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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QBE3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00948

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245337**

2.STATE VENDOR OR MEDICAID NO.
(L2) **248627000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LINDEN**
(L4) **105 WEST LINDEN STREET**
(L5) **STILLWATER, MN** (L6) **55082**

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 **06/02/2014** (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 **67** (L18)

13.Total Certified Beds **67** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 06/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/28/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5337

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 04/11/14. On 06/02/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 05/16/14, the Department of Public Safety completed a PCR. Based on these PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 04/11/14, effective 05/21/14. Refer to the CMS-2567B for both health and life safety code.

Effective 05/21/14, the facility is certified for 67 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5337

June 9, 2014

Ms. Julie Ludwig, Administrator
Golden Livingcenter - Linden
105 West Linden Street
Stillwater, Minnesota 55082

Dear Ms. Ludwig:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 21, 2014 the above facility is certified for:

67 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 skilled nursing facility beds.

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

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 3, 2014

Ms. Julie Ludwig, Administrator
Golden LivingCenter - Linden
105 West Linden Street
Stillwater, Minnesota 55082

RE: Project Number S5337023 and Complaint Number H5337021

Dear Ms. Ludwig:

On May 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 11, 2014 that included an investigation of complaint number H5337021. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 16, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 11, 2014, effective May 21, 2014 and therefore remedies outlined in our letter to you dated May 2, 2014, will not be imposed.

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

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245337	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/21/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **05/21/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	06/03/2014	16022	06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245337	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

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 **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/21/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **05/21/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/21/2014**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	06/03/2014	16022	06/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/11/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245337	A. Building / B. Wing: 01 - MAIN BUILDING 01	5/16/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

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 Reg. # NFPA 101 LSC K0029	Correction Completed 04/09/2014	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 04/30/2014	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/09/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/AK	Date: 06/03/2014	Signature of Surveyor: 12424	Date: 05/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/8/2014		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: QBE3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00948

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245337**
2.STATE VENDOR OR MEDICAID NO.
(L2) **248627000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LINDEN**
(L4) **105 WEST LINDEN STREET**
(L5) **STILLWATER, MN** (L6) **55082**

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 **04/11/2014** (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 **67** (L18)

13.Total Certified Beds 67 (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
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE-NE II 05/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/27/2014 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5337

At the time of the standard survey completed 04/11/14 the facility was not in substantial compliance and the most serious deficiencies 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 are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4707

May 2, 2014

Ms. Julie Ludwig, Administrator
Golden LivingCenter - Linden
105 West Linden Street
Stillwater, Minnesota 55082

RE: Project Number S5337023 and Complaint Number H5337021

Dear Ms. Ludwig:

On April 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5337021.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5337021 that was found to be substantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 May 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 21, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 11, 2014 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	C 04/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint H5337021 investigation was also completed at the time of the standard survey. The complaint was substantiated and deficiencies were issued at F282, F309, F312, F315.	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 is 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. In addition, preparation and submission of this Plan of Correction does not constitute an admission or 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. 5/13/14 SER	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	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 a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	

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

[signature] Executive Director 5/8/14

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

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician of a change in condition for 1 of 1 resident (R23) who had complaints of chest pain. Findings include: The quarterly Minimum Data Set (MDS) dated 2/11/4, identified R23 as an alert and oriented resident with diagnoses including hypertension, Parkinson's disease, anxiety disorder and schizophrenia. The MDS identified R23 as requiring supervision with bathing and as being independent with ambulation. R23 did not have a history of falls nor did he have complaints of pain during the MDS assessment period. Random observations of R23 were conducted during survey, 4/7/14 from 6:00 p.m. to 8:00 p.m., on 4/8/14 from 8:00 a.m. to 4:30 p.m., on 4/9/14 from 7:00 a.m. to 3:30 p.m., on 4/10/13 from 8:00 a.m. to 4:30 p.m., and on 4/11/14 from 8:00 a.m.	F 157	F157 -Res. #23 has been seen by the NP to assess for "cardiac changes" on 4/22/2014 -All residents have the potential to be affected by the deficient practice. -Licensed nursing staff have been educated to notify and document notification of MD, family, and ED/DNS in the event of a change of condition. - Weekly audits will be conducted to ensure appropriate notification takes place in the event of a change of condition. Audits will be reviewed at QAPI and action planned as needed. - DNS or designee is the responsible party. -Corrective action will be completed by 5/21/2014 RECEIVED MAY 12 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 157	Continued From page 2 to 12:00 p.m. R23 was observed to be able to ambulate independently without the use of assistive devices. R23 did not express concerns of pain, shortness of breath or discomfort. During interview on 4/8/14, at 10:30 a.m., R23 denied complaints of pain. A progress note, dated 3/4/14 at 11:08 p.m., indicated R23 displayed signs of confusion. He asked the staff for a doctor's phone number, was able to ambulate independently with a cane, and complained of chest pain and numbness in his left hand. R23's blood pressure was 154/86 and his pulse was 94. R23 denied shortness of breath. The record lacked follow-up documentation regarding these cardiac signs and symptoms. The next progress note was dated 3/5/14, at 5:58 a.m. and indicated R23 had been walking in the hallway, leaned against the wall and slid to the floor. R23 stated he was anxious and complained of chest tightness and left arm numbness. R23's blood pressure was 147/83 and the pulse was 92. The record lacked follow-up documentation regarding these cardiac signs and symptoms. The current physican Order Summary Report dated 3/4/14, indicated R23 received Cozaar 12.5 milligrams (mg) daily and Norvasc 10 mg daily for the treatment of chronic high blood pressure. The care plan dated 12/2/13, directed the staff to observe and report signs of chest pain and abnormal vital signs. Review of the vital signs record revealed R23's diastolic blood pressure (the lower number or the pressure when the heart is at rest) occasionally	F 157		

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F 157	Continued From page 3 was below 40 (normal range 60-80). On 1/4/14, 1/11/14, 1/18/14, 1/25/14, 2/8/14 and 2/15/14, R23's diastolic pressure was noted to be below 50. Review of the nurses' notes for those corresponding dates, lacked indication that staff had documented any type of concern related to R23's cardiac status. Review of the physician's note, dated 3/6/14, lacked indication the physican had been notified of any concerns related to R23's cardiac status. On 4/10/14, at 8:30 a.m. the director of nurses (DON) stated R23 had a long history of anxiety problems and at times he complained of chest tightness. The DON confirmed R23 had resided in the facility for only 5 months, and during that time the episodes on 3/4/14 and 3/5/14 were the first that staff members had identified any concerns related to chest pain. In addition, she stated if a resident displayed lower than usual blood pressure (systolic or diastolic) she would expect the staff to recheck the blood pressure and document the result. On 4/10/14, at 8:45 a.m. the assistant director of nurses (ADON) stated R23 had a history of high blood pressure. She confirmed if a resident displayed blood pressures which were high or low, she would expect the staff to call a supervisor for clarification or direction, monitor the resident, and report the concern to a physican as needed. The ADON confirmed R23 displayed cardiac distress symptoms and the facility did not report the concern to the primary physican. The undated Notification of Change in Resident Heath Status policy directed the staff to consult the resident's physican if there was an acute	F 157		

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F 157	Continued From page 4 illness or a significant change in the resident physical status. The policy specifically identified a life threatening condition as a potential "heart attack" and directed the staff to notify the the physican immediately.	F 157		
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 observation, interview and document review, the facility failed to ensure that prompt efforts were made by the facility to resolve resident grievances for 1 of 2 residents (R62) who expressed a grievance to facility staff. Findings include: Prompt efforts were not made to resolve concerns expressed by R62. R62 was observed in the therapy bathroom on 4/8/14, at 11:00 a.m. R62 expressed to the certified occupational therapy assistant (COTA) that the extra, clean briefs and other supplies should not be next to the toilet, uncovered as they were, and within inches of the toilet seat. R62 was expressing concern for infection control and further elaborated on the shower room toilet that she used as not being clean and stated, "People should wipe off the toilet seat when they use it and have it clean for the next person." R62 stated	F 166	F166 -Grievances from Res. #62 has been resolved. - All residents have the possibility of being affected by the deficient practice. - All staff have been educated on the grievance process, to include initiating and forward the appropriate paperwork, per policy. - A Grievance log has been initiated and will be reviewed, as needed, in daily Stand-up with the IDT team. Grievances will be reviewed at QAPI and action planned as needed. - SS or designee is the responsible party. -Corrective action will be completed by 5/21/2014	

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F 166	Continued From page 5 she was frustrated that the situation has been ongoing, she has reported the toilet concerns to nursing assistants and it has not been resolved to her satisfaction. R62 verified this has been reported before but that no action has been taken that she is aware of. R62 stated, "This really iritates me because I raised my children to clean up after themselves and it is not happening here, I have to clean the toilet before I use it." During an interview on 4/9/14, at 1:00 p.m. with the COTA she said that she told the occupational therapist (OT) what R62 complained about on 4/8/14. Interview with the OT revealed no concern/grievance had been completed and that the therapy department focused on the clinical outcomes and did not have time to deal with resident concerns. OT stated, typically the concerns are verbally passed on to someone else. Both the COTA and OT verified they had not filled out a concern form but will pass the information along to someone else. According to the OT, the information had not yet been passed on regarding R62's concern. The facility policy dated 8/10, titled Grievance Procedures read, "It is the responsibility of the employee hearing the grievance to complete the form and submit it for follow-up and resolution."	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242		

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F 242	Continued From page 6 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 2 of 2 residents (R16, R23) the opportunity to make choices in bathing schedules; in addition, the facility failed to provide the opportunity for 1 of 1 resident (R48) to rise early in the morning as they chose. Findings include: R16 was not offered the opportunity to choose her own bathing schedule. Review of the quarterly Minimum Data Set (MDS) dated 2/7/14, identified R16 was alert and oriented and required limited assistance with personal bathing. The care plan dated 2/12/14, directed the staff to assist with bathing. On 4/8/14, at 9:20 a.m., during interview, R16 stated she received a weekly shower on Sunday afternoon. She stated she would prefer to not bathe on Sunday because she frequently had company on Sunday and the bathing schedule occasionally interrupted the one day a week her family members were able to visit. The clinical record lacked documentation of previous life routine or history of bathing frequency. The clinical record lacked evidence R16 was offered a choice in bathing schedule. The North Bath List dated 4/19/13, indicated R16	F 242	F242 -Res. #16 and #23 have been asked their desired bathing schedule and it has been initiated. Res. #48 is to be up and in her w/c by 5:00 am q day. - All residents have the potential to be affected by the deficient practice. - Licensed staff have been educated that the resident has the right to determine, among other things, the times they will get up or go to bed and the times they will have their bath or shower. Upon admission, all residents are to be asked their preference of schedule for bathing. This preference is to be documented on the "bathing list" by the admitting nurse. - Current new admissions documentation will be reviewed within 48 hours of admission to ensure resident's day/time preferences have been documented for bathing. Random audits will be conducted with admission, quarterly, annual and change of condition care conferences to ensure residents preferred bathing schedule is being met. Any required changes will be made at that time. Audits will be reviewed at QAPI and action planned as needed. - DNS or designee is the responsible party. - Corrective action will be completed by 5/21/2014	

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F 242	Continued From page 7 received a single bath on Sunday afternoons. An additional note on the bath list directed the staff not to change the bath schedule without management staff permission. R23 was not offered the opportunity to choose his own bathing schedule. The quarterly MDS dated 2/11/4, identified R23 was alert and oriented. The MDS identified R23 as being independent in all activities of daily living (ADLs), but required supervision with bathing. The care plan dated 12/4/13, directed staff to assist R23 with bathing activities. The plan did not indicate how often R23 was to receive a bath. On 4/8/14, at 10:30 a.m. R23 stated he received a weekly shower at the facility. R23 explained he would prefer to bathe three times a week. The clinical record lacked documentation of previous life routine or history of bathing frequency. The clinical record lacked evidence R23 was offered a choice in bathing schedule. The South Bath List dated 4/23/13, indicated R23 received a weekly bathing assistance on Saturday afternoons. On 4/10/13, at 8:40 a.m. the licensed social worker (LSW)-A stated she did not routinely ask residents about their past bathing preferences. LSW-A stated the nursing staff would ask questions related to bathing patterns. On 4/10/13, at 8:45 a.m. nursing assistant (NA)-B and NA-D stated the bathing schedule had been established according to what room the residents	F 242		

