and change R245's dirty clothing within a reasonable time, R245 would start to pull and tug on her soiled clothing in an attempt to take it off. FMJ said that staff considered this as R245 exhibiting behaviors. FMJ stated no one would like to sit in their own urine/bowel movement (BM) soiled clothing for hours without making an attempt to take it off. FMJ stated, although the management said they had re-trained their staff, the problem persisted week after week, because she did not notice any changes despite multiple verbal and written grievances brought to the management's attention. When asked what management consisted of, FMJ said the current management staff included the administrator, the director of nurses, and the director of social services. The grievance tracking log from April through September 2015 were reviewed on 10/22/15 and the grievances voiced by FMK and FMJ were noted on these logs. For 04/22/15 incident with R129 the resolution was noted as family brought additional clothing and the aide was educated. However; it did not address if the family was made aware of this plan. The 5/2/15 incident with R129 was also noted in the log and the resolution documented was to accommodate request as much as possible and redirect/educate employee. The grievance tracking log had identified the	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 166	Continued From page 4 concern brought to the attention of staff for R245, dated 8/30/15. R245's family (FMJ) reported R245 had BM under R245's nails, in and around mouth. The night shift staff indicated R245 was not soiled when they made their rounds, "just wet, and clothes were not in the laundry and were "soaking wet." The resolution section had documentation that this concern was unfounded, "no s/sx [sign/symptoms] of allegation" noted. The 8/31/15 note for R245 in the grievance log indicated findings were shared with [FMJ] and [FMJ] stated, "it must have happened after 10P." On 10/23/2015, at 10:11 a.m. the administrator (ADM) stated, the concern forms are used to document the family, resident or staff concerns for management to follow-up. ADM added, this was also discussed at the quality assurance monthly meetings. The concern form was reviewed by the whole team and an investigation was started to find out the truth. The investigative process involved interviewing all parties involved and coming up with a viable resolution for the concern. ADM added, the resolution might include re-training the staff involved or adjusting the plan of care for the resident and that this information would be shared with the family member. ADM stated, R245 was experiencing some diarrhea when the concern was brought up to the management so they consulted with the physician/nurse practitioner for anti-diarrhea medication to help R245. ADM stated the family might not be in agreement with the discussed resolution, but they did follow-up on the concerns brought to their attention. When asked why the family members felt that the follow-up was not discussed with them, ADM did not provide any specific answers and added this was an ongoing process.	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 166	Continued From page 5 The facility's Grievance policy and procedure, revised on 01/19/15 indicated the grievance forms would be used to investigate and resolve grievances in a timely manner, within five working days. The management would be involved in investigation and resolution process. After the investigation is completed the person voicing grievances would be informed of the resolution. It indicated if a resolution is not reached, there would be a formal meeting set up with the person who voiced concerns and with management to attempt to resolve the issues.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 -R213, R151, R79 reports have been reviewed and follow up was completed as indicated by the Executive Director. -All residents have the potential to be affected. -Education has been provided to the leadership team on the guidelines for reporting and the facility Vulnerable Adult Policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 6 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were thoroughly investigated, reported to the administrator immediately and reported immediately to the state agency for 3 of 6 residents (R151, R79, 213) reviewed for incidents. Findings include: R151, according to facility documents, was assessed 6/13/15 and 9/1/15 to have moderate cognitive impairment. R151 was interviewed on 10/20/15, at 10:01a.m. and expressed being verbally abused by a registered nurse [RN-C] who worked on the transitional care unit (TCU) when R151 was first admitted for rehabilitation. R151 expressed being very particular about medications and wanted to be involved in all	F 225	-All facility reports and investigations will be reviewed by the Executive Director and the Director of Social Services for guideline and policy compliance. Any negative finds will be reported immediately and monitoring/auditing of all other concerns will be reported monthly to QA&A. -Executive Director/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 7 decisions regarding the medications he was taking. R151 explained that he had asked RN-C what the medications were for, and RN-C was insistent to "just take the medicine". R151 said he reported this to the charge nurse and stated he did not want this nurse to give him medications because she was verbally abusive. R151 went on further to explain that he didn't know what RN-C was doing with the medications and that "emotionally" R151 did not have "confidence" in the nurse. Furthermore R151 stated that he felt "intimidated" when RN-C stood in the bedroom doorway waiting for R151 to take the medication. R151 thought there were meeting minutes on this interaction because of reporting the incident to the charge nurse but identified that no one had followed up with him about the resolution to the verbal abuse. Document review of the plan of care dated 6/23/15, for R151 indicated an individual abuse prevention assessment and plan of care with a goal which directed: Resident will be free from abuse and the approaches read, Conduct annual training on abuse prevention and reporting for associates. Follow VA/Abuse Prevention Policy and Procedure; file reports to CEP/MDH per policy and procedure PRN (whenever necessary) Observe and provide safe environment. Medicate per orders; monitor for SE (.....) During an interview on 10/22/15, at 9:51 a.m. RN-A and RN-F verified knowing about the altercation between R151 and RN-C and that RN-C was not to be involved with caring for R151. On 10/22/15, at 10:27 a.m. RN-A, RN-F and the director of social services (DSS) were unable to find any documentation regarding the altercation	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 8 R151 reported. There was no evidence that the incident was reported to appropriate persons or that a thorough investigation had been conducted. R79 who was assessed as cognition severely impaired, had bruises of unknown origin reported to the state agency, however, the facility failed to conduct a thorough investigation of the bruises and failed to interview other residents and staff, as directed by the facility policy. A routine interview was conducted with R111 (R79's roommate) assessed on 9/1/15 as cognitively intact. During this interview on 10/20/15, at 2:52 p.m. R111 was questioned about seeing residents at the facility being abused. R111 expressed concerns for her roommate R79 and stated, "She has no one to stick up for her." Furthermore R111 said she has heard her roommate "cry" when caregivers are with her and has heard the care givers tell her roommate to "stop crying". R111 expressed the aides talk down to her roommate and call her a "baby." R111 feels the staff are "rough and mean" and said they yank her shirt off, causing her paralyzed arm to fall hard. R111 said that she has told many staff but no one has gotten back to her about the concerns, and no one has interviewed her about her roommate, who cannot speak for herself. During document review of facility reported cases to the State Agency there was a report on R79 from 10/14/15, due to bruising of unknown origin. R79 was observed with bruises on right buttock measuring 7.5 cm (centimeter) X 8.0 cm Dark purple in color. Bruise on left buttock measuring	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 9 2.8 cm X 2.4 cm. Facility staff speculated the bruising could have been caused by the seat belt buckle if the resident sat on the buckle. There was no further investigation. R79's roommate (R111) was not interviewed. When interviewed on 1022/2015, at 11:51 a.m. SSD and RN-A verified they were not aware of R111 expressing concerns for her roommates care. When interviewed on 10/23/15 at 10:57 a.m. SSD and RN-A verified there was a Vulnerable Adult report for bruising of unknown origin submitted for R79 but the roommate R111 was not interviewed according to the policy and procedure to determine knowledge of the event. When interviewed on 10/23/15 at 11:20 a.m. the director of nursing (DON) verified according to the policy roommate R111 should have been interviewed regarding roommate R79's new bruises of unknown origin. The facilities current Policy and Procedure dated March 2012, was titled, Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or injuries of Unknown Source in Accordance With Federal and Minnesota State Vulnerable Adult Act Requirements, In reviewing the document under the section titled, Protection, read, B. Where the circumstances of the alleged violation warants, the DNS [director nursing services] or Charge Nurse shall initiate a physical and mental assessment of the resident and document the findings. Factual information only shall ve documented, not assumptions. The DNS shall also notivy the attending physician regarding	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 10 the alleged violation and findings and document the contact. The policy continues to define abuse as, an infliction of injury, unreasonable confinement, or punishment that results in physical harm, pain or mental anguish. It may be verbal, sexual, physical or mental. Under the title Neglect, read, a failure or omission to supply a resident with care or services that are needed to obtain and or maintain the resident's health and safety. It includes the failure to provide care or services to avoid physical harm, mental anguish, or mental illness. Under the policy section titled Investigation, read, A. All investigations shall be conducted by the ED [executive director] or DNS, In the event an alleged violation occurs when neither of these people are in the facility, the charge nurse is responsible for initiating the investigation procedure and promptly reporting the alleged violation to the ED and DNS. B. The investigation shall include interviews of associates, visitors or residents who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions or speculation. R213'significant Minimum Data Set dated 9/10/15, indicated R213 was cognitively intact. R213's current plan of care dated 8/28/15, identified R213 was at risk for impaired communication and that staff should allow calm, unhurried environment to encourage communication, maintain eye contact and listen carefully and encourage patient to verbalize	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 11 needs. A verification of investigation report dated 9/6/15, indicated that R213 woke up with a headache so did not want to go to breakfast at that time. After taking Tylenol her headache got better, she turned on her light and told staff that she was ready to go down to breakfast. R213 stated that when nursing assistant (NA)-H returned to her room she was in the bathroom and as soon as NA-H entered the room she "yelled at me and said I was a liar." R213 stated she could not get out of the bathroom and listened to her for what seemed a long time, but was probably just a couple of minutes. R213 stated she was very shaken up and spent most of the day outside of her room. R213 stated she did not want NA-H near her. The investigative report indicated R213 had no history of behaviors and was able to "articulate her needs and us [sic] the call light appropriately." The investigative report indicated the alleged perpetrator (NA-H), another nursing assistant, (NA-I) and the DON were the only persons interviewed. There was no further investigation of the incident. Review of the investigative report indicated the allegation of verbal abuse was not submitted to the state agency until 9/7/15, one day after the incident occurred. During an interview on 10/22/15, at 2:16 p.m. the ED verified the incident occurred on 9/6/15 and was reported on 9/7/15. ED stated it should have been reported immediately and "is unacceptable." During an interview on 10/23/15, at 11:09 a.m. the DON stated she was told there was a disagreement between R213 and an aide with	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 225	Continued From page 12 other staff present, so she instructed staff to put it on an investigation form and changed nursing aide assignment for R213. DON stated the next day R213 stated staff screamed at her and it was determined that it should be reported. During an interview on 10/23/15, at 11:09 a.m. SSD verified that she made no attempts to interview other residents or staff members. The facility Abuse Prevention Policy titled, "Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or injuries of Unknown Source in Accordance With Federal and Minnesota State Vulnerable Adult Act Requirements" with revision date of March 2012, indicated "the facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and the Common Entry Point as required by State and Federal law." The policy further indicated any occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property be reported immediately to the executive director and reportable incidents must be reported immediately to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F226 -R213, R151, R111, and R79 reports have been reviewed and all follow up has been completed by the Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were thoroughly investigated, reported to the administrator immediately and reported immediately to the state agency for 3 of 6 residents (R151,79, R213) reviewed for abuse. Findings include: The facility Abuse Prevention Policy titled, "Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or injuries of Unknown Source in Accordance With Federal and Minnesota State Vulnerable Adult Act Requirements" with revision date of March 2012, indicated "the facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and the Common Entry Point as required by State and Federal law." The policy further indicated any occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property be reported immediately to the executive director and reportable incidents must be reported immediately to the state agency. Reviewing of the policy document under the section titled, Protection, read, B. Where the circumstances of the alleged violation warants, the DNS [director nursing services] or Charge Nurse shall initiate a physical and mental assessment of the resident and document the findings. Factual information only shall be	F 226	-All residents have the potential to be affected. -Education has been provided to the leadership team on the guidelines for reporting and the facility Vulnerable Adult Policy. -All facility reports and investigations will be reviewed by the Executive Director and the Director of Social Services for guideline and policy compliance. Any negative finds will be reported immediately and monitoring/auditing of all other concerns will be reported monthly to QA&A. -Executive Director/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 14	F 226		