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F 242	Continued From page 8 were assigned to. The NAs explained changes would be made if the family members had requested a change, but stated they did not routinely ask residents about their bathing preferences. On 4/10/14, at 9:40 a.m. the assistant director of nursing (ADON) stated within 72 hours of admission the facility "informed" residents when they would be receiving a bath, according to the bath schedules. ADON stated the facility did not have a system to offer residents a choice regarding bathing preferences or schedules. ADON stated the facility could easily make changes and accommodate resident requests for bathing preferences. On 4/10/14, at 2:40 p.m. the director of nurses (DON) stated residents should have been offered choices in bathing. DON stated she was unaware the facility did not have a system to allow residents to choose their own bath days or frequency. The Social Services Policy and Procedure Manual page 93 dated 10/2009, under the heading entitled Resident Choice, directed the social service staff to act as a liason between facility and resident to ensure appropriate communication was related to help residents make informed decision. The policy directed the social service staff to gather information to assist resident in being able to make individual decisions and choices regarding activities, schedules and health care; that reflected resident interests and preferences for what residents liked to do and when they liked to do it. Example identified in the manual included "bath schedules."	F 242		

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F 242	Continued From page 9 R48 was not allowed to get up in the morning as requested. On 4/07/14, at 4:56 p.m. R48 indicated she would like to get up at 5:00 a.m., but there is a rule here that you can't get up until 6:00 a.m. R48 indicated her back usually hurts from being in bed all night and she needed to go to the bathroom (BR). R48 stated, "I've told them but they still won't get me up. They [the facility staff] don't seem to have enough people to help me get up and dressed in the early morning. My call light has been on for long periods of time because when I put it on in the morning they know what I want." R48 denied having an incontinence accident waiting for help and pointed to a clock on the wall above her bed. R48 stated, "I look at that so I know how long I have to wait to get help." On 4/9/14, at 7:17 a.m. R48 was observed in her room sitting in her wheelchair. When asked what time she had gotten up, R48 stated she had put her call light on to get up up around 5:00 a.m. and stated, "But they wouldn't let me get up until 6:15 a.m. I told them I want to get up around 5, go to the BR, and then I would sit here and leisurely get ready. They won't let me." On 4/9/14, at 11:25 a.m. the nursing assistant (NA)-J stated staff did get R48 up "but we do not get her dressed because that takes too long" and stated it took up to 25 minutes. NA-J stated there were only "two of us [staff] to do cares for everyone [residents] that want things done right away in the morning. She is allowed to get up and stay up, but no, she is not dressed." The quarterly MDS dated 2/4/14, indicated R48	F 242		

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F 242	Continued From page 10 was congitively intact. Although, the current nursing sleep distrurbance care plan updated 2/10/14, directed staff to assist R48 in establishing a daily routine and to assess her usual the sleep patterns, the undated Nursing Assistant sheet (a form used by NA staff to direct resident care) directed to have R48 out of bed before 6:00 a.m. On 4/9/14, at 2:09 p.m. R48's family (F)-L indicated getting R48 up early had been an ongoing concern. F-L indicated she had told "many people [facility staff]"and had "brought it up with management" and at care conference. F-L stated, "It is not getting done consistently. Most of the people I have spoken to it just doesn't seem to do any good. There are some aides that will do it, but not consistently." F-L also stated some days there was "just not enough staff" to get the work done and indicated R48 had also told them that. On 4/9/14, at 2:15 p.m. the social worker (SW)-A stated she thought the concern of R48 getting up in the morning had been resolved. SW-A stated, "We discussed it at care conference." SW-A stated she did not fill out a concern form, as it was treated as a "request" rather than a concern. On 4/9/14, at 2:40 p.m. ADON indicated she thought the issue had been resolved and stated, "It is on the nursing assistant sheet to get up before 6:00 a.m."	F 242		
F 244 SS=E	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	F 244		

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F 244	Continued From page 11 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 complaints from the resident council for 5 of 5 residents (R11, R16, R23, R48, R62) who voiced concern regarding call lights not being answered timely and concerns there was not sufficient staff. Findings include: The facility failed to follow up on resident council concerns expressed by R11, R16, R23, R48, R62. During initial interviews with R11 on 4/7/14, at 7:18 p.m.; R16 on 4/8/14, at 9:22 a.m.; R23 on 4/8/14, at 10:35 a.m.; R48 on 4/7/14, at 5:09 p.m.; R62 on 4/7/14, at 6:51 p.m., concerns regarding call lights not being answered timely and concerns there was not enough staff at the facility were expressed. According to the resident council minutes for December 2013, January 2014, February 2014, March 2014 and April 2014, the identified residents had attended resident council in the past five months and had expressed their concerns at the resident council meetings however, the individual concerns were not reflected in the resident council minutes. The Resident Council Minutes for November 2013 indicated, "The floor was opened to the residents for comments, questions or concerns	F 244	F244 -R11, R16, R23, R48, and R62 have had there concerns regarding call light response and staffing concerns, voiced in resident council, addressed. -All residents have the potential to be affected by the deficient practice. -Director of Activities has been educated regarding the requirements for following the facility grievance protocol when hearing resident concerns during the Resident Council meetings. - A Grievance log has been initiated and will be reviewed, as needed, in daily Stand-up with the IDT team. Grievances and resolution will be reviewed at QAPI and action planned as needed. - Director of Activities or designee is the responsible party. -Corrective action will be completed by 5/21/2014	

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F 244	Continued From page 12 and residents at this time did not have any." The minutes indicated the resident council meeting was cancelled in December due to holiday parties, but would schedule two meetings in January. The 1/6/14, minutes indicated, "Two residents commented on cold rooms." The 1/20/14, minutes indicated the meeting addressed a concern about the north shower room fan. The 2/24/14, resident council meeting minutes addressed the resident request for birthday list every month on the calendar has been done. No further resident comments, questions or concerns. The 3/24/14, meeting minutes addressed resident concerns regarding the smokers going out the dining room door during meal times. On 4/9/14, at 9:45 a.m. the director of activities (DA) verified concerns for call lights being answered and concerns for staffing had come up at resident council, but wouldn't be reflected in the minutes if only one resident had expressed the concern. DA stated, "If one individual concern I would pass it on to the nurse later, an individual concern is not put in the minutes." DA verified a concern form was not generated from the resident council minutes, but after reviewing the grievance procedure validated a form should have been generated regarding complaints from the resident council meetings. The facility's Grievance Procedures policy directed, "The Grievance Forms should also be completed when grievances are noted during the Resident Council or Family Council meetings."	F 244		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		

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F 252	Continued From page 13 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a clean comfortable and homelike environment for 11 of 35 (R12, R24, R16, R23, R25, R67, R73, R4, R8, R21, R55) residents who required staff to provide clean rooms/bathrooms/shower rooms and/or wheel chairs. Findings include: R4's room was observed to have a pervasive urine odor. The quarterly Minimum Data Set (MDS) dated 1/17/14, identified R4 as being totally incontinent of bladder. On 4/11/14, at 8:00 a.m. housekeeping staff member (HSKP)-B was observed to be mopping R4's room. The room was observed to have a very strong pervasive urine odor. HSPK-B stated the room frequently had a strong urine odor. She stated the floor had been scrubbed, the bathroom had been cleaned and R4's bedding had been changed. She stated she had attempted to find the source of the odor and noted the sink appeared to be the source of the smell. HSKP-B stated she was aware of the odor, but had been unsuccessful in reducing or eliminating the odor.	F 252	F252 -Cleaning have been completed in rooms for Resident #'s 12, 24, 16, 23, 25, 67, 73, 4 and 8 to provide a clean, comfortable, and homelike environment. -All residents have the potential to be affected by the deficient practice. -Housekeeping staff have been educated to keep resident rooms clean and odor free. Staff have been educated on the use of the "Building Engines" system in order to log in maintenance issues to be repaired or to contact housekeeping as needed to provide cleaning. In the absence of housekeeping, staff has been educated to provide for the clean-up of accidental spills and dirt as needed. -Random weekly audits will be conducted to ensure completion of identified maintenance issues and to ensure resident rooms are a safe, comfortable and homelike environment. -ED or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 252	Continued From page 14 When questioned if the facility had any type of cleaning products specific to eliminating or reducing urine or human waste odors, HSKP-B stated she was not aware of any special products. During numerous observations on 4/7/14, 4/8/14 and 4/9/14, there were strong urine odors in the bathroom grout and floor tile around the toilet seat floor mount with what appeared to be yellow, brown stains in various areas. These observations/odors were in the bathrooms used by R12, R24, R16, R23, R25, R67, R73. A urine like odor was also present in the south shower room. During numerous observations on 4/7/14, 4/8/14 and 4/9/14, there were a variety of stains, spills, dust, on the wheel chairs of R4, R8, R21, R55 from the census sample observations. When interviewed on 4/10/14, at 9:30 a.m. the director of housekeeping (DH) verified the urine odor in the bathroom areas, tub room and the need to clean the wheel chairs better. The DH confirmed she had been on her hands and knees with a toothbrush working on the tiles around the toilets and would check with their chemical company for a product that would eliminate the urine odors more effectively. Although the facility had a cleaning schedule for wheel chairs, they were currently in transition of expecting the night aides to clean the wheel chairs on the night shift. Interviews with the DH on 4/10/14, at 9:30 a.m., verified the wheel chairs are not signed out as cleaned according to the documented schedule. During confidential	F 252		

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interviews with two night nursing assistants it was verified they do not have time to clean wheelchairs as there are often only two nursing assistants in the facility to care for 60 residents on the night shift.

A review of the untitled wheel chair cleaning document/schedule for March and April 2014, revealed R4, R8, R21 and R55 did not have their wheel chairs cleaned.

During observation on 04/09/2014 at 7:51 a.m. R8's wheelchair was dirty with white dried multiple spots on the sides of the wheelchair and on the foot rests. When inquired nursing assistant (NAR)-D indicated night shift staff was responsible for wheelchair cleaning and she was unsure as to when R8's wheelchair was last cleaned. R8 coughed up thick yellow sputum onto her palm, NAR-D gave R8 a tissue paper to clean up her palm. NAR-D stated she would clean R8's wheelchair today.

On 04/09/2014 at 9:05 a.m., NAR-D stated, showing a 3 ring binder, that since September 2013 the night shift staff was responsible for cleaning the wheelchair. NAR-D stated R8's wheelchair needed to be cleaned and the white spots on wheelchair might be the dried up sputum or her food. There was no documentation in the 3 ring binder as to when R8's wheelchair was last cleaned.

On 04/09/2014 at 10:24 a.m. NAR-D wheeled R8's wheelchair into the bathroom for cleaning.

On 04/10/2014 at 3:22 p.m. Assistant Director of Nursing (ADON) indicated the night staff was

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F 252	Continued From page 16 responsible for cleaning resident's wheelchairs and they needed to clean R8's wheelchair. She stated the staff needed to be retrained on their responsibilites and they needed to increase monitoring of staff to make sure they were completing their assigned tasks.	F 252		
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 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 the plan of care was periodically revised for 3 of 4 residents (R8, R67, R20) in the sample.	F 280	F280 -Res. #8 had her care plan reviewed and updated to reflect current pressure ulcer status and interventions. Res. #67 had his care plan updated and revised to include behaviors specific to urinating in inappropriate places. Res. #20 is no longer a resident at this facility. -All residents have the potential to be affected by the deficient practice. -IDT has been educated to review and update resident care plans, as needed, in conjunction with resident care conferences and prn change of condition. - Random audits will be conducted with admission, quarterly, annual and change of condition care conferences to ensure care plans have been reviewed and are up to date. Audit results will be reviewed at QAPI and action planned as needed. -RNAC or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 280	Continued From page 17 Findings include: R8 had recurring pressure ulcers on coccyx area; the plan of care lacked to identify current impaired skin integrity and stage II pressure ulcer on coccyx. R8 was admitted to the facility on 11/11/2005, with diagnoses that included Multiple Sclerosis (MS), dementia, contracture of lower leg joints, failure to thrive and personality disorder. During observations of morning cares and coccyx pressure ulcer on 04/09/2014 at 8:00 a.m. licensed practical nurse (LPN)-A removed the old Tegaderm saturated with yellowish drainage, cleansed the deep pressure ulcer with normal saline vial, applied flaygl and followed with clean Tegaderm. The wound base was not visible, the edges were macerated and LPN-A did not measure the pressure ulcer, she indicated the wound was measured by a RN weekly. The physician's documentation, dated 01/07/2014, indicated R8 has had significant muscle and subcutaneous tissue wasting due to MS and experienced recurrent pressure ulcers, R8 had been treated for ulcer on coccyx which was healed and another new ulcer was developed within, "the last 24 hours." The physician's note described a 1 cm by 1 cm stage II pressure ulcer on coccyx. The previous pressure ulcer was proximal and left and was lateral to this new ulcer. The nurse practitioner's documentation, dated 03/25/2014, revealed R8 had a nonhealing sacral ulcer with occasional drainage. R8 had been receiving flaygl gel for two weeks which had	F 280		

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F 280	Continued From page 18 resulted in some macerated edges and no change in ulcer size. It further added, the treatment changed from gel to flagyl powder followed by Tegaderm, which needed to be changed daily. The plan of care dated, 03/18/2013, indicated R8 was at risk for pressure ulcer and impaired skin integrity related to a history of healed stage two pressure ulcer to coccyx. The goal with a target date of 02/28/2014 revealed R8's skin would remain intact through next review period and the interventions included to float heels, air mattress, nutritional/hydration support, and to offload R8 every 2 hours. It lacked the current status of R8's skin integrity of a stage III pressure ulcer on coccyx as identified in the quarterly MDS dated 02/14/2014. On 04/10/2014 at 3:22 p.m. the assistant director of nursing (ADON) indicated she tried to document weekly on R8's coccyx pressure ulcer status; however, she missed on R8's weekly documentation. ADON stated R8 has had recurring pressure ulcers due to her comorbid conditions. ADON acknowledge it would be difficult to evaluate if the pressure ulcer was worsening or improving without proper documentation. It lacked the documentation if the skin integrity was improving or declining of R8's coccyx pressure ulcer. There was no other documentation available nor provided regarding R8's coccyx pressure ulcer. ADON verified R8 had a stage II pressure ulcer on coccyx. She indicated it was missed. After reviewing the wound evaluation flow sheets and the pressure ulcer care plan, ADON stated the plan needed to be revised to reflect R8's current	F 280		

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pressure ulcer status and the weekly wound evaluation flow sheets needed to be completed.

The facility's skin integrity guideline, policy/procedures, revised in 2013, directed staff to develop a routine to review residents with wounds or at risk on a weekly basis and document. It directed the staff to develop a plan of care and listed interventions to be implemented.

R67: During an interview with R67 on 4/8/14 at 10:09 a.m., a very strong stale urine odor was evident outside the room and in the room.

On 4/9/14 at 7:15 a.m. observed R67 ambulating from the room with his walker. R67 did not have an odor however the room did have an odor of stale urine along with an odor outside the room. On 4/9/14 at 9:04 a.m., interview with R67 regarding odor in the room, R67 was unable to confirm or deny an odor of urine.

On 4/9/14 at 9:10 a.m. maintenance was observed replacing the mattress in R67's room. Maintenance (M)-A said, "I guess [R67] urinated on the top of the mattress so we are switching it out."

Interview with another resident, R11, on 4/9/14 at 9:30 a.m. confirmed there was an odor out in the hall but not all the time. She indicated it is from one of the residents across the hall.
On 4/9/14 at 10:05 a.m. privacy curtains were observed being replaced in R67's room because, according to the contracted housekeeper (H)-C, "they were soiled."

The annual minimum data set (MDS) dated

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F 280	Continued From page 20 12/27/13 indicated R67 was continent of urine. R67 was identified as having a cognition score of 11 out of 15. The care area assessment (CAA) dated 12/27/13 indicated R67 was at risk for urinary incontinence due to needing limited assistance at times due to urgency. The bowel and bladder (B & B) record dated 3/26/14 through 3/28/14 indicated R67 was totally continent of urine. The care plan dated 1/10/14 indicated R67 had functional incontinence and directed staff to monitor and report changes, provide assistance, and evaluate frequency and timing of incontinence episodes. The behavior portion of the care plan identified R67 as voiding in inappropriate places. The approaches however were not specific to the issue. Behavior sheets for 3/14 identified a behavior as urinating in inappropriate places however most of the month was blank and the few areas documented on indicated no problems. Nursing assistant (NA)-B was interviewed on 4/11/14 at 10:15 a.m. and indicated [R67] is not incontinent. [R67] just stands up and will urinate where ever he feels like it. He will urinate in the waste basket or out in the hall. When reminded that it was inappropriate [R67] just says, oh ok. Interview with assistant director of nursing (ADON) on 4/11/14 at 10:24 a.m. about urinary incontinence. She indicated it is a behavior. We have put notes on the door identifying his bathroom, and have given him a urinal. She agreed the care plan was not specific to his behaviors of urinating in inappropriate places.	F 280		

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F 280	Continued From page 21 R20: The care plan was not revised after R20 developed a pressure ulcer on her coccyx. Resident 20 was admitted to the facility on 6/2/11 and expired on 3/22/14. On 3/14/14, R20 was admitted to hospice care as she had slowly deteriorated due to heart disease, diabetes, and advanced Alzheimer dementia. A significant change minimum data set (MDS) dated 1/14, indicated R20 had no open areas. The care area assessment (CAA) indicated R20 was at risk for development of pressure ulcers with a Braden (a scale to determine skin breakdown risk) of 15. A score of 15-18 resident was deemed to be at risk. R20 needed extensive mobility assist, and was always incontinent. The care plan updated 2/3/14 indicated a Braden of 15 (at risk) with history of skin lesions related to cancer of the cheek and right eye brow area. The care plan did nolt identify the current skin breakdown. On 1/28/14, the nurses notes (NN) indicated, stable, skin intact. On 2/3/14, nurses notes indicated small open area on left buttock. A wound evaluation flow sheet was started on 2/3/14 which described the wound as .3 x .5 cm open area on left upper buttocks close to the coccyx. On 2/10/14 the staff documented on the wound care flow sheet, same abrasion on left buttock measured .1 x .3 cm. The wound care flow sheet directed staff, continue to monitor. On 2/17/14 the staff documented the area as healed. On 2/24/14 the nurses notes identified an open area on the coccyx measuring 1.5 cm X .75 cm. The area was cleaned and a dressing applied.	F 280		

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F 280	Continued From page 22 The nurse told the nursing assistant (NA) to turn and repositioned the resident every 1-2 hours until directed otherwise and to apply barrier cream. The comprehensive weekly skin assessment form dated 2/26/14 indicated open area on coccyx. The physician progress notes dated 2/11/14 and 3/14/14 did not address the open area on the coccyx. The physicians orders from 2/4/14 through 3/22/14 did not address the open area or treatment. Interview with the assistant director of nursing (ADON) on 4/10/14 at 4:30 p.m. indicated she did not think there would be any wound care documentation and wound care plan because R20 did not have a wound. When the nurses notes were reviewed the ADON said she was not aware of the open area and if there was one, the care plan should have been revised.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R23) with cardiac concerns, 1 of 1 resident (R21) with venous stasis ulcers, 2 of 2 residents (R12, R8) who	F 282		

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	245337	A. BUILDING _____ B. WING _____	C 04/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

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F 282	Continued From page 23 required assistance with range of motion, and for for 1 of 2 residents (R55) who required assistance with repositioning. Findings include: R23's cardiac care plan was not followed while displaying complaints of chest pain. The care plan dated 12/2/13, directed the staff to observe and report signs of chest pain and abnormal vital signs. Review of the vitals record indicated R23's diastolic blood pressure (the lower number or when the pressure when the heart was at rest) occasionally was below 40. (normal range 60-80) On 1/4/14, 1/11/14, 1/18/14, 1/25/14, 2/8/14 and 2/15/14, R23's diastolic pressure was noted to be below 50. Review of the nurses notes for the corresponding dates, lacked indication the staff had documented any type of concern related to R23's cardiac status. Review of the physicians note dated 3/6/14, lacked indication the physican had been notified of any concerns related to R23's cardiac status. On 4/10/14, at 8:30 a.m. the director of nurses (DON) confirmed the care plan had not been followed. R21 did not receive wound care as directed by the care plan.	F 282	F282 -Res. #23 has been seen by the NP to evaluate and assess cardiac changes. Res. #21 is receiving wound care as directed by the care plan. Res. #12 and Res. #8 are receiving ROM per their care plans. Res. #55 care plan is being followed for stimulation, personal hygiene, and positioning. -All residents have the potential to be affected by the deficient practice. -All nursing staff have been educated to provide resident cares and services according to their individualized care plans. -Random weekly audits will be conducted to ensure resident cares and services are provided according to identified care plan interventions. Audit results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party - Corrective action will be completed by 5/21/2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 24 The care plan dated 3/26/14, directed the staff provide dressing to the venous ulcer on the front of the shins as directed by the physican. The Physican's Orders and Signature Form dated 3/25/14, directed the staff to apply a mepilex (foam dressing) to the left shin open area every three days and as needed. If draining present moisten with wound cleanser before removing. The order further directed the staff to keep the area open to air for one hour before changing the dressing. On 4/9/14, at 9:25 a.m. R21 was observed sitting in a wheelchair in her room with her pants pulled up over her knees. A dressing was observed with the date of "3/28/14" written on it. On 4/10/14, at 7:44 a.m. RN-C stated he had removed R21's dressing at 7:00 a.m. and was waiting for a hour before replacing the dressing. He stated the dressing he removed had been dated 3/28/14. Review of R21's electronic treatment record indicated the dressing had been changed on 3/28/14, 3/31/14, 4/3/14, 4/6/14 and on 4/9/14, R21 had refused the dressing change. On 4/10/13, at 10:44 a.m. RN-C applied a fresh dressing to R21's stasis ulcer. On 4/10/14, at 11:00 a.m. RN-C confirmed R21's dressing had been in place since 3/28/14, (14 days) and not been changed every three days as directed by the physican's orders and care plan. R12 did not receive assistance with range of motion according to the care plan.	F 282		

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F 282	Continued From page 25 The care plan dated 1/24/13, directed the staff to transfer R12 with a full body mechanical lift and to provide range of motion to the lower extremities with dressing and undressing. On 4/9/13, at 7:05 a.m. R12 was observed to be sitting his wheelchair fully dressed. R12's feet were observed to be contracted in an inward position and were resting on foot rests. R12 was observed to maneuver his wheelchair with his hands. Review of the Restorative Nursing book did not include a documentation sheet for R12 for the months of 4/2014, 3/2014, 2/2014 and 1/2014. On 4/10/13, at 11:30 a.m. the assistant director of nursing (ADON) stated the plan of care directed the staff to complete a range of motion program and that R12 was to be receiving range. On 4/10/13, at 3:00 p.m. the DON confirmed R12 had not received range of motion services as directed by the care plan. R8 did not receive passive range of motion according to the plan of care during the morning cares. R8's plan of care for physical functioning deficit, dated 12/09/2013, directed staff to perform passive range of motion (PROM) to bilateral lower extremities with cares. However, during the observation of morning care on 04/09/2014 from 7:51 a.m. to 8:30 a.m. two Nursing Assistants (NAR)-D and (NAR)-M provided total assistance with grooming, placing clothing on and transferring R8 using a Hoyer lift from bed to the	F 282		

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F 282	Continued From page 26 wheelchair. The NARs did not provide any PROM to R8's extremities and wheeled R8 to the dining room. On 04/10/2014 at 2:30 p.m. NAR-M stated they usually perform PROM for R8, however, on 04/09/2014 they forgot to do it because they were, "rushing to provide timely cares to the residents." On 04/10/2014 at 3:22 p.m., Assistant Director of Nursing (ADON) stated the staff needed to follow R8's plan of care related to PROM during the morning cares. When asked for the copies of the PROM documentation, ADON provided April 2014 data and stated she was unable to find the previous months. When reviewed April 2014 form, the staff had initialed for 4/09/2014, when asked ADON stated they should not be initialing the form if they had not completed the PROM. ADON added, the staff needed to be retrained and closely monitored. R55's care plan was not followed for social stimulation, personal hygiene and positioning. A review of the plan of care revealed R55, "Needs staff encouragement with off loading/side lying position. History of pressure ulcer, Braden scale 16 Provide pressure reduction/relieving mattress-air mattress (R55 does not have an air mattress) Toileting plan to check and change every two hours and provide staff assist of 2/offer commode or bed pan upon rising, before,after meals. every bedtime, and to have a turning and repositioning schedule per tissue tolerance." During numerous observations throughout the	F 282		