documented, not assumptions. The DNS shall also notify the attending physician regarding the alleged violation and findings and document the contact.

The policy continues to define abuse as, an infliction of injury, unreasonable confinement, or punishment that results in physical harm, pain or mental anguish. It may be verbal, sexual, physical or mental. Under the title Neglect, read, a failure or omission to supply a resident with care or services that are needed to obtain and or maintain the resident's health and safety. It includes the failure to provide care or services to avoid physical harm, mental anguish, or mental illness.

Under the policy section titled Investigation, read, A. All investigations shall be conducted by the ED [executive director] or DNS, In the event an alleged violation occurs when neither of these people are in the facility, the charge nurse is responsible for initiating the investigation procedure and promptly reporting the alleged violation to the ED and DNS. B. The investigation shall include interviews of associates, visitors or residents who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions or speculation.

R151 was assessed 6/13/15 and 9/1/15, to have moderate cognitive impairment, according to facility documents. During interview on 10/20/15, at 10:01a.m. R151 expressed being verbally abused by a registered nurse [RN-C] working on the TCU (transitional care unit) when R151 was first admitted for rehabilitation. R151 stated that he reported this to the charge nurse and thinks there are meeting minutes on this interaction but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 15 no one has ever gotten back to him about the resolution to the verbal abuse. During an interview on 10/22/15, at 9:51 a.m. RN-A and RN-F verified knowing about the altercation between R151 and RN-C and that RN-C was not to be involved with caring for R151. On 10/22/15, at 10:27 a.m. RN-A, RN-F and the director of social services (DSS) were unable to find any documentation about the altercation R151 was expressing. R79, assessed by the facility as having cognition of severely impaired, had bruises of unknown origin reported to the state agency, however the facility failed to thoroughly investigate the bruises and failed to interview other residents and staff, as directed by the facility policy. During document review of facility reported cases to the State Agency there was a report on R79 from 10/14/15, due to bruising of unknown origin. R79 was observed with bruises on right buttock measuring 7.5 cm (centimeter) X 8.0 cm Dark purple in color. Bruise on left buttock measuring 2.8 cm X 2.4 cm. Facility staff speculated the bruising could have been caused by the seat belt buckle if the resident sat on the buckle. There was no further investigation. Resident's roommate was not interviewed. During a routine interview with R111, (roommate of R79), who assessed on 9/1/15 as being cognitively intact, was interviewed on 10/20/15, at 2:52 p.m. When questioned about seeing residents at the facility being abused, R111 expressed concerns for her roommate R79 and stated, "She has no one to stick up for her."	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 16	F 226		

Furthermore R111 said she has heard her roommate "cry" when caregivers are with her and has heard the care givers tell her roommate to "stop crying". R111 expressed the aides talk down to her roommate and call her a "baby." R111 feels the staff are "rough and mean" and said they yank her shirt off, causing her paralyzed arm to fall hard. R111 said that she has told many staff but no one has gotten back to her about the concerns, and no one has interviewed her about her roommate, who cannot speak for herself.

When interviewed on 10/22/15, at 11:51 a.m. SSD and RN-A verified they were not aware of R111 expressing concerns for her roommates care.

When interviewed on 10/23/15 at 10:57 a.m. SSD and RN-A verified there was a Vulnerable Adult report for bruising of unknown origin submitted for R79 but the roommate R111 was not interviewed according to the policy and procedure to determine knowledge of the event.

When interviewed on 10/23/15 at 11:20 a.m. the director of nursing (DON) verified according to the policy roommate R111 should have been interviewed regarding roommate R79's new bruises of unknown origin.

R213 reported an allegation of verbal abuse which was not thoroughly investigated and submitted immediately to the state agency according to the facility policy.

R213's current plan of care dated 8/28/15, identified R213 was at risk for impaired communication and that staff should allow calm, unhurried environment to encourage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 17	F 226		

communication, maintain eye contact and listen carefully and encourage patient to verbalize needs.