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F 282	Continued From page 27 days of the survey, the only time that R55 got up out of bed was on Wednesday 4/9/14 at 9:45 a.m. to attend church services. R55 did not get up and come out of her room for any meals nor were staff observed to encourage R55 to get up. Interview with nursing assistant NA-A, NA-J and NA-E on 4/9/14, at 8:00 a.m. verified R55 does not get out of bed except for church services. Furthermore they verified R55 is not offered a commode or bedpan and uses the incontinence brief for toileting needs. The plan of care directs staff, "I have diagnosis of depressive disorder, encourage me to get involved in activities related to my interests, encourage time out of room for meals and time in Recreation programs for socialization and stimulation." The plan of care read, "At risk for dental problems related to Oral candidiasis, daily use of lower denture, use of upper partial and dependency for oral care. Nursing staff to encourage compliance with MD order treatment, Re-approach as needed. Update MD with on going refusals. A review of the physician orders read, "activity level up with assistance and weight bearing status up with assistance. The most recent psychology notes dated, May 16, 2012 direct staff to "pattern time where she is out of her room with other people on a daily basis. I suggest coming out for meals in addition to the time she is up for therapy."	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 28 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 provide 1 of 1 resident (R23) with appropriate care and services for cardiac needs. In addition, the facility failed to provide the highest practicable services for the care and treatment of venous status ulcers for 1 of 1 resident (R21) with stasis ulcers and the facility failed to provide assistance with repositioning for 1 of 2 resident (R55) dependent upon staff for repositioning. Findings include: R23 displayed symptoms of cardiac distress and did not receive appropriate care or services. The quarterly Minimum Data Set (MDS) dated 2/11/4, identified R23 as an alert and oriented resident with diagnoses including hypertension, Parkinson's disease, anxiety disorder and schizophrenia. The MDS identified R23 as requiring supervision with bathing and as being independent with ambulation. R23 did not have a history of falls nor did he have complaints of pain during the MDS assessment period. During random observations during survey on	F 309	F309 -Res. #23 has been seen by the NP to evaluate and assess cardiac changes. Res. #21 is receiving wound care as directed by the care plan. Res. #55 care plan is being followed for stimulation, personal hygiene, and positioning. -All residents have the potential to be affected by the deficient practice. -All nursing staff have been educated to provide resident cares and services according to their individualized care plans. -Random weekly audits will be conducted to ensure resident cares and services are provided according to identified care plan interventions. Audit results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party - Corrective action will be completed by 5/21/2014.	

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F 309	Continued From page 29	F 309		

4/7/14 from 6:00 p.m. to 8:00 p.m., on 4/8/14, from 8:00 a.m. to 4:30 p.m. on 4/9/14 from 7:00 a.m. to 3:30 p.m., on 4/10/13, from 8:00 a.m. to 4:30 p.m. and on 4/11/14, from 8:00 a.m. to 12:00 p.m. R23 was observed to be able to ambulate independently without the use of assistance devices. He did not express concerns of pain, shortness of breath or discomfort.

During interview on 4/8/14, at 10:30 a.m. R23 denied complaints of pain.

Progress note dated 3/4/14 at 11:08 p.m. indicated R23 displayed signs of confusion. He was asked the staff for a doctors phone number, was able to ambulate independently with a cane and complained of chest pain and numbness in his left hand. R23's blood pressure was noted to be 154/86 and his pulse was 94. R23 denied shortness of breath. The record lacked follow up documentation regarding the cardiac symptoms.

The next progress note was dated 3/5/14, at 5:58 a.m. indicated R23 had been walking in the hallway, leaned against the wall and slid to the floor. R23 stated he was anxious and complained of chest tightness and left arm numbness. R23's blood pressure was 147/83 and the pulse was 92. The record lacked follow up documentation regarding cardiac symptoms.

The current physican Order Summary Report dated 3/4/14, indicated R23 received Cozaar 12.5 milligrams (mg) daily and Norvasc 10 mg daily for the treatment of chronic high blood pressure.

The care plan dated 12/2/13, directed the staff to observe and report signs of chest pain and abnormal vital signs.

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F 309	Continued From page 30 Review of the vitals record indicated R23's diastolic blood pressure (the lower number or when the pressure when the heart was at rest) occasionally was below 40. (normal range 60-80) On 1/4/14, 1/11/14, 1/18/14, 1/25/14, 2/8/14 and 2/15/14, R23's diastolic pressure was noted to be below 50. Review of the nurses notes for the corresponding dates, lacked indication the staff had documented any type of concern related to R23's cardiac status. Review of the physicians note dated 3/6/14, lacked indication the physican had been notified of any concerns related to R23's cardiac status. On 4/10/14, at 8:30 a.m. the director of nurses (DON) stated R23 had a long history of anxiety problems and at times he complained of chest tightness. The DON confirmed R23 had resided in the facility for 5 months and during that time, the episodes on 3/4/14, and 3/5/14, were the first the staff members had identified any concerns related to chest pain. In addition, she stated if a resident displayed lower than usual blood pressure (systolic or diastolic) she would expect the staff to recheck the blood pressure and document the result. On 4/10/14, at 8:45 a.m. the assistant director of nurses (ADON) stated R23 had a history of high blood pressure and would have expected the pressures to be higher. She confirmed if a resident displayed blood pressures which were high or low, she would expect the staff to call a supervisor for clarification or direction, monitor the resident and report the concern to a physican	F 309		

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F 309	Continued From page 31 as needed. The ADON confirmed R23 displayed cardiac distress symptoms and the facility did not respond appropriately. A policy regarding appropriate care and services for cardiac patients was requested but not provided. R21 did not receive wound care as directed by the physican. The admission MDS dated 3/20/14, identified R21 as a cognitively impaired resident with diagnoses including dementia, failure to thrive and peripheral vascular disease. The MDS indicated R21 required limited assistance with bed mobility, transfer and ambulation. In addition, the assessment revealed R21 had two venous and arterial stasis ulcers. The Pressure Ulcer CAA dated 3/20/14, identified R21 at risk for the development of pressure ulcers. R21 had two venous stasis ulcers bilaterally on the lower extremities. The assessment directed the staff to provide wound care as ordered. The care plan dated 3/26/14, directed the staff to provide dressing to the venous ulcer on the front of the shins as directed by the physican. The Physican's Orders and Signature Form dated 3/25/14, directed the staff to apply a mepilex (foam dressing) to the left shin open area every three days and as needed. If draining present moisten with wound cleanser before removing. The order further directed the staff to keep the area open to air for one hour before changing the	F 309		

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F 309	Continued From page 32 dressing. On 4/9/14, at 9:25 a.m. R21 was observed sitting in a wheelchair in her room with her pants pulled up over her knees. A dressing was observed with the date of "3/28/14" written on it. On 4/9/14, at 3:20 p.m. registered nurse (RN)-C stated he had noticed R21's dressing was dated 3/28/14, and had attempted to change the dressing, however, R21 had refused the treatment. On 4/10/14, at 7:44 a.m. RN-C stated he had removed R21's dressing at 7:00 a.m. and was waiting for a hour before replacing the dressing. He stated the dressing he removed had been dated 3/28/14. On 4/10/13, at 7:50 a.m. R21 was observed resting in bed. The left shin was observed to be open to air. A black scab was noted on the shin. Review of R21's electronic treatment record indicated the dressing had been changed on 3/28/14, 3/31/14, 4/3/14, 4/6/14 and on 4/9/14, R21 had refused the dressing change. Review of the Progress Notes from 3/28/13 - 4/10/13, lacked documentation of R21 refusing dressing changes. A Progress Note dated 3/25/14, indicated the wound on the left leg measured 5 centimeters (cm) by 4 cm by 0.3 cm. On 4/10/13, at 8:10 a.m. the assistant director of nursing (ADON) stated the dressing was to be changed every three days as directed by the physican's orders. She confirmed the record lacked documentation as to why R21 had not	F 309		

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F 309	Continued From page 33 received dressing changes as ordered. On 4/10/13, at 10:44 a.m. RN-C measured R21's scabbed area. The area measured 2.5 cm by 2 cm. RN-C then dated a fresh dressing with "4/10/14" and applied it to R21's stasis ulcer. On 4/10/14, at 11:00 a.m. RN-C confirmed he had not had time to replace R21's dressing within one hour of removing the old dressing. He confirmed R21's dressing had been in place since 3/28/14, (14 days) and not been changed every three days as directed by the physican's orders. A wound care policy was requested but not provided. R55 did not receive turning and positioning. During observation on 4/7/14, at 4:45 p.m. R55 was lying on her back with both heels against the mattress. When asked about her turning in the bed and changing her position, R55 stated, "My family brought me a bigger bed, but then the staff had trouble moving about in the room, so they took the bed out." R55 verified she typically lies flat on her back because there was no room in the bed to turn and be positioned on her sides. Staff "boost" her up in the bed for meals. R55 verified she could not use an overhead trapeze for positioning due to a shoulder injury. 4/8/14 during numerous observations throughout the day R55 remained in bed on her back without a change in position. Interview with R55 at 10:43 a.m. revealed that she did not think there was enough staff at the facility to routinely get her up. R55 indicated her wheel chair was uncomfortable and stated she has back pain when sitting up.	F 309		

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F 309	Continued From page 34 When interviewed on 4/9/14, at 7:00 a.m. nursing assistant (NA)-E and NA-J verified R55 only gets up for church on Wednesdays or if there is a special event in the facility, but typically just for church on Wednesday. When asked about turning and positioning the staff verified R55 is always on her back. When interviewed at 9:30 a.m., NA-A verified another staff member helped to boost R55 up in bed for breakfast but there had been no position change. The plan of care directed staff, "I have diagnosis of depressive disorder, encourage me to get involved in activities related to my interests, encourage time out of room for meals and time in Recreation programs for socialization and stimulation." A review of the physician orders read, "activity level up with assistance and weight bearing status up with assistance. The most recent psychology notes dated, May 16, 2012 direct staff to "Pattern time where she is out of her room with other people on a daily basis. I suggest coming out for meals in addition to the time she is up for therapy." Interview with the occupational therapy director (OT) on 4/11/14, at 9:45 a.m. regarding the wheel chair positioning indicated OT has supplied a 6 inch bariatric cushion for positioning in the wheel chair but this has resulted in no back support when sitting up in the chair. Therapy has not evaluated the positioning of R55 for back support or for a reclining wheel chair which would provide better specialty positioning for R55 and an opportunity to be up for meals and attend activities of interest. OT indicated R55 should be further assessed, when up in the wheel chair, to	F 309		

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GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

(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 35 assure indivdual needs are accommodated.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care to residents to ensure personal cleanliness for 1 of 2 residents (R55) who were dependent upon staff to perform personal cares. Findings include: R55 was not provided morning care prior to breakfast, when observed the morning of 4/9/14, from 7:00 a.m. until 8:30 a.m. Two nursing assistants (NAs) assisted R55 to boost up in bed for breakfast at 8:30 a.m. After breakfast a staff person removed the resident's breakfast tray, and lowered the resident's bed to a supine position, however, the resident was not offered any morning cares. Morning observations were again conducted on 4/11/14, from 8:00 a.m. until 9:34 a.m. and again R55 was not offered morning cares. The resident's fingernails were untrimmed and were jagged with dirty nailbeds on the right hand. The resident's hair was also unclean, and her mouth appeared dry. The resident reported, "They never took the partial out of my mouth all night to soak it and I still have three of my own	F 312	F312 -Res. #55 is receiving necessary services to maintain good nutrition, grooming, personal cares, and oral hygiene. - All residents have the potential to be affected by the deficient practice. -Nursing staff have been educated to provide cares as identified in the care plan. - Random weekly audits will be conducted to ensure resident cares and services are provided according to identified care plan interventions. Audit results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party - Corrective action will be completed by 5/21/2014.	