A verification of investigation report dated 9/6/15, indicated that R213 woke up with a headache so did not want to go to breakfast at that time. After taking Tylenol her headache got better, she turned on her light and told staff that she was ready to go down to breakfast. R213 stated that when nursing assistant (NA)-H returned to her room she was in the bathroom and as soon as NA-H entered the room she "yelled at me and said I was a liar." R213 stated she could not get out of the bathroom and listened to her for what seemed a long time, but was probably just a couple of minutes. R213 stated she was very shaken up and spent most of the day outside of her room. R213 stated she did not want NA-H near her. The investigative report indicated R213 had no history of behaviors and was able to "articulate her needs and us [sic] the call light appropriately." The investigative report indicated the alleged perpetrator (NA-H), another nursing assistant, (NA-I) and the DON were the only persons interviewed. There was no further investigation of the incident.

R213's significant Minimum Data Set dated 9/10/15, indicated R213 was cognitively intact and needed assist of one for locomotion off the unit to areas such as the dining room. The Care Area Assessment dated 9/10/15, indicated R213 was on an antidepressant medication but showed no side effects.

During an interview on 10/22/15, at 2:16 p.m. the ED verified the incident occurred on 9/6/15 and was reported on 9/7/15. ED stated it should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 226	Continued From page 18 been reported immediately and "is unacceptable." During an interview on 10/23/15, at 11:09 a.m. the DON stated she was told there was a disagreement between R213 and an aide with other staff present, so she instructed staff to put it on an investigation form and changed nursing aide assignment for R213. DON stated the next day R213 stated staff screamed at her and it was determined that it should be reported. During an interview on 10/23/15, at 11:09 a.m. SSD verified that she made no attempts to interview other residents or staff members.	F 226		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon cocerns from resident council meetings which included 9 residents. 1 of 9 residents (R111) voiced a concern that had specifically been brought up at the meetings and had not been followed up on Findings include: R111's quarterly MDS, dated 9/1/15, identified R111 as able to make self-understood and	F 244	F244 -R111 received direct communication and follow up on her concerns -All residents who attend resident council have the potential to be affected. - The process for complaint follow up in resident council has been modified. Education on the new process has ben conducted for the leadership team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 244	Continued From page 19 understand others with BIMS score of 15 (cognitively intact). R111 was interviewed on 10/22/15 at 3:17 p.m. and stated that when nursing assistants (NA's) are delivering ice water, R111 tries to talk to them about concerns with how the ice water is delivered, but the NA's walk out of the room. R111 explained that this was brought up during resident council meetings, however, no follow-up had been done. Review of resident council minutes for August and September 2015 identified the following: 8/13/15: "Nursing: 1. Residents stated that nursing assistants walk out of the room when they are still talking to them. Staff say they will come back to help and they never come back." There was no grievance/concern form regarding residents' concerns. 9/10/15: "Nursing: 1. Residents stated that nursing assistants walk out of the room when they are still talking to them. Staff say they will come back to help and they never come back." However, there was no grievance/concern form regarding residents concerns. Review of an email dated 8/18/15 at 4:06 p.m. from director of therapeutic recreation (DTR) to the administrator, sent to the administrator, director of nursing, director of social services (DSS) and director of environment that read, "Here are the minutes for the August Resident Council. Because there were only two weeks between the meetings, I noted that responses were not received yet. I have attached both July and August resident council minutes and need each of you to respond to both meetings so I can address the issues in Sept. The Sept meetings will be on 9/10/15."	F 244	-Monthly audits of the resident council meeting minutes will be followed up from the prior month. Newly identified concerns will be brought to the attention of the department identified in the concern with the results reported to QA&A. -Director of Therapeutic Recreation/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 244	Continued From page 20 During interview on 10/23/15 at 12:30 p.m. DSS explained that the expectation was that staff fill out grievance/concern forms for any complaints and route them so that the concerns can be followed up on. DSS stated there were no grievance or concern forms regarding resident complaints of nursing assistants walking away from them from the resident council meetings or specific to R111. DSS explained that a new grievance/concern form would be completed "now." On 10/23/15 at 12:53 p.m. DTR expressed, "I did not fill out any grievance/concern form because it was not an individual concern as more than one resident responded about the concerns. My expectation in general is that I will talk with social services, nursing or whichever department, if they are aware of the concern and if the process has been started already by filling out the grievance/concern form and I or my staff could initiate a grievance/concern form." The facility's Grievance policy and procedures, revised on 01/19/15 indicated the grievance forms would be used to investigate and resolve grievances in a timely manner, within five working days. The management would be involved in investigation and resolution process. After the investigation is completed the person voicing grievances would be informed of the resolution. It indicated if a resolution is not reached, there would be a formal meeting set up with the person who voiced concerns and the management to attempt to resolve the issues.	F 244		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 280	Continued From page 21 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure participation in care planning and interdisciplinary input prior to the use of a lap belt and sensor alarm for 1 of 2 patients (R289) reviewed for participation in care planning. Findings include: The facility failed to attempt to include R289 in the decision to implement a lap belt and sensor alarm and failed to ensure his delegated decision making proxy, (F)-A was fully informed of risks, benefits and alternatives. The facility failed to include input from all relevant members of the interdisciplinary team prior to initiating an alarm.	F 280	F 280 -R289 had a care conference and the use of a mobility alarm was addressed. -All residents have the potential of not participating in care plan. -The system for involving and communicating care plan updates/changes with resident and responsible parties has been reviewed and revised. -Education with the leadership team on how and when to involve IDT, residents/responsible parties on care planning, updating interventions during care conferences or PRN will be completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 280	Continued From page 22 R289's cognitive loss and dementia care area assessment, dated 10/6/15, revealed R289 had moderately impaired cognition and difficulty with orientation related to a diagnosis of cancer and cerebrovascular disease. The communication care area assessment, dated 10/6/15, revealed R289 was usually understood in relation to his ability to express ideas and wants. On 10/19/15 at 6:04 p.m. R289 was observed standing up from his wheelchair to get in bed. R289 was wearing a lap belt and sensor alarm that made a loud sound when R289 stood up and unlatched the belt. R289 was asked by surveyor if staff included him in the decision to institute the lap belt and sensor alarm. R289 responded "negative, they just strapped it on me." R289 added that he did not like the alarm and it made him feel insecure because he felt like staff were tracking him. On 10/21/15 at 8:55 a.m. R289 was observed finishing breakfast, stacking his juice and coffee cup and wheeling away from the table. As R289 leaned slightly forward his lap belt and sensor alarm sounded and could be heard across a dining room full of residents and staff. On 10/21/15 at 1:37 p.m. the nurse manager, (RN)-C explained R289 was admitted with a wheelchair and lap belt. However, the lap belt was not utilized until after a fall on 10/5/15. When asked what discussion the facility had with R289 about the lap belt and sensor alarm being placed RN-C responded that a team of three nurses ensured R289 could unlatch the seat belt portion, but did not attempt to ask R289 his opinion on the lap belt sensor alarm or discuss risks, benefits	F 280	F280 -Random weekly audits will be conducted of care conferences, and care plan updates that resident/responsible parties have been involved/communicated with. Audit results will be presents at QA&A for review and action planning. -Director of Social Services/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 280	Continued From page 23 and alternatives. RN-C explained the facility contacted R289's family member and designated alternate decision maker, (F)-A regarding the use of the lap belt and sensor alarm. When asked about what conversation facility staff had with F-A, RN-C reported nursing staff told F-A the lap belt and sensor alarm would prevent falls, but did not discuss risks, benefits and less restrictive alternatives to the use of an alarm. RN-C reported only nursing staff were involved in the decision to place the alarm. RN-C was not aware of any input sought from R289's hospice team, social services, physician, nurse practitioner, recreation or occupational and physical therapy. On 10/21/15 at 5:58 p.m. F-A was interviewed via phone. When asked what the facility told her about the lap belt and sensor alarm, F-A responded "well, nothing really." F-A reported she was told the lap belt and sensor alarm would prevent falls, but was not informed of risks, benefits and alternatives. On 10/22/15 at 1:26 p.m. the administrator was asked for a policy on alarm use and what resource the facility was using to support the use of a lap belt and sensor alarm being used as an evidence based measure to prevent falls. The administrator responded she had been using alarms for 30 years and the manufacturers of alarms told them they worked. No documentation was provided to support the evidenced based use of a lap belt and sensor alarm being used to prevent falls or a policy on alarm use. On 10/23/15 at 9:31 a.m. the assistant director of nursing (RN)-E, reported the facility interdisciplinary team including nursing, social service, recreation and administrator was made	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 280	Continued From page 24	F 280		

aware of the placement of a lap belt and sensor alarm on R289 the day after it was placed, during a daily meeting. RN-E noted a document, dated 10/6/15 which indicated "[R289] alarming? seat belt self releasing" No further information on interdisciplinary team input was documented. RN-E could not find evidence the hospice staff, occupational and physical therapy, physician or nurse practitioner was notified about the placement of a lap belt and sensor alarm device on R289.

Progress Notes, dated 9/29/15 through 10/21/15 were reviewed. On 10/5/15 a note included "Family asked what we could do to prevent future falls, stated we could put a chair alarm on w/c [wheelchair]." No discussion of risks, benefits or alternatives was noted. The note indicated the physician and hospice were notified of the fall, "MD notified of fall and also notified hospice nurse [name], who came to visit with resident." However there was no indication the physician or hospice was notified of placement of lap belt and sensor alarm. On 10/5/15 a note indicated "Chair alarm, resident's wheel chair has seat belt alarm, will use that to alert staff, On command resident is able to release seat belt." There were no notes including input sought from the resident on placement of the lap belt and sensor alarm.

A review of all physician and nurse practitioner orders and progress notes from 9/29/15 through 10/21/15, did not include any documentation on the use of a lap belt and sensor alarm such as an order, input or facility notification that a lap belt and sensor alarm was placed on R289.

A review of the Post Fall Investigation/Plan, dated 10/5/15, revealed three nurses attended an IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 280	Continued From page 25 [Interdisciplinary Team] Review and Recommendations meeting and noted "Date of last fall: 1st fall; Current interventions in place: call light in reach; New interventions in place: alarming seat belt/able to self release" Review of Hospice IDT Care Plan, Updates and Facility Documentation Report, dated 10/1/15 to 10/21/15, revealed a note on 10/12/15 indicating "Pt's [patient's] privacy, dignity and independence have always been essential to his well being." The documentation did not include the hospice had been notified and provided an opportunity to give input on use of a lap belt and sensor alarm. The Falls Care Plan, dated 10/7/15, revealed R289 was at risk for falls. Interventions included "alarming w/c [wheelchair] belt in place. pt [patient] able to self release." No intervention included reviewing the use of lap belt and sensor alarm risks, benefits and alternatives with R289 or F-A. The Falls care area assessment, dated 10/6/15, included R289 was at risk of falls and used a bed alarm and lap belt and sensor alarm. The assessment directed staff "Provide input from resident and/or family/representative regarding this care area." This information was not included in the assessment.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 -R113 and R9 care plans have been reviewed and revised as indicated related to urinary incontinence and risk for pressure ulcer/skin integrity, and are receiving care per care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 282	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure care plan interventions were followed for 1 of 3 residents (R9) in the sample who was at risk for pressure ulcers and for 1 of 3 residents (R113) who was dependent on staff for toileting needs. Findings include: R9's plan of care for bed mobility dated, 8/26/10 directed staff assistance of 1-2. Assist to turn/reposition Q hr (every hour) per request and PRN (whenever necessary). The plan of care for pressure ulcer dated 3/20/15 read, Encourage to offload Q 2 hr. Provide pressure reducing wheel chair cushion. Provide pressure reduction; relieving mattress. R9 did not have a position change on 10/19/15, for three hours and forty-five minutes and on 10/21/15 R9 did not have a position change for three hours and thirty minutes. During observations on 10/19/15, at 5:06 p.m. R9 was lying in bed, supine, with the head of the bed elevated twenty degrees. When interviewed, R9 expressed buttock pain and being in the same position since shortly after lunch. Surveyor turned on the call light for assistance and at 5:13 p.m. nursing assistant (NA)-A was informed R9 was complaining of buttock pain and wanted to change position. During interview at this time with NA-A validated last cares and position change for R9 was at 1:40 p.m. and R9 was left in the supine position. NA-A verified R9 did not have a position change for three hours and forty-five minutes.	F 282	-All residents have the potential to be affected. Residents identified with urinary incontinence and skin integrity risk care plan and CNA sheets have been reviewed and revised as indicated and are receiving care per care plan. -Nursing staff and CNAs will be educated to provide cares in compliance with identified interventions in the resident care plan. -Random weekly audits will be conducted on resident(s) to ensure appropriate cares have been completed in conjunction with identified care plan interventions. Audit results will be presented at QA&A monthly. -DNS/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 282	Continued From page 27 During continuous observation of R9, on 10/21/15 at 10:35 a.m. licensed practical nurse (LPN)-C administered pain medication because R9 complained of pain in buttocks which R9 rated as a "nine and three-quarters." R9 requested to use the toilet for a bowel movement. At 10:53 a.m. RN-A informed R9 the aide was on break, but they would find another staff member to assist. At 11:15 a.m. R9 was transferred (three hours and thirty minutes without a position change after getting up at 7:45 a.m). R113's care plan indicated functional, stress incontinence and directed staff to provide 1 person assist to toilet, use of brief/pads for incontinence protection and to monitor and report changes in ability to toilet or continence status. Review of the undated NA care sheet indicated R113 was incontinent of bowel and bladder and to "toilet upon rising, after meals and at HS [bedtime]. Check/change on noc [night] rounds." During continuous observation, on 10/22/2015 from 7:20 a.m. to 7:48 a.m., nursing assistant (NA)-E was observed to assist R113 with morning cares. NA-E did not offer or ask R113 if she would like to go on the toilet. During an interview on 10/21/15, at 2:57 p.m. nursing assistant (NA)-G stated R113 is incontinent when he goes to help her, "I did not toilet her yesterday when I was here." During an interview on 10/23/15, at 9:14 a.m., registered nurse (RN)-A stated R113 does not request to go to the toilet, she is "check and	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 282	Continued From page 28 change" and has always worn a brief. During an interview on 10/23/15, at 12:11 p.m. NA-A stated R113 was incontinent and did not use the toilet. During an interview on 10/23/15, at 12:25 p.m. RN-A verified that R113's care plan and NA care sheet instructed staff to toilet upon rising, after meals, at HS and to check/change at night. RN-A stated that if any care plan or NA care sheet instructed staff to take a resident to the toilet, she would expect it to be done.	F 282		
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 visits by hospice providers were coordinated with the facility to promote communication and appropriate care for 1 of 2 residents (R9) reviewed for hospice services. Findings include: R9 was not shaved for 5 days	F 309	F309 -R9 had a coordinated meeting with Hospice and facility Nurse Manager to ensure coordination of care is provided, and needs at the end-of-life to maintain highest level of well-being. -Residents receiving hospice/end of life services have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 309	Continued From page 29 During an observation on 10/19/15, at 5:06 p.m. R9 had a heavy growth of facial whiskers and acknowledged not being shaved because of waiting for the hospice aide to provide the shave. When questioned further, R9 did not know when the hospice aide would be coming but preferred the hospice aide shave because R9 trusted the hospice aide would clean the razor properly and did not trust the facility staff would take care of the shaver as well due to past experiences. R9 verified feeling better when clean shaven but was concerned about the staff training for proper shaving and cleaning of the shaver at the facility. Nursing assistant NA-F assisted R9 out of bed on 10/19/15, at 5:13 p.m. and when questioned did not know when the hospice aide would be in and did not know where to look up when hospice would be coming into the facility for R9. NA-F verified R9 was in need of being shaved. During an observation on 10/20/15, at 8:08 a.m R9 was up in the chair waiting to go to breakfast. R9 had a heavy growth of facial whiskers and again acknowledged did not shave because is waiting for the hospice aide. R9 did not know when the hospice aide would be in. During an observation on 10/21/15, at 7:45 a.m. morning cares were completed by nursing assistant (NA)-D who was helping the unit until NA-C arrived, and there was no offer to shave fascial hair. When questioned about the shaving NA-D implied hospice would shave R9 but NA-D did not know when hospice would be in and did not know where to look up when hospice would be in to provide cares. NA-C was interviewed at 9:30 a.m. and did not know when the hospice aide would be in for R9 and did not know where to look up the information. NA-C and NA-D	F 309	-Licensed staff will be educated to provide interventions, cares, and services to enable the resident to maintain his/her highest level of well-being in accordance with the resident's wishes and to document deviations/refusals from the care planned interventions as the resident wishes. Staff also educated on the coordination of cares by facility and hospice. -Random weekly audits will be conducted on resident(s) to ensure appropriate cares have been completed in conjunction with identified care plan interventions. Audit results will be presented at QA&A for review and action planned as needed. -Nursing Managers/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 309	Continued From page 30 verified R9 was in need of shaving. During an interview with licensed practical nurse (LPN)-C on 10/21/15, at 8:30 a.m. revealed not knowing when hospice would be in and did not know where to look up the information since she was new to the facility. During an interview with registerd nurse (RN)-A on 10/21/15, at 10;35 a.m. revealed not knowing when the hospice aide would be in this week for R9 and would need to get back to surveyor. During an interview on 10/22/15, at 9:33 a.m. NA-E was questioned when hospice would be in to provide services for R9 and NA-E re-affirmed did not know when hospice would be in and did not know where to look up the information. Document review of the plan of care dated 7/10/10 indicated hospice focused cares in general and personal hygiene assistance of one. There was no plan of care for shaving and no indication that only hospice provides shaving. There was no indication of R9's concern to be sure the shaver was cleaned properly after use. Although the plan of care directed staff to coordinate the plan of care with hospice,there was no indication the facility staff knew when hospice staff would be in to see R9 to coordinate the care. A review of the undated, nursing assistant care sheet, read, Hospice schedule in group C restorative book. On 10/22/15, RN-A produced a document that was titled, Physician Verbal Order dated, 10/17/15, and read, "Decrase [sic] aide visits to 1X/wk for week of 10/18-10/24 only. Resume aide visits 2X/wk starting week of 10/25."