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F 312	Continued From page 36 teeth." The resident reported the observations were "typical" of care that had been provided to her that week. NA-A was then interviewed at 9:30 a.m. verified oral care had also not been provided for the resident that morning. R55's quarterly Minimum Data Set (MDS) dated 3/28/14, indicated the resident required extensive assistance with hygiene and total assistance with bathing. An annual MDS dated 1/2/14 showed the resident had not displayed any mood or behavioral problems during the assessment period, including refusing care. R55's oral care plan revised 4/25/13 read, "At risk for dental problems related to oral candidiasis, daily use of lower denture, use of upper partial and dependency for oral care. Nursing staff was to provide oral care twice daily including denture/partial care, and encourage the resident to comply with care. The self care impairment care plan revised 1/31/13 indicated the resident was dependent on staff to provide personal hygiene cares. A nurse practitioner's note dated 2/7/14, indicated the resident "sometimes" resisted care.	F 312		
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	F 314		

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F 314	Continued From page 37 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for 2 of 3 residents, (R20, R8) who were identifed to be at risk for developing pressure ulcers. Findings include: R20, identified to be at risk for development of pressure ulcers, developed an open area on the buttocks and coccyx area. R20 was admitted to the facility on 6/2/11 and expired on 3/22/14. On 3/14/14, R20 was admitted to hospice care as she had slowly deteriorated due to heart disease, diabetes, and advanced Alzheimer dementia. A significant change minimum data set (MDS) dated 1/24/14, indicated R20 had no open areas. The care area assessment (CAA) indicated R20 was at risk for development of pressure ulcers with a Braden (a scale to determine skin breakdown risk) of 15. A score of 15-18 resident was deemed to be at risk. R20 needed extensive mobility assist. On 1/28/14, the nurses notes (NN) indicated, stable, skin intact. On 2/3/14, nurses notes indicated small open area on left buttock. A wound evaluation flow sheet was started on 2/3/14 which described the wound as .3 x .5 cm open area on left upper buttocks close to the coccyx. On 2/10/14 the staff documented on the	F 314	F314 -Res. #8 is receiving necessary treatment and services to promote healing, prevent infection and prevent new pressure sores. Res. #20 is no longer a resident at this facility. -All residents at risk of developing pressure ulcers have the potential to be affected by the deficient practice. -All nursing staff have been educated to provide resident cares and treatments according to their individualized care plans and MD orders. -Random weekly audits will be conducted to ensure resident cares and treatments are provided according to identified care plan interventions and MD orders. Audit results will be reviewed at QAPI and action planned as needed. -ADNS or designee is the responsible party - Corrective action will be completed by 5/21/2014.	

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F 314	Continued From page 38 wound care flow sheet, same abrasion on left buttock measured .1 x .3 cm. The wound care flow sheet directed staff, continue to monitor. On 2/17/14 the staff documented the area as healed. The care plan updated 2/3/14 indicated a Braden of 15 (at risk) with history of skin lesions related to cancer of the cheek and right eye brow area. The care plan did not address the risk of skin breakdown. On 2/24/14 the nurses notes identified an open area on the coccyx measuring 1.5 cm X .75 cm. The area was cleaned and a dressing applied. The nurse told the nursing assistant (NA) to turn and reposition the resident every 1-2 hours until directed otherwise and to apply barrier cream. The comprehensive weekly skin assessment form dated 2/26/14 indicated open area on coccyx. The physician progress notes dated 2/11/14 and 3/14/14 did not address the open area on the coccyx. The physicians orders from 2/4/14 through 3/22/14 did not address the open area or treatment. Interview with the assistant director of nursing (ADON) on 4/10/14 at 4:30 p.m. indicated she did not think there would be any wound care documentation and wound care plan because R20 did not have a wound. When the nurses notes were reviewed the ADON said she was not aware of the open area and if there was one, it should have been added to the care plan along with interventions and treatment. R8 had recurring pressure ulcers on coccyx area;	F 314		

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the plan of care lacked to identify current ulcer and the weekly evaluation/treatment documentation was not completed to reflect the wound size, exudate, wound bed and periwound characteristics.

R8 was admitted to the facility on 11/11/05, with diagnoses that included Multiple Sclerosis (MS), dementia, contracture of lower leg joints, failure to thrive and personality disorder.

The quarterly Minimum Data Set (MDS) assessment, dated 02/18/14, identified R8 as non-ambulatory and relied on staff for all assistance with activities of daily living. It added, R8's cognition was impaired and had one stage I or greater pressure ulcer. The MDS identified one stage III pressure ulcer, measurements in centimeter (cm) of length 1.5 cm, width 1.0 cm, and depth 0.5 cm. Previous quarterly MDS, dated 11/25/2013 indicated R8 was at risk for pressure ulcers and had no unhealed pressure ulcers.

During observations of morning cares and coccyx pressure ulcer on 04/09/14 at 8:00 a.m. licensed practical nurse (LPN)-A removed the old Tegaderm saturated with yellowish drainage, cleansed the deep pressure ulcer with normal saline vial, applied flaygl and followed with clean Tegaderm. The wound base was not visible, the edges were macerated and LPN-A did not measure the pressure ulcer, she indicated the wound was measured by a RN weekly.

The physician's documentation, dated 01/07/14, indicated R8 has had significant muscle and subcutaneous tissue wasting due to MS and experienced recurrent pressure ulcers, R8 had

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been treated for ulcer on coccyx which was healed and another new ulcer was developed within, "the last 24 hours." The physician's note described a 1 cm by 1 cm stage II pressure ulcer on coccyx. The previous pressure ulcer was proximal and left and was lateral to this new ulcer.

The physician's and nurse practitioner's documentation dated, 1/24/14 and 03/06/14, described a stage II pressure ulcer on R8's coccyx. The nurse practitioner's note dated 03/06/14, indicated R8's coccyx pressure ulcer was becoming worse and was increasing in size. The note further revealed the ulcer had increased in depth and there was necrotic tissue present; the treatment was changed from flagyl powder to flagyl gel to assist with debridement.

The physician's documentation, dated 03/04/14, indicated R8 has had significant muscle and subcutaneous tissue wasting due to MS and has had problems with recurring pressure ulcers. It added R8 was treated for coccyx pressure ulcer in, "the fall of 2013," and that ulcer healed up and re-opened on the first week of January 14.

The nurse practitioner's documentation, dated 03/25/14, revealed R8 had a nonhealing sacral ulcer with occasional drainage. R8 had been receiving flaygl gel for two weeks which had resulted in some macerated edges and no change in ulcer size. It further added, the treatment changed from gel to flagyl powder followed by Tegaderm, which needed to be changed daily.

The plan of care dated, 03/18/2013, indicated R8 was at risk for pressure ulcer and impaired skin

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integrity related to a history of healed stage two pressure ulcer to coccyx. The goal with a target date of 02/28/14 revealed R8's skin would remain intact through next review period and the interventions included to float heels, air mattress, nutritional/hydration support, and to offload R8 every 2 hours.
It lacked the current status of R8's skin integrity of a stage III pressure ulcer on coccyx as identified in the quarterly MDS dated 02/14/14.

The weekly wound evaluation flow sheet, dated 01/06/14 to 04/06/14, facility used to document if the pressure ulcer was improving or worsening was incomplete.

The wound evaluation flow sheets had the following information:
On 01/06/14 the pressure ulcer on coccyx was identified as "other wound" and not as a pressure ulcer. The measurement listed as Length (L) 0.5 cm., Width (W) 0.7 cm, Depth (D) 0.1 cm.; there was no exudate (drainage); no infections of wound bed, periwound was white with pink edges. The treatment of non sting barrier spray and tegaderm was documented to be applied to the coccyx ulcer every other day.
On 01/18/14 coccyx pressure ulcer measurement was L 0.4 cm, W 0.5 cm and it indicated the ulcer was improving.
On 01/23/14 measurement of L1.3 cm, W 1.0 cm was documented. However, no other information regarding the pressure ulcer status was documented.
On 1/30/14 L 1.5 cm, W 1.0 cm.
On 02/06/14 L 1.2 cm, W 1.0 cm, D 0.1 cm.
On 03/26/14 L 1.5 cm, W 1.0 cm.
On 04/06/14 L 1.0 cm, W 1.0 cm D 0.5 cm.
The wound evaluation flow sheet dated 01/30,

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F 314	Continued From page 42 02/06, 02/13, 02/20, 02/27, 03/04, 03/11, 03/26 and 04/06/14 were left blank for drainage status, wound bed infection status, surrounding tissue health, current treatment and wound improvement/worsening status. On 04/10/14 at 3:22 p.m. the assistant director of nursing (ADON) indicated she tried to document weekly on R8's coccyx pressure ulcer status; however, she missed on R8's weekly documentation. ADON stated R8 has had recurring pressure ulcers due to her comorbid conditions. ADON acknowledged it would be difficult to evaluate if the pressure ulcer was worsening or improving without proper documentation. It lacked the documentation if the skin integrity was improving or declining of R8's coccyx pressure ulcer. There was no other documentation available nor provided regarding R8's coccyx pressure ulcer. ADON verified R8 had a stage II pressure ulcer on coccyx. She indicated it was missed. After reviewing the wound evaluation flow sheets and the pressure ulcer care plan, ADON stated the plan needed to be revised to reflect R8's current pressure ulcer status and the weekly wound evaluation flow sheets needed to be completed. The facility's skin integrity guideline, policy/procedures, revised in 2013, directed staff to develop a routine to review residents with wounds or at risk on a weekly basis and document. It directed the staff to develop a plan of care and listed interventions to be implemented.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 43 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 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for 1 of 3 residents, (R55) who required help with toileting needs. Findings include: R55 was observed numerous times throughout the days of the survey. The only time that R55 was out of bed was on Wednesday 4/9/14 at 9:45 a.m. to attend church services. R55 was not offered assist to use the commode or bed pan. The resident reported the observations were "typical" of care that had been provided to her that week. R55's quarterly Minimum Data Set (MDS) dated 3/28/14, indicated the resident required extensive assistance with hygiene and total assistance with bathing. A review of the plan of care revealed R55, "Toileting plan to check and change every two hours and provide staff assist of 2/offer commode or bed pan upon rising, before, after meals. every	F 315	F315 -Res. #55 is receiving necessary care and services and appropriate treatment to prevent urinary tract infections and restore as much normal bladder function as possible. -All residents have the potential to be affected by the deficient practice. - Nursing staff have been educated to provide toileting assistance as identified in the resident's plan of care. -Random weekly audits will be conducted to ensure resident toileting is provided according to identified care plan interventions. Audit results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. - Corrective action will be completed by 5/21/2014.	

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F 315	Continued From page 44 bedtime." Interview with nursing assistant NA-A, NA-J and NA-E on 4/9/14, at 8:00 a.m. verified R55 does not get out of bed except for church services. Furthermore they verified R55 is not offered a commode or bedpan and uses the incontinence brief for toileting needs.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion services (ROM) to prevent further decrease of ROM for 2 of 3 residents (R12, R8) in the sample who had limitations in range of motion. Findings include: R12 did not receive assistance with range of motion according to the care plan. The quarterly Minimum Data Set (MDS) dated 12/30/13, identified R12 as having moderate cognitive impairment and cerebral palsey. The assessment indicated R12 required extensive	F 318	F318 -Res. #8 and Res. #12 are receiving ROM per their care plans. -All residents with limited ROM have the potential to be affected by the deficient practice- -Nursing staff have been educated in the basics of ROM and the need to perform as recommended by therapy to improve decreasing ROM and prevent loss of ROM. - Random weekly audits will be conducted to ensure ROM is provided according to identified care plan interventions and therapy recommendations Audit results will be reviewed at QAPI and action planned as needed. -RNAC or designee is the responsible party. - Corrective action will be completed by 5/21/2014.	

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assistance with all activities of daily living, was non ambulatory and had functional limitations of range of motion in the lower extremities.

The care plan dated 1/24/13, directed the staff to transfer R12 with a full body mechanical lift and to provide range of motion to the lower extremities with dressing and undressing.

On 4/9/13, at 7:05 a.m. R12 was observed to be sitting in the wheelchair fully dressed. R12's feet were observed to be contracted in an inward position and were resting on foot rests. R12 was observed to maneuver the wheelchair with his hands.

On 4/9/14, at 10:00 a.m. nursing assistant (NA)-A stated R12 would allow minimal range of motion during dressing. She stated the staff attempt range of motion, but R12 does not always comply with the program.

On 4/10/13, at 10:33 a.m. NA-D stated the range of motion program is attempted, but the staff did not have time to complete the documentation.