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 309	Continued From page 31 A document review of the facility 2006 policy titled, Shaving the Resident, read; to remove facial hair and improve the resident's appearance and morale	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 ensure 1 of 3 residents (R9) in the sample who was at risk for pressure ulcers received the necessary care and treatment to prevent pressure ulcers. Findings include: R9 did not have a position change on 10/19/15, for three hours and forty-five minutes and on 10/21/15 R9 did not have a position change for three hours and thirty minutes and acquired a new open area 1.8 X 2.5 centimeter size to the right sacrum. Document review of R9's quarterly Minimum Data Set (MDS) dated 9/1/15, indicated cognition was	F 314	F314 -R9 was seen by the Nurse Practitioner and the facility Wound Nurse, skin and wound care was reviewed. -Residents identified as at risk for the development of pressure ulcers have the potential to be affected. -Nursing staff will be educated to provide care and services as, identified in the care plan, that promote healing of pressure ulcers. Licensed staff has been educated to document refusals/non-compliance with the recommended interventions/cares.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 314	Continued From page 32 moderately impaired, was able to make needs known and was at risk for development of pressure ulcers. There were no unstageable skin issues and no pressure ulcers identified. A review of R9's plan of care for bed mobility dated, 8/26/10 directed assistance of 1-2. Assist to turn/reposition Q hr (every hour) per request and PRN (whenever necessary). The plan of care for pressure ulcer dated 3/20/15 read, Encourage to offload Q 2 hr. Provide pressure reducing wheel chair cushion. Provide pressure reduction; relieving mattress. During observations on 10/19/15, at 5:06 p.m. R9 was lying in bed, supine, with the head of the bed elevated twenty degrees. When interviewed, R9 expressed buttock pain and being in the same position since shortly after lunch. Surveyor turned on the call light for assistance and at 5:13 p.m. nursing assistant (NA)-A was informed R9 was complaining of buttock pain and wanted to change position. During interview at this time with NA-A validated last cares and position change for R9 was at 1:40 p.m. and R9 was left in the supine position. NA-A verified R9 did not have a position change for three hours and forty-five minutes. At 5:25 p.m. R9 was positioned in the wheel chair with the use of a mechanical stand. R9 did not bear body weight. Observation of the bed linen revealed R9 had been lying on a double folded bath blanket, dressed in pants and shirt. R9 was positioned in the wheel chair with a pressure relieving cushion in place. Observation of R9 at 6:31 p.m. in the dining room revealed R9 was leaning to the left side in the specialty wheel chair. There was no documentation or assessment in R9's medical record to reference this complaint of buttock pain.	F 314	-Random weekly audits will be conducted on residents with identified pressure ulcers to ensure cares and services offered promote healing of said pressure ulcer(s), identified care plan interventions and/or documentation of refusal/non-compliance with identified cares/interventions. Audit results will be presented at QA&A for review and action plan as needed. -Wound Nurse/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 314	Continued From page 33 During observations of 10/21/15, at 6:30 a.m. R9 was lying in bed, supine with the head of the bed elevated twenty degrees. R9 was watching television and waiting to get up for the day. When interviewed, R9 expressed wanting to get up because of having buttock pain. R9 verified it was the same buttock pain discussed during interview on 10/19/15. R9 said he did not have a position change during the night, and not sure when positioning occurred on nights. At 6:59 a.m. NA-D assisted R9 with morning cares. At 7:10 a.m. R9 was turned to the right side. R9 was incontinent of bowel, R9 was not incontinent of urine due to a supra pubic catheter for neurogenic bladder. R9 did not know what time he was incontinent of bowel. There were numerous deep red creases, wrinkling and crevices to the skin surrounding posterior thighs and buttocks and an open quarter size wound was observed higher up closer to the right sacral area which was not affected by the bowel incontinence. NA-D was not aware of the open area and left the room to get the nurse. Registered nurse (RN)-A measured the wound and documented on the facility form dated 10/21/15, titled, Wound Evaluation Flow Sheet, right buttock measurement length 1.8 and width 2.5 units of measure: centimeter, and referred to the area as denuded (loss of epithelial associated with urine and feces) On 10/21/15, at 7:45 a.m. R9 was positioned in the wheel chair with the use of the mechanical stand. There were two, double folded, bath blankets wrinkled up on top of the pressure relieving mattress sheet. When interviewed at 8:00 a.m. RN-A verified folded bath blankets are used on all the residents for positioning to aide in boosting the residents in the bed. When	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 314	Continued From page 34 questioned about excess linen negating the benefits of the pressure relieving mattress, RN-A did not know and would check into the manufacturer recommendations. During continuous observation of R9, on 10/21/15 at 10:35 a.m. licensed practical nurse (LPN)-C administered pain medication because R9 complained of pain in buttocks which R9 rated as a "nine and three-quarters." R9 requested to use the toilet for a bowel movement. At 10:53 a.m. RN-A informed R9 the aide was on break, but they would find another staff member to assist. At 11:15 a.m. R9 was transferred (three hours and thirty minutes without a position change after getting up at 7:45 a.m). A review of the facility policy dated, January 2011, titled, Skin Integrity Guideline, directed, "Minimal linen under prone skin areas, i.e., only one incontinent pad or draw sheet should be used." A review of the manufacturer recommendations dated 2014, and titled, Invacare, under intended use read, a "cotton combination or linen bed sheet and any one of these would be the only item deployed between the support surface and the user."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F315 -R113 care plan and CNA sheets have been reviewed and revised as indicated related to toileting assistance, and is receiving care per care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 315	Continued From page 35 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents (R113) reviewed for urinary incontinence received the appropriate treatment and services to restore as much normal bladder function as possible. Findings include: R113 was admitted on 9/14/15. The admission Minimum Data Set dated 9/21/15, indicated R113 had severe cognitive impairment, was always incontinent of bowel and bladder and needed extensive assist of one for toileting. The Care Area Assessment dated 9/21/15, indicated R113 was not reliably able to ask for assistance, staff should attempt to anticipate needs and check and change every two hours and as needed providing peri-care with every incontinent episode. R113's Bladder Assessment Form date 9/17/15 indicated R113 had stress incontinence and a treatment program of scheduled toileting/habit training. R113's care plan indicated functional, stress incontinence and to provide 1 person assist to toilet, use of brief/pads for incontinence protection and to monitor and report changes in ability to toilet or continence status. Review of the Comprehensive Narrative Assessment Summary dated 9/28/15 indicated	F 315	-All residents needing assistance with toileting have the potential to be affected. -Licensed staff and CNAs have been educated on provided toileting assistance per care plan. -Random weekly audits that toileting assistance is provided per care plan. -Audit results will be presented at QA&A for review and action planning as indicated. -Nurse Managers/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 315	Continued From page 36 R113 required assist of one for transfers and toileting and "per Bowel and Bladder assessment and Care Tracker" she is incontinent of bowel and bladder. The assessment summary indicated R113 "will achieve her highest level of dryness if toileted upon rising, after meals, and at hour of sleep. Staff will check/change on night shift rounds." Review of the undated NA care sheet indicated R113 was incontinent of bowel and bladder and to "toilet upon rising, after meals and at HS [bedtime]. Check/change on noc [night] rounds." During continuous observation, on 10/22/15 from 7:20 a.m. to 7:48 a.m., nursing assistant (NA)-E was observed to assist R113 with morning cares. NA-E removed a saturated incontinent product and used saniwipes to wipe R113's peri area front to back and put a clean incontinent product on R113. NA-E did not offer or ask R113 if she would like to go to on the toilet. During an interview on 10/19/2015, 3:58 p.m. R113 stated toileting was an issue because it "takes so long." During an interview on 10/21/15, at 1:55 p.m. R113 stated they come and help when she asks to go to the bathroom, but "I went in my brief this morning because." During an interview on 10/21/15, at 2:57 p.m. nursing assistant (NA)-G stated R113 is incontinent when he goes to help her, "I did not toilet her yesterday when I was here." During an interview on 10/23/15, at 9:14 a.m.,	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 315	Continued From page 37 registered nurse (RN)-A stated R113 does not request to go to the toilet, she is "check and change" and has always worn a brief. RN-A stated we did a three day bowel and bladder assessment and "she is still on an evaluation period until we can get her to her best." During an interview on 10/23/15, at 12:11 p.m. NA-A stated R113 was incontinent and did not use the toilet. During an interview on 10/23/15, at 12:25 p.m. RN-A verified that R113's care plan and NA care sheet instructed staff to toilet upon rising, after meals, at HS and to check/change at night. RN-A stated that if any care plan or NA care sheet instructed staff to take a resident to the toilet, she would expect it to be done.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe mechanical lift/stand transfers were implemented for 1 of 2 residents (R9) reviewed for safe transfers with the mechanical device.	F 323	F323 -R9 lift assessment has been completed; care plan and CNA sheets have been updated as indicated. -Residents identified as needing a mechanical stand lift have the potential to be affected. -Nursing staff and CNAs have been educated on the left assessment and guidelines for use of the mechanical stand lifts and what to do if a resident refuses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 38 Findings include: Observation of a transfer with the mechanical stand on 10/19/15, at 5:13 p.m. revealed R9 did not bear any body weight during the transfer. R9 had both knees bent and pressed into the top of the left knee positioner pad. The mechanical device sling was positioned properly around R9's back but because R9 was unable to stand and bear any body weight, the sling rode up under both arms giving the appearance R9 was stretched out with arms exaggerated over head. R9 expressed pain during the transfer in both arms. During an interview following the transfer, nursing assistant (NA)-F said R9 has not been bearing weight with the device and NA-F has reported the situation to the charge nurses. NA-F did not think using the stand was a safe way to transfer R9 since R9 was unable to bear any body weight. During a second observation of a transfer with the mechanical stand on 10/21/15, at 7:45 a.m. with NA-D, again, R9 had both knees bent and pressed into the top of the left knee positioner. The mechanical device sling was positioned properly around R9's back but because R9 was unable to stand and bear any body weight, the sling rode up under both arms giving the appearance R9 was stretched out with arms exaggerated over head. R9 expressed pain during the transfer in both arms. During an interview following the transfer, nursing assistant (NA)-D said R9 has not been bearing weight with the device and NA-D has reported the situation to the charge nurses. NA-D verified using the stand was not a safe way to transfer R9 since R9 was unable to bear any body weight.	