The Occupational Therapy Plan of Care dated 2/21/13, identified R12 as having contractures of the hips, knees and feet.

The Physical Therapist Progress and Updated Plan of care dated 10/17/12, directed the nursing staff to provide passive range of motion to the lower extremities with cares.

Review of the Restorative Nursing book did not include a documentation sheet for R12 for the months of 4/2014, 3/2014, 2/2014 and 1/2014.

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F 318	Continued From page 46 The Progress Notes from 1/2014- 4/2014, lacked documentation related to R12's restorative program. On 4/10/13, at 11:25 a.m. the director of nursing (DON) stated she had been at the facility since 12/2013, and was unaware R12 had a range of motion program. She stated she had understood R12 had refused the range of motion program in the past, so the program had been discontinued. On 4/10/13, at 11:30 a.m. the assistant director of nursing (ADON) stated the plan of care directed the staff to complete a range of motion program and that R12 was to be receiving range. She stated she had been assigned to monitor the range of motion program upon hire at the facility in 1/2014, but had not been able to fully evaluate the program. She was unsure if R12 was to have a program or not, but confirmed R12 had limitations in his lower extremities. She confirmed if R12 had refused the program, he could have been referred to the physical therapist for further evaluation. She verified the clinical record did not address R12's range of motion program. The Restorative Guidelines dated 2013, directed the staff to document daily in the restorative record to indicate the programs were complete. The guidelines also directed the RN restorative coordinator to document monthly on each resident the status and the response to the current plan of care. It indicated when a resident was discharged from the restorative program, a progress note was to be completed.	F 318		

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F 318	Continued From page 47 R8 did not receive passive range of motion according to the plan of care during the morning cares. R8 was admitted to the facility on 11/11/2005, with diagnoses that included Multiple Sclerosis (MS), dementia, contracture of lower leg joints. The quarterly Minimum Data Set (MDS) assessment, dated 02/18/2014, identified as non-ambulatory and relied on staff for all assistance with activities of daily living. It added, R8's cognition was impaired. The communication documentation from therapy staff to nursing staff, dated 05/16/2012 directed nursing staff to perform bilateral passive range of motion to bilateral extremities daily with cares to maintain range of motion. R8's plan of care for physical functioning deficit, dated 12/09/2013, directed staff to perform passive range of motion (PROM) to bilateral lower extremities with cares. However, during the observation of morning care on 04/09/14 from 7:51 a.m. to 8:30 a.m. two nursing assistants (NAR)-D and NAR-M provided total assistance with grooming, placing clothing on and transferring R8 using a Hoyer lift from bed to the wheelchair. The NARs did not provide any PROM to R8's extremities and wheeled R8 to the dining room. On 04/10/14 at 2:30 p.m. NAR-M stated they usually perform PROM for R8, however, on 04/09/14 they forgot to do it because they were, "rushing to provide timely cares to the residents." On 04/10/14 at 3:22 p.m., Assistant Director of	F 318		

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F 318	Continued From page 48 Nursing (ADON) stated the staff needed to follow R8's plan of care related to PROM during the morning cares. When asked for the copies of the PROM documentation, ADON provided April 2014 data and stated she was unable to find the previous months. Review of April 2014 form, the staff had initialed for 4/09/14. Interview with the ADON stated staff should not be initialing the form if they had not completed the PROM.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 -The facility has an established target behavior and side effect monitoring system Res. #75, Res. #23, and Res. #47 are currently being monitored for targeted behaviors as well as potential side effects of the psychotropic medication they are prescribed. -All residents receiving psychotropic medication have the potential to be affected by the deficient practice. - Random weekly audits will be conducted to ensure monitoring of identified target behaviors and potential side effects. Audit results will be reviewed at QAPI and action planned as needed. - SS and RNAC are the responsible parties. - Corrective action will be completed by 5/21/2014.	

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F 329	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continued use of antipsychotic medications for 3 of 6 residents (F75, R23, R47) prescribed psychotropic medications and were reviewed for unnecessary drug use. Findings include: R75 was observed on 4/7/14 from 4:30 to 5:30 p.m. while seated in her wheelchair in the dining room. She was looking down at the floor and was loudly yelling out, "Help me! Help me! Help me!" at 4:35 p.m. NA-M asked the resident if she wanted something. R75 replied, "I don't know. Where do I go?" The NA-M explained dinner would be arriving soon. R75 complained of being cold, and NA-M covered the resident with a blanket and then left the dining room area. R75 began yelling out again, "Help me! Help me! Help me!...intermittently and stopping only to take a breath. A health information (HIM)-A staff person asked the resident if she needed something, to which she replied, "I don't know. Help me! Help me!" HIM-A informed the resident supper would be served shortly, and then left the resident, who watched the staff person leave and continued yelling. The yelling could be heard from the dining room to the far end of the hallway and continued until 5:29 p.m. when the dining cart arrived. R75 then ate her meal in the dining room without yelling out from 5:30 p.m. until 6:15 p.m. At 6:30 p.m. R75 began yelling in the same manner for help. At 6:45 p.m. a staff person assisted R75 to her room, where she continued yelling from 7:00 to 7:30 p.m.	F 329		

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F 329	Continued From page 50 R75 was admitted to the facility in 12/13, with diagnoses including sleep disturbance, senile/vascular dementia with delusional features, unspecified psychosis, anxiety and depressive mood. A licensed psychologist's made recommendations on 1/8/14, to locate R75 near the nurses' station since she appeared to find comfort being located near staff to decrease her fears of being alone in the world. In addition, it was recommended R75 would have benefited from sensory therapy modalities, such as aromatherapy, use of soft textile items, and healing touch. After reports R75 was yelling non-stop throughout the day and sleeping poorly at night, the Geriatric Nurse Practitioner's (NP) documentation dated 1/21/14, showed R75's Haldol (antipsychotic) was increased to 0.5 mg three times daily and Trazodone (antidepressant commonly used to promote sleep) was increased to 25 mg three times daily. R75's MDS assessments revealed the resident was discharged for inpatient treatment for increased behavioral symptoms from 1/31/14 to 2/12/14. Psychiatric hospital staffs' discharge recommendations dated indicated R75's behaviors stabilized and she met her goals. No aggressive behavior, striking out, throwing objects towards staff or peers had occurred over the previous several days. Hospital discharge instructions included, "Offer a busy box to rummage through with items to sort, stack and manipulate to keep occupied, provide magazines, puzzles, music, coffee and snacks." It also recommended to repositioning into a recliner chair and provide positive reinforcement.	F 329		

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F 329	Continued From page 51 NP documented on 2/21/14, R75 was prescribed Risperdal (antipsychotic) 0.25 mg twice daily and as needed every 4 hours. Cymbalta (antidepressant) 60 mg daily; Neurontin (anticonvulsant with off label use to treat social phobias) 50 mg every 4 hours for anxiety was also initiated, with Haldol was discontinued and Trazodone only at bed time. NP notes dated 3/4/14, indicated R75 was on Cymbalta, delayed release, 60 mg tablet once daily for unspecified personality disorder with a start date of 2/12/14. Risperdal solution 0.25 mg twice daily and as needed every 4 hours for agitation, the start date was 2/13/14. Trazodone 50 mg daily at bedtime for sleep disturbance and may repeat one time before 3:00 a.m. if R75 was still awake; the start date was 2/12/14. NP notes dated 4/5/14, indicated since R75 return to the nursing home staff had reported frequent episodes of poor sleep at night, calling out and had been receiving Risperdal 0.25 mg twice daily and every 4 hours as needed. Less agitation was noted and the resident was frequently engaged in the unit activities. Trazodone 50 mg at bedtime was used and as needed if resident was not asleep by 3:00 a.m. It was noted the current medications were effective in decreasing agitation associated with delusional thinking and to continue Trazodone for insomnia and staff was to monitor sleep. On 4/7/14, at 5:00 p.m. a licensed practical nurse (LPN)-E who reported working on the unit full time and was very familiar with R75 was interviewed. LPN-E reported R75 hollered out daily, and there was nothing the staff could do to help the resident. In addition, the resident was prescribed behavior controlling medications, but they were not beneficial.	F 329		

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F 329	Continued From page 52 Although recommendations by professionals (licensed psychologist and hospital staff) were clearly spelled out for staff to utilize, with the exception of a blanket and supper, the interventions were not offered to R75 on 4/7/14 when she repeatedly called out for help and was mostly unable to articulate her needs. Daily Behavioral Monitoring sheets for March 2014 were incomplete, and revealed only 15 days of documentation for the day shift, three days on the evening shift were documented, and zero was marked for two days on the night shift. April 2014 sheets were also incomplete with 4/3 and 4/5 day shift and 4/8/14 evening shift documenting R75 shouted, "help," and swore at staff. Interventions included re-directing, returning R75 to her room and toileting were marked. The outcome was documented as improved on day shift and no change for the evening shift. Other days on the form were left blank. Conclusions could not be drawn as to the effect the non-pharmacological interventions had on the resident's behavior. It was also not noted whether resident experienced any side effects from the medication use. On 4/10/14 at 8:15 a.m. LSW-A nursing staff needed to fill out the forms that had been developed in order to help the behavioral team determine what behaviors were being displayed, what interventions had been tried, and were they working in order to determine the efficacy and continued need for psychotropic medications. When LSW-A had asked the nursing staff why they had not competed the documentation, they responded that they did not have time. On 4/10/14. at 3:22 p.m. the assistant director of	F 329		

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nursing (ADON) stated she was aware behavioral documentation, non-pharmacological interventions and side-effect monitoring was not being completed consistently. She explained that the management staff was all new and were trying to re-educate their nursing staff on importance of documenting consistently. The ADON added, she knew R75 prior to her admission to the facility and there was a lot more that they could do for R75 to provide comfort to her. ADON added R75's behaviors had not subsided despite of her psychiatric hospitalization.

On 4/11/14, at 10:25 a.m. R75 hollered out from her room, "Help me! Help me! Help me!" Another resident wheeled herself to the nursing station and reported to LPN-F that R75 was hollering for help in her room. When LPN-F went to R75's room, the resident stopped yelling.

On 4/11/14, at 10:30 a.m. LPN-F explained R75, "hollers out all of the time, help me, help me, help me." She added R75 had been receiving several psychotropic medications for her behaviors but added, "They don't do a thing. They don't work and I don't know why they have her on all of these medications when they don't do anything." She reported that the previous weekend R75 yelled out for help constantly, and had been aware on all three shifts. LPN-F stated that the more the resident yelled, the more agitated she became. "She becomes very agitated, frustrated and she is suffering. She doesn't get enough sleep at night." LPN-F expressed concern that the medications were not effective before nor were they effective after the resident was hospitalized and wondered, "I don't know why they don't do something for her."