F 323	-Random weekly audits, of residents identified as needing a mechanical stand lift, will be conducted to ensure appropriate interventions are in place. Audit results will be presented at QA&A for review and action planned as needed. -Nurse Managers/designee is the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 39 Document review of the form dated 10/4/15, titled, Lift Mobility Status, indicated R9 could bear weight on both legs. The undated policy, titled, Resident Transfer Guidelines, read, All residents who have been assessed as being totally dependent or semi-dependent will require the use of a mechanical lift. R9's plan of care dated 12/31/14, indicated at risk for falls and to use the mechanical stand with transfers. When interviewed on 10/21/15, at 7:58 a.m. RN-A verified the mechanical stand would not be a safe device for R9 due to inability to bear body weight.	F 323	F371 -Education and immediate intervention took place at the time of the noted incident of hard hygiene by the Dietary Manager. -All residents that eat facility meals have the potential to be affected. -All dietary staff will be educated on when and how to wash hands between duties. -Random weekly audits will be conducted of direct observation of hand hygiene. Audit results will be presented at QA&A for review and action planned as needed. -Registered Dietician will be responsible party.	12/2/15
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate techniques for hand hygiene maintained during food preparation which had the potential to impact 25 of 25 residents with pureed diets of the 163 residents who resided in the facility. Findings include:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 371	Continued From page 40 During a tour of the kitchen on 10/22/15 at 10:22 a.m. Cook-A was observed pureeing fish and putting it into metal containers. Cook-A was observed to open the dirty garbage can lid, and without washing her hands, continued to puree fish. Cook-A then used a bucket of soapy sanitizer water to clean off the surfaces of the metal cabinets and machine used to puree fish. While cleaning her area, Cook-A dropped a knife on the floor and picked it up and put it near the sink to be washed. Cook-A then, without washing her hands, put the cap on a bottle of lemon juice, dated it and put it in the fridge. Cook-A then picked up the metal containers of pureed fish and placed them in the oven. Cook-A proceeded to the clean dish area and then clean dish cupboard to get a metal container out and retrieved a bag of frozen spinach, opened it and poured it into the metal container. When asked about hand washing during food preparation, Cook-A responded that her hands were clean from being in sanitizer water. The dietary manager [DM] directed Cook-A to wash her hands. DM reported Cook-A should clean her hands after touching garbage, the floor and cleaning her area with soapy sanitizer water prior to touching clean food and food equipment. DM explained Cook-A should use the approved hand washing sinks. The hand-washing policy, undated, directed staff: "Wash hands and exposed portions of arms:...After handling any soiled or contaminated equipment, cleaning clothes, utensils, dishes trays, soiled aprons or trashcan lids...After picking something up from the floor." The policy further directed staff "Use only an approved hand-washing lavatory to wash hands."	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 441 SS=E	Continued From page 41 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F441 -R9, R151, R113 rooms have been cleaned by housekeeping. Facility lifts have been sanitized. Blood Glucometers are cleaned per protocol. Insulin syringes are being disposed/transported of per protocol. -Licensed staff will be educated on the acceptable standard of disinfection of the glucometer, transport/disposal of insulin syringes. CNAs will be educated on sanitizing of mechanical lift stands between resident use. -Random weekly audits will be completed to ensure compliance with appropriate infection control procedures during the use of the glucometer and sanitizing mechanical lift stands between residents and disposal/transport of insulin syringes. Audit results will be presented at QA&A for review and action planned as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper sanitation of the glucometer machine for 1 of 3 residents (R151), observed for glucometer, failed sanitary hand hygiene during personal cares for 2 of 5 residents (R9, R151), failed to cover a draining wound for 1 of 1 (R9) observed with draining wound and failed to sanitize the mechanical stand after use for 2 of 2 (R9, R151) observed for transfers with a mechanical device and failed to ensure appropriate infection control measures were used during cares for 1 of 3 residents (R113) reviewed for urinary incontinence. Findings include: On 10/21/2015, at 8:40 a.m. licensed practical nurse (LPN)-C came into R151 room, set the container of supplies on the bedside stand without providing a clean barrier. LPN-C without washing hands, donned gloves and proceeded to remove supplies for an accucheck. After completing the accucheck LPN-C removed gloves and without washing hands, LPN-C sanitized the glucometer machine using an alcohol wipe for 10-15 seconds. When interviewed on 10/21/15, at 8:45 a.m., LPN-C did not know a bleach solution was to be used on the glucometer for sanitizing nor did LPN-C know that the facility bleach wipe according to manufacturer recommendations required keeping the surface wet for 1 minute. LPN-C verified handwashing should have been	F 441	-Director of Clinical Education or designee are the responsible party.	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 43 performed prior to donning gloves and after completing the procedure when gloves were removed. A review of the un-dated facility policy titled, Obtaining and testing Drop of Blood, read,1. Prepare barrier on bedside table to place your equipment (paper towel, Kleenex, paper plate, etc.) 3. Wash and dry hands, put on gloves. 11. Remove gloves and wash hands. A review of the policy for Clorox commercial germicidal wipes directed, keep the surface wet for one minute. During observation of insulin administration at 9:00 a.m.LPN-C walked through the hallway with R151's insulin pens in the uniform pocket. Also, in the uniform pocket, LPN-C pulled out a pair of gloves, donned the gloves without washing or sanitizing hands and proceeded to administer the insulin to R151. After giving both doses of Insulin, LPN-C removed gloves, discarded, and left the area without washing or sanitizing hands. RN-A re-educated LPN-C on 10/21/15 at 9:15 a.m. on how to correctly perform a Glucometer check. RN-A indicated that putting insulin pens into staff uniform pockets was not a standard of practice for infection control. Observation of catheter bag emptying for R9 on 10/19/15, at 5:13 p.m. revealed NA-A came into the bedroom and without washing or sanitizing hands, donned a pair of gloves and proceeded to empty the catheter urine bag. NA-A did not use an alcohol wipe to sanitize the tubing before or after draining the bag of urine. NA-A emptied the urinal with the urine into the toilet, rinsed the urinal and set it on the back of the toilet. NA-A removed contaminated gloves and without	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44 sanitizing or washing hands donned another pair of gloves to assist R9 in getting up using the mechanical stand device. When interviewed on 10/19/15, at 5:25 p.m. NA-D verified hands are to be sanitized or washed after removing gloves, and an alcohol wipe should have been used on the portal after draining the catheter bag of urine per industry standard and facility policy. During observation of R9 on 10/19/15, at 5:13 p.m. there was an area on the bedding of red wet substance in an approximate 3-4 inch area of the bedding in proximity to the right posterior humorous arm. When R9 was up in the wheel chair there was an open draining area approximately 1-2 inches wide and 3-4 inches long that was beefy red and moist. R9 raised the right arm in the wheel chair and there was a direct correlation to the specialty seating rim of the wheel chair and R9 rubbing the posterior right arm on this surface. Licensed practical nurse (LPN)-A brought in medication for R9 and surveyor pointed out the open draining right posterior arm and bed linen. LPN-A acknowledged this wound area had been a problem area for R9. Further observation of R9 at 7:00 p.m. revealed no covering to this draining area and there were red spots on posterior shirt sleeve. During observation on 10/20/15, at 8:08 a.m. R9 was sitting up in the wheel chair in the bedroom and there was no dressing on the open wound posterior right arm and again observed R9 rubbing the right arm against the rim of the specialty wheel chair positioning device. During observation on 10/21/15 at 7:58 a.m. there was red wet smeared substance on the bedding in proximity to the right posterior arm. Noted R9	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 45 sitting up in the wheel chair, no dressing on the open area posterior right arm. LPN-C came into the room and surveyor asked what was known about the open wound. LPN-C responsible for R9 did not know about the open area because of being new. RN-A came into the room and surveyor pointed out the draining wound as evidenced by the bed linen and observation of R9 sitting in the wheel chair revealed again rubbing posterior right arm on the wheel chair specialty padding. RN-A verified the wound had been being treated for well over a year but now sees how R9 is rubbing the wound on the wheel chair. RN-A verified the wound should have been covered. During interview with the director of nursing (DON) on 10/23/15, at 1:00 p.m. verified a dressing should have been applied per industry infection control standards to any draining wound upon discovery until further clarification of physician orders. During R9 morning cares on 10/21/15, at 7:02 a.m. nursing assistant NA-D took a box of gloves out of the bathroom and set them on the bedside tray table. NA-D donned gloves without washing or sanitizing hands and proceeded to remove R9's bed covers. R9 complained of feet burning and NA-D applied Eucerin cream to both feet. NA-D removed gloves and without washing hands donned another pair of gloves to obtain clothing from the closet, put on socks, NA-D removed the brief tabs and provided peri care using wet wipes in a package. Then NA-D turned R9 to the right side revealing incontinent bowel movement (BM). NA-D cleaned up the BM using the wet wipes. Because a wound was noted on the sacral area, NA-D removed gloves and without washing or sanitizing hands left the room	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46	F 441		

to get the nurse to visualize the wound. NA-D returned to the room, washed hands in the bathroom sink for 10 seconds, dried and donned a new pair of gloves. At 7:12 a.m., RN-A came into the room and without sanitizing or washing hands donned a pair of gloves and proceeded to measure the new wound. RN-A removed gloves and left the room without sanitizing or washing hands. NA-D continued with morning cares, retrieving a wash cloth, wetting it under running water in the bathroom, left the water running and returned to rinse out wash cloth, dropping the wash cloth in the sink in the rinsing process, returned to R9 and referred to washing "arm pits". There was no soap on the wash cloth. NA-D set the wet contaminated wash cloth on R9's tray table, applied R9's brief and pants threading the catheter through the pants leg. NA-D removed gloves and donned another pair of gloves without sanitizing or washing hands. NA-D applied a barrier of white substance to the new discovered wound on the sacral area and again without sanitizing or washing hands donned another pair of gloves to finish dressing R9. Removing pillows from the bed, putting on shoes, and informing R9 would need to get the mechanical stand. NA-D removed gloves and left the room without sanitizing or washing hands. At 7:36 a.m. NA-D returned to the room, washed hands for 10 seconds in the bathroom sink and donned gloves. R9 was not observed during this continuous observation to receive hand washing. R9 grabbed onto the handles of the mechanical stand device. NA-D adjusted R9 into the wheel chair and took the mechanical stand device back into the hallway without sanitizing the remote control or handle bars where resident held. NA-D gathered up the linen and trash, disposed of gloves and without sanitizing hands left the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 When interviewed regarding handwashing, NA-D was not sure how many seconds to spend with handwashing. During morning cares on 10/21/15, at 8:33 a.m. R151 was incontinentof bowel movement (BM) and requested to be changed. LPN-B donned a pair of gloves without sanitizing or washing hands and proceeded to take wet wipes and clean up the BM. LPN-B removed gloves and washed hands for 13 seconds. At 8:47 a.m. NA-C came into perform morning cares for R151 and proceeded to put the wash cloth in the contaminated sink, run water on the wash cloth and donned a pair of gloves without washing hands. LPN-B returned to assist NA-C and pointed out the basin to use for the wash cloth. LPN-B donned a pair of gloves without sanitizing or washing hands. LPN-B provided perineal cleansing and removed gloves and without sanitizing or washing hands donned another pair of gloves NA-C handed over to LPN-C. NA-C was holding R151 in position and assisting with personal hygiene. NA-C removed gloves and without sanitizing or washing hands left the room to get the mechanical stand device used to get R151 out of bed. NA-C returned with the mechanical device that had been used for R9 earlier and was not sanitized. NA-C donned a pair of gloves without sanitizing or washing hands and assisted LPN-B with brief application for R151. LPN-B took the dirty linen out of the room and did not sanitize or wash hands after removing gloves. LPN-B returned to the room, donned gloves without sanitizing or washing hands and proceeded to assist in the mechanical stand transfer. R151 was able to grab on to the mechanical handles. R151 was not observed washing hands during	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 continuous observation of morning cares. NA-C wearing the contaminated gloves from applying resident brief and clothing, worked the mechanical control of the device. After R151 was positioned in wheel chair and ready to be taken to breakfast, NA-C removedgloves and moved the mechanical device into the hallway. NA-C returned to the room and proceeded to wash hands for 10 seconds. When interviewed NA-C did not know the facility policy for the number os seconds for handwashing and did not know if there was a policy to sanitize the mechanical stand after each resident use for infection control. The facility did not have a specific policy for sanitizing the mechanical stand after resident use but when interviewed on 10/23/15, at 1:00 p.m. the director of nursing (DON) verified the control device and handles residents grab on to should be sanitized inbetween resident use. The facility staff were to follow the Center for Disease control Guidelines for 20 second vigourous handwashing inbetween glove use. During continuous observations, on 10/22/2015 from 7:20 a.m. to 7:48 a.m., nursing assistant (NA)-E was observed to assist R113 with morning cares. NA-E entered the room, closed the door, went to the closet, asked R113 what clothes she would like and without washing her hands, put on gloves. NA-E pulled back the bed covers, pulled a saturated incontinent product down between R113's legs, used saniwipes to wipe R113's peri area front to back, throwing each saniwipe away after one use. NA-E took off her gloves, asked R113 to roll to the left and without washing hands, put on new gloves. NA-E asked R113 to roll over again, wiped her backside, threw all saniwipes in the waste basket, put a clean incontinent product	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 on asking R113 to roll back and forth to fasten it. NA-E did not offer or ask R113 if she would like to go to on the toilet. NA-E took off her gloves and without washing her hands pulled R113's pants halfway up. NA-E assisted R113 to sit up with her legs over the edge of the bed. NA-E went to the sink, put the washcloth in the sink, turned on the water and without washing her hands, put a glove on her right hand. R113 laid herself back down on the bed, NA-E put a glove on her left hand, assisted R113 to sit back up and proceeded to wash R113's top of head and face. NA-E put the used washcloth in a plastic bag on the floor, cueing R113 to hold onto the grab bar with her right hand. NA-E then took off both gloves, and without washing R113's upper body, put her shirt on. R113 kept laying back onto the bed with NA-E gently assisting her to an upright position. NA-E then put R113's shoes on, put a transfer belt around her waist at which time R113 layed back down. NA-E assisted her to a sitting position, cued R113 to hold the right armrest of the wheelchair with her left hand and assisted her to stand. NA-E pulled up her pants, cued her to pivot and sit in the wheelchair. Using the transfer belt NA-E repositioned R113 in her wheelchair, put the wheelchair footrests on and wheeled R113 out into the hallway outside her room. NA-E came back into the room, put gloves on and changed the bed. When asked if the bedding is changed everyday, NA-E stated "only when it is wet" and verified that the bedding and soaker pad was indeed wet. Registered nurse (RN)-A saw R113 in the hallway and asked if she could put on her wig, brought R113 back into her room to arrange it and stated she was taking her out to the dayroom. NA-E took her gloves off, took the plastic bag of dirty linen down the hallway, opened the door to the soiled laundry room and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50 dropped off the plastic bag of linens. NA-E then went directly into the next room which was the common bath area and retrieved clean washcloths, walking down the hallway past R113's room, with the washcloths under her right armpit. At no time during the observation period did NA-E use alcohol gel or wash her hands before or after gloving. NA-E was interviewed at this time, 7:48 a.m., "I guess I should have washed my hands before leaving the room." NA-E stated she was changing her gloves, but didn't wash her hands. When asked when hands should be washed, NA-E stated "after any different part of the body." During an interview on 10/22/15, at 7:49 a.m., RN-A stated she would expect "standard hand washing", that hands should be washed if they were soiled and before and after cares. RN-A stated "we provide hand sanitizer and encourage using this unless hands are visibly soiled, then need to wash." On 10/22/2015 at 8:50 a.m., RN-A stated she "re-educated" NA-E giving her a peri care/hand washing audit tool. Review of the facility Handwashing/Hand Hygiene policy with revision date August 2014 indicated that the facility considers hand hygiene the primary means to prevent the spread of infections. Under Routine Hand Hygiene, the policy directed staff to use an alcohol-based hand rub or alternatively soap and water for the following situations: a) before and after coming on duty, b) before and after direct contact with residents, f)before donning sterile gloves, h) before moving from a contaminated body site to a clean body site during resident care, i) after	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51 contact with a resident's intact skin, l) after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident and m)after removing gloves. The policy further directed staff to perform hand hygiene before and after applying non-sterile gloves.	F 441		