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F 329	Continued From page 54 On 4/14/14, at 4:00 p.m. the consulting pharmacist (CP)-A returned the surveyor's call regarding R75 and stated that she had recommended staff monitor medication side effects including orthostatic blood pressures (to determine if pressure abnormally dropped from lying to sitting to standing position). CP-A stated the consultation report was with the director of nursing (DON). She tried to review the nursing staffs' behavior and side effect monitoring, and to then document her recommendations which were then forwarded to the DON and physician for review and comment. R23 physician orders dated 3/4/14, included Seroquel (antipsychotic) 100 milligrams (mg) three times daily, Zyprexa (antipsychotic) 10 mg daily, clonazepam 1 mg (anti-anxiety) three times a day, Effexor XR (antidepressant) 225 mg daily, Trazodone HCL (antidepressant commonly used to promote sleep) 100 mg at bedtime. Throughout various survey observations on 4/7/14 from 6:00 to 8:00 p.m. on 4/8/14, from 8:00 a.m. to 4:30 p.m. on 4/9/14 from 7:00 a.m. to 3:30 p.m. on 4/10/13, from 8:00 a.m. to 4:30 p.m. and on 4/11/14, from 8:00 a.m. to 12:00 p.m. R23 was observed on numerous occasions and interacted appropriately with others. R23's care plan dated 11/27/13, identified the resident as having trouble concentrating and directed staff to administer anti-anxiety medications. In addition, the resident utilized antipsychotic and antidepressant medications	F 329		

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F 329	Continued From page 55 and staff was to administer the medications as ordered and monitor for side effects. The plan did not address specific target behaviors or mood monitoring for efficacy of the various psychotropic medications. A psychological evaluation completed 1/22/14, identified R23 as requiring continued psychotherapy for the treatment of schizophrenia and an adjustment disorder, and it was noted R23 was well-adjusted to the facility environment. The quarterly Minimum Data Set (MDS) dated 2/11/14, identified R23 as being cognitively intact, with diagnoses including schizophrenia, anxiety, and Parkinson's disease, with daily psychotropic medication use. It was noted R23 had trouble falling asleep and felt tired, but no maladaptive behavior was identified. Behavioral concerns were not identified in Progress Notes were reviewed from the time of R23's admission in 11/13 to the time of the survey on 4/9/14. Daily Behavior Observation sheets were located in R23's record for the months of 3/14 and 4/14. Target behaviors identified on the 3/14 sheet revealed the resident was being monitored for making rude/sarcastic/angry remarks, suspiciousness, and/or threatening peers or staff. Documentation was largely blank for the month, with only the night staff recording none of the behaviors observed on three different days. For 4/14, different target behaviors were identified of mumbling and pacing, heavy breathing, sweating, statements of depression or anxiety, and making accusations. Again the sheet was largely blank, with night staff documenting that none of the behavior had been observed.	F 329		

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F 329	Continued From page 56 Interviews were conducted with various staff regarding R23's behaviors on 4/10/14. At 8:45 a.m. two nursing assistants (NA)-E and NA-B reported R23 displayed nighttime behavioral issues of making loud requests to staff and turning up the volume on his television. At 9:00 a.m. NA-D stated R23 did not display maladaptive behaviors. At 9:50 p.m. the assistant director of nursing (ADON) explained that is a resident was displaying aberrant behavior, the staff was to make a note of it in the resident's progress notes. At 10:00 a.m. a licensed social worker (LSW)-A reported that nursing staff was to document each shift whether target behavior was displayed. The facility's behavioral documentation system had recently changed and she was aware staff were not completing documentation as they should have been. She had reported this concern to the nurse managers. LSW-A was unaware R23's target behavior was different from 3/14 to 4/14, but said she would look into it. The facility conducted weekly interdisciplinary behavior monitoring meetings, where residents who had medication changes or who were displaying maladaptive behavior were discussed. At 3:00 p.m. the director of nurses (DON) reported being aware staff had not been consistently monitoring and documenting resident behavioral symptoms. R47's physician Order Summary Report dated 3/4/14, revealed orders for Cymbalta (antidepressant) 60 mg daily and Depakote Sprinkles (seizure medication commonly used to treat behavioral symptoms) 500 mg twice daily. R47 displayed appropriate behavior during	F 329		

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observations during the survey. On 4/10/14, at 3:50 p.m. the resident was in her room and responded appropriately when spoken to. On 4/11/14, at 9:05 a.m. the resident was seated with peers in the dining room. R47 was observed sitting in the dining room with peers. She was not observed to display behaviors.
On 4/11/14, at 9:50 a.m. R47 received assistance from NA-F and the ADON to ambulate in the hallway. She tolerated the activity well and was not observed to display behaviors.

NA-F reported on 4/11/14, at 10:00 a.m. R47 did not display aberrant behaviors.
At 10:05 a.m. NA-A stated R47 had a history of pinching and yelling at staff, but was easily redirected. She stated R47 had not displayed behavioral issues in the past month.

R47's significant change MDS dated 8/5/13, indicated R47 had little interest in activities, feeling down, expressing concerns of tiredness and having little energy, and displayed behavioral symptoms 1-3 days a week. The corresponding Psychotropic Medication Care Area Assessment (CAA) also dated 8/5/13, identified R47 as utilizing daily antidepressant medication and directed the staff to monitor for side effects of the medication. A subsequent quarterly MDS dated 1/24/14, identified R47 as displaying no mood or behavioral issues.

R47's care plan dated 1/17/14, identified social phobias and difficult processing in noisy areas and new situations, with a plan to avoid large groups. The resident was noted as having a history of verbal and physical abuse to others and making negative statements.

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A psychological evaluation for R47 was completed on 2/5/14, and revealed R47 had difficulty with impulse control and a history of hitting others. The psychologist recommended moving the resident slowly through tight quarters, speak clearly to the resident and inform her prior to providing care.

R47's Progress Notes from 1/10 to 4/7/14, noted on 1/23/14 the resident struck another resident and "sometimes gets agitated." Notes on 2/2/14 and 2/21/14, read: "No mood or behaviors noted beside the occasional crying and tearfulness." No other behavioral or mood documentation was noted.

The Daily Behavioral Observation sheet for April and March 2014, indicated the facility was monitoring R47 for fast pacing, angry/agitated/slamming of objects, delusional/paranoid statements and negative statements about herself. The forms were mostly blank with the night shift noting zero behaviors for April and zero behaviors noted on three days on the night shift, with the rest of the form left blank.

On 4/11/14, at 10:20 a.m. the DON confirmed the facility was monitoring R47 for fast pacing behaviors, yet R47 was no longer able to ambulate independently. She confirmed the behavior monitoring was inappropriate for R47 and in need of revision.

The facility's Behavior Management Guideline policy revised 2013, directed the staff to establish a monitoring system for target behaviors, interventions and medication effectiveness and side effects.

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F 353 F 353 SS=E	Continued From page 59 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with residents, family, staff and review of documents, the facility failed to ensure sufficient qualified nursing staff were available to meet the needs of residents. 9 of 61 residents observed/interviewed (R55, R8, R12, R20, R11, R23, R16, R48, R62), as well as family members and staff persons voiced concerns regarding lack of staff persons to assure resident needs were met. Findings include:	F 353 F 353	F353 -R55, R8, R12, R20, R11, R23, R16, R48, and R62 will have their needs met in a dignified, appropriate and timely manner per their plan of care and the resident's preference. -All residents have the potential to be affected by the deficient practice. -Appropriate levels of staffing are reviewed daily and adjustments made as needed. The facility continues to advertise for all nursing staff positions, as well as utilization of available staff from sister facilities as the need arises. The facility will schedule resident and family educational meetings to address staffing needs/concerns. All staff have been re-educated on call light response, provision of cares per the resident's plan of care, resident right of self-determination, and resident dignity. -Call light, Provision of Care/ADL, Resident interview and observation audits will be conducted weekly by IDT with results to be reviewed for resolution of concerns/grievances as needed. Results/resolutions will be shared with concerned parties with follow-up as needed by identified Departments. Interviews will be conducted at each care conference with resident/family members to note and address any concerns or grievances as well. This information will by reviewed with each QAPI meeting monthly to further address and action plan. -ED is the responsible party. - Corrective action will be completed by 5/21/2014.	

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	245337	A. BUILDING _____ B. WING _____	C 04/11/2014

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F 353	Continued From page 60 R55, on 4/8/14, during numerous observations throughout the day remained in bed on her back without a change in position. Interview with R55 at 10:43 a.m. revealed that she did not think there was enough staff at the facility to routinely get her up. R55 was not provided morning care prior to breakfast when observed the morning of 4/9/14, from 7:00 a.m. until 8:30 a.m. Two nursing assistants (NAs) assisted R55 to boost up in bed for breakfast at 8:30 a.m. After breakfast a staff person removed the resident's breakfast tray, lowered the resident's bed to a supine position, however, R55 was not offered any morning cares. Morning observations were again conducted on 4/11/14, from 8:00 a.m. until 9:34 a.m. and again R55 was not offered morning cares. The resident's fingernails were untrimmed and were jagged with dirty nailbeds on the right hand. The resident's hair was also unclean, and her mouth appeared dry. The resident reported, "They never took the partial out of my mouth all night to soak it and I still have three of my own teeth." The resident reported the observations were "typical" of care that had been provided to her that week. NA-A was interviewed at 9:30 a.m. and verified oral care had also not been provided for the resident that morning. R8 had recurring pressure ulcers on coccyx area; the plan of care did not identify the current ulcer and the weekly evaluation/treatment documentation was not completed to reflect the wound size, exudate, wound bed and periwound characteristics. The wound evaluation flow sheet dated 01/30, 02/06, 02/13, 02/20, 02/27, 03/04, 03/11, 03/26 and 04/06/14 were left blank for drainage status, wound bed infection status,	F 353		

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F 353	Continued From page 61 surrounding tissue health, current treatment and wound improvement/worsening status. On 04/10/14 at 3:22 p.m. the assistant director of nursing (ADON) indicated she tried to document weekly on R8's coccyx pressure ulcer status; however, she missed on R8's weekly documentation. ADON stated R8 has had recurring pressure ulcers due to her comorbid conditions. ADON acknowledged it would be difficult to evaluate if the pressure ulcer was worsening or improving without proper documentation. There was no other documentation available nor provided regarding R8's coccyx pressure ulcer. ADON verified R8 had a stage II pressure ulcer on coccyx. She indicated it was missed. After reviewing the wound evaluation flow sheets and the pressure ulcer care plan, ADON stated the plan should have been revised to reflect R8's current pressure ulcer status and the weekly wound evaluation flow sheets should have been completed. R8 did not receive passive range of motion according to the plan of care during the morning cares. During observation of morning care on 04/09/14 from 7:51 a.m. to 8:30 a.m. two nursing assistants (NAR)-D and NAR-M provided total assistance with grooming, placing clothing on and transferring R8 using a Hoyer lift from bed to the wheelchair. The NARs did not provide any PROM to R8's extremities and wheeled R8 to the dining room. On 04/10/2014 at 2:30 p.m. NAR-M stated they usually perform PROM for R8, however, on 04/09/2014 they forgot to do it because they were, "rushing to provide timely cares to the residents." On 4/8/14, at 1:30 p.m. R12 stated the facility	F 353		

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F 353	Continued From page 62 was short of nursing staff during the day and evening hours. The 12/30/13, quarterly MDS for R12 identified R12 was moderately cognitively impaired. R12 did not receive assistance with range of motion according to the care plan. On 4/10/13, at 11:30 a.m. the assistant director of nursing (ADON) stated the plan of care directed the staff to complete a range of motion program and that R12 was to be receiving range. She stated she had been assigned to monitor the range of motion program upon hire at the facility in 1/2014, but had not been able to fully evaluate the program. She was unsure if R12 was to have a program or not, but confirmed R12 had limitations in his lower extremities. She confirmed if R12 had refused the program, he could have been referred to the physical therapist for further evaluation. She verified the clinical record did not address R12's range of motion program. R20, identified to be at risk for development of pressure ulcers, developed an open area on the buttocks and coccyx area. Interview with the ADON on 4/10/14 at 4:30 p.m. indicated she did not think there would be any wound care documentation and wound care plan because R20 did not have a wound. When the nurses notes were reviewed the ADON said she was not aware of the open area and that it should have been added to the care plan along with interventions and treatment. Interview with R11 on 4/9/14 at approximately 8:45 a.m., stated, "they are short." R11 indicated she didn't need staff help but her roommate puts her call light on in the morning and wants to get up but she can't because they don't have enough people to help her get up to the bathroom and get	F 353		

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F 353	Continued From page 63 dressed. R23 was interviewed on 4/8/14, at 10:35 a.m. R23, identified on the quarterly MDS dated 2/11/14 as alert and oriented, voiced concerns regarding call lights not being answered timely and stated the facility was short of nursing staff in the evening. R23 stated the concern had been expressed at resident council meetings. R16 was interviewed on 4/8/14, at 9:22 a.m. R16 identified on the quarterly MDS dated 2/7/14 as being alert and oriented, voiced concerns regarding call lights not being answered timely and stated the facility was frequently short of staff. R16 stated she occassionally had to wait for a long time for the staff to answer her call light in the evening. R16 stated the concern had been expressed at resident council meetings. R48 was interviewed on 4/7/14, at 5:09 p.m. R48 was identified on the quarterly MDS dated 2/4/14, for the brief interview for mental status (BIMS) as being 14 of 15 as a result of the assessment. R48 voiced concerns regarding call lights not being answered timely and concerns that there was not enough staff at the facility. R48 stated the concern had been expressed at resident council meetings. R62 was interviewed on 4/7/14, at 6:50 p.m. R62, identified as alert and oriented on the quarterly MDS dated 2/27/14, voiced concerns regarding call lights not being answered timely and concerns that there was not enough staff at the facility to care for the residents. R62 described two occasions in which she had experienced incontinence episodes because the	F 353		