F5105027

APPROVED
By Tom Linhoff at 2:41 pm, Dec 07, 2015

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

PRINTED: 11/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	245105		10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 21, 2015. At the time of this survey, Golden Livingcenter Lake Ridge was found not to be 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	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and it also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance	

RECEIVED
DEC - 1 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane White	Executive Director	11-25-15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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 Living Center Lake Ridge was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The entire building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detectors at all smoke barrier doors that are held open and with detection in areas open to the corridor. The facility has 30-foot on center corridor smoke detection in the 1983 addition (Woodhill) that is on the fire alarm system.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code. The building is divided into 9 smoke zones with 1/2 hour fire rated barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 175 beds and had a census of 160 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a hazardous area in accordance with the following requirements of	K 029	K 029 -Any new construction or remodel will be supervised by the Director of Maintenance for conduit ceiling per fire code. -The actual completion date is Dec. 2, 2015 -Director of Maintenance/designee is the responsible party.	12/2/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 2000 NFPA 101, Section 8.4.1 and/or 19.3.5.4. This deficient practice could affect residents and staff as a fire within this room could make the corridor untenable. Findings include: During the facility tour between the hours of 12:30 PM and 4:30 PM on 10/21/2015, observations revealed that the boiler room corridor side wall had penetrations around pipes and conduits that were not sealed with a fire rated material.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period and vary the times in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 160	K 050	K 050 Fire drills were conducted on night shift, but times were not varied. Annual calendar has been developed to ensure varied times. A varied time fire drill will be conducted on the night shift by Nov. 30, 2015. Executive Director, will monitor the Director of Maintenance who is the responsible party to ensure implementation of annual calendar with varied fire drill times which will be reviewed at monthly safety committee.	12/2/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 4 residents. Findings include: On facility tour between 12:30 PM and 4:30 PM on 10/21/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility missed an Evening-shift fire drill in the 1st quarter and conducted Night-Shift fire drills between the hours of 3:30 AM, 3:00 AM, 3:00 AM, 3:30 AM not varying the times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Maintenance Supervisor.	K 050		