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F 353	Continued From page 64 nursing staff were not able to assist her timely. Interviews with family members and facility staff were conducted: Family member (F)-L was interviewed on 4/9/14 at 2:09 p.m. and stated, " I've told them to get my mother up early but it doesn't seem to get done consistently. Some rule mom said about can't get up before 6. I don't think they have enough people to help." 4/10/14 at 11:45 a.m. F-M was interviewed and indicated there are not enough people to help everyone. "On Mar 28 and 29th there were 2 aides for the floor. Showers don't get done, residents don't get toileted, and meals sit until staff can feed the residents. Nurses are too busy passing pills to help. Staff can't seem to get the range of motion done for the residents that need it." Interview with F-N on 4/11/14 at 10:00 a.m. revealed there are good staff working at the home but there are not enough staff. "They seem fearful of management. They can't seem to get all their work done." On 04/07/14 at 5:00 p.m., Licensed Practical Nurse (LPN)-E stated he worked full time primarly on a unit that has two nursing assistants during the evening shift. LPN-E indicated it was challenging finishing up all of the needed work with three staff on this unit because most of the residents needed extensive assistance, since they exhibited behaviors.	F 353		

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F 353	Continued From page 65 On 04/07/14 at 5:05 p.m., Nursing Assistant (NAR)-M stated she had been working since 6 a.m. this morning and was working the evening shift too. NAR-M stated her shift would end around 8 p.m. today. She said they have had three NARs when the beds were all full, otherwise were only two NARs and one nurse on this unit. NAR-M stated they worked as a team and tried to get their work done for these complex, vulnerable residents who have multiple behaviors. She said it was very difficult to accomplish all that needed to be done. On 4/10/14 at 8:24 a.m., Registered Nurse (RN)-C stated that he did not have enough time to get his work done. RN-C stated that he had to pass food trays, assist NAR's with transfers, provide treatments, administer medications, inform physician on the residents condition changes, complete new admit paperwork and document. RN-C said that he did the best that he could in the given time, and felt he could not complete all of the tasks needed to provide adequate cares to the residents. He said there was a lack of enough help in this home to provide adequate and safe cares to the residents. On 04/11/14 at 8:00 a.m. Licensed Practical Nurse (LPN)-F stated she was extremely tired because she had been working since last night. LPN-F stated, she started her shift at 10:30 p.m. last night and could not leave untill 12:30 p.m. today when another nurse would relieve her. LPN-F said she could not go home because one of the nurses did not come on duty this morning and was mandated to stay until a nurse showed up. LPN-F indicated the management was aware of staff who call in, not showing up for duty, and	F 353		

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F 353	Continued From page 66 it makes it very difficult for the rest of the staff to provide safe cares to these vulnerable adults who are dependent on them. LPN-F stated, "I actually feel sick to my stomach," when "I am put in this predicament." LPN-F stated the staff here are fed-up, they are tired of working short and are burned out of overtime. LPN-F added, another nurse upstairs (LPN-C) had also been working since 10:30 p.m. last night and would not be able to leave until 2:30 p.m. today. LPN-F shared her fustrations by stating, how do they, "expect us to provide safe and reasonable cares." LPN-F added staff have talked with the management about not having enough help and were told that there was enough staff; there was nothing done, "it is very furstrating." On 04/11/14 at 11:20 p.m. Social Worker (SS) stated that she was aware that the staff was not documenting consistantly on monitoring of behaviors, side effects, and were not offering non-pharm interventions consistently. SS stated nine of ten staff verbalized to her that there was not time to document, when she asked them why they were not completing the necessary documentation. Nursing assistant (NA)-K on 4/9/14 at 8:17 a.m., stated, "I usually work days and yes, we are short staffed and we have to stay over. Today is not my day to work but I was called in. I don't like it when I'm getting ready to go home and then I have to stay. We are very busy. Sometimes the management staff will help us. They don't get our people up but they will spot us for our lifts. Last weekend was terrible. We worked with only 2 NA's up here because they had to pull our 3rd person to go help downstairs. We can't always	F 353		

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F 353	Continued From page 67 get our work done when short. Last weekend baths were not done as there was only 2 of us working. We do the best that we can. At the end of my shift they wanted me to stay but I was just too tired." On 4/10/14, at 9:00 a.m. NA-E stated she was frequently expected to work her shift and would be mandated to work the next shift because the oncoming shift did not have enough staff to care for the residents. She stated this occurred 1-2 times per week. On 4/10/14, at 10:33 a.m. NA-D stated the nursing assistants were unable to complete their documentation because they did not have enough staff to complete the cares and document appropriately. On 4/10/14, at 11:00 a.m. RN-C stated he did not have time to complete cares for the residents and complete appropriate documentation. He stated he was doing the best he could, but there were not enough hours in the day to complete the task. On 4/11/4, at 10:00 a.m. NA-A stated the facility did not have enough nursing staff members to complete all of the duties required on each shift. She stated the staff work very hard to complete the cares for the residents, but they were not able to complete the documentation the way that they should. On 4/11/14, at 10:05 a.m. a staff person, who wished to remain anonymous, stated frequently being needed to work additional shifts. Stated, being on prescription medications and was	F 353		

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F 353	Continued From page 68 unable to to leave the facility to take prescribed medications, when an additional shift was worked. On 4/10/14, at 9:30 a.m., during confidential interviews with two night nursing assistants, it was verified they do not have time to clean wheelchairs as there are often only two nursing assistants in the facility to care for 60 residents on the night shift. On 4/10/13, at 2:50 p.m. the director of nursing (DON) confirmed the facility had experienced recent staffing difficulties. She stated the facility had experienced a staff turn over and not all of the nursing positions had been filled, which left open shifts. She stated the facility was working on hiring additional nursing staff. On 4/11/14 at 2:19 p.m. the administrator and DON were interviewed and indicated being well aware of the concerns about being short staffed. They indicated being new management to the facility and have been trying to solve the staffing issue and per the union contract we may change the schedule to meet the needs of the residents. If staff are telling you they have to work over their shift, that is correct. The posted schedule is not the true hours. The actual hours worked are the payroll hours. DON agreed it is inconceivable with 2 aides upstairs and 2 nurses but sometimes they do work that way and stated, " I, myself would be willing to come in but they need to call me." The administrator and DON indicated that when staffing issues are identified a sign up sheet is posted 2 weeks prior for staff to sign up, but staff are not picking up the shifts and so there are	F 353		

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F 353	Continued From page 69 shifts not covered. The administrator and DON indicated that sometimes when staff are called to come in they refuse because they don't know when they will be able to leave once they get here, which is understandable, or staff call in knowing full well that other staff will be forced to stay over so it becomes a vicious cycle. "We have tried to hire staff". According to the DON, staffing should be as follows: Staffing downstairs (which has a 20 bed capacity) days and evenings 1 nurse and 2 nursing assistants (NA's). Days and evenings upstairs, (which has a 47 bed capacity), 2 nurses and 4 NA's. On nights, 2 nurses and 3 NA's are in the building. 1 NA should float in-between the floors, however that is not always conceivable. If they get busy downstairs the float NA may have to stay downstairs. That would leave 1 NA and 1 nurse upstairs (2nd floor). That is not feasible for the entire shift to have just 1 NA and 1 nurse on 2nd floor. At least 2 people on 2nd floor want to get up early and be dressed for the day and that takes time. On day shift they cannot work with just 2 aides upstairs and 2 nurses. They need to have 2 nurses and 4 aides. The staffing report for 21 days, from March 21 through April 9th, 2014, identified the facility had experienced nursing staff shortages of one to four staff members on 3/22/14, 3/23/14, 3/25/14, 3/26/14, 3/30/14, 4/2/14, 4/4/14 along with several staff working overtime and leaving early. According to the daily nursing hours on 3/29/14 on the night shift, only one nurse was present in the building.	F 353		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility staff posting did not include the actual hours worked of licensed and unlicensed nursing staff. This had the potential to affect 61	F 356	F356 -The facility is posting the actual hours worked by licensed and unlicensed nursing staff -All residents and visitors have the potential to be affected by the deficient practice. -Scheduler has been educated to include the actual hours worked on all posted daily staffing schedules. -Random monitoring will be conducted to ensure actual hours worked is listed on the daily nursing staff postings. Results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 356	Continued From page 71 of 61 residents who resided in the facility, along with families and visitors Findings include: During the initial tour on 4/7/14, at approximately 2:00 p.m. the nursing hours posting was observed by the entrance of the facility. The posting was noted to lack actual hours of licensed and unlicensed nursing staff as well as the number of licensed nursing staff for the p.m. shift. When reviewed on subsequent days 4/8/14, 4/9/14, and 4/10/14 the nursing hours posting was again observed to lack the required actual hours. Review of the nursing hours postings from 3/21/14, through 4/10/14, revealed the actual hours were routinely excluded from the posting. On 4/11/14 at 2:19 p.m. the DON was interviewed regarding the posted staffing hours and lack of actual hours worked and agreed the hours posted were not accurate, per the requirement.	F 356		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 72 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that the central supply room, which contained stock medications and supplies, was kept locked. Residents, visitors and/or unauthorized staff were not observed to enter the central supply room. Findings include: On 4/7/14 at 1:15 p.m. the central supply room door at the end of north hallway was observed to be unlocked. When opened, it contained stock medications and supplies. The supply room was next to the exit door at the end of the hallway.	F 431	F431 -Stock medication are contained in the locked Central Supply Room in a locked cabinet. The licensed nursing staff have the key to this cabinet. -All residents have the potential to be affected by the deficient practice. -Licensed staff have been educated to keep the storage cabinet with OTC medication locked except when removing medication to restock med carts. -Random weekly audits will be conducted to ensure the medication storage cabinet is locked. Results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 431	Continued From page 73	F 431		

Resident rooms were across the hall and next door. At 7:00 p.m., the room was checked again and it remained unlocked.

On 4/8/14, at 1:40 p.m. during medication cart review, licensed practical nurse (LPN)-B was interviewed regarding the use of stock medications. LPN-B stated the facility utilized several type of stock medications and that the overflow medications were kept in the Central Storage closet. When asked if the Central Storage closet was to be locked, LPN-B stated it was to be locked at all times. LPN-B then walked to the Central Storage area and noted the door was unlocked. LPN-B stated only the nursing staff were to have access to the storage room, as she locked the door.

On 4/9/14 at 7:15 a.m. the door to the central supply room was observed to be unlocked.

On 4/9/14, at 3:17 p.m., during interview, the director of nurses (DON) stated the Central Storage closet was to be locked at all time times and the only staff members who were to have access to the closet were the nursing staff.

On 4/11/14, at 10:00 a.m. the assistant director of nursing (ADON) entered the Central Storage Closet. A shelf on the back wall of the closet was observed to contain multiple medication bottles. The medications included calcium D, vitamin B 12, zinc, vitamin C, magnesium, vitamin D, Senna, Senna S, Aspirin 81 mg, Aspirin 325 mg, Tylenol, saline nasal spray, Miralax, Milk of Magnesia, artificial tears, Peptobismal, Bengay, cough syrup and antifungal creams. The ADON stated the central supply area contained over 100 bottles of various over the counter medications

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F 431	Continued From page 74 and that the room was to be locked at all times. The Storage of Medication policy dated 5/2012, bullet B read: "Only licensed nurse, pharmacy personnel and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, cart and medication supplies are locked when not attended by persons with authorized access.	F 431		
F 441 SS=E	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.	F 441	F441 -Appropriate infection control measures are taken in the provision of wound care to Res. #21 and Res. #16 and during the performance of blood glucose monitoring of Res. #4 and Res. #29 -All residents have the potential to be affected by the deficient practice. -Licensed Nursing staff have been educated on the requirements to practice good infection control techniques in the provision of wound care and in the process of performing blood glucose monitoring. -Random weekly audits will be conducted to ensure the wound care and blood glucose monitoring are provided using appropriate infection control techniques. Results will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 441	Continued From page 75 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to ensure appropriate infection control measures were taken during wound care for 2 of 3 residents (R21, R16) observed during wound care and failed to ensure appropriate measures were taken during blood glucose monitoring for 2 of 3 residents (R4, R29) observed. Findings include: R21 and R16 did not receive wound care with appropriate infection control measures. The admission Minimum Data Set (MDS) dated 3/20/14, identified R21 as having two venous and arterial stasis ulcers. The Physican's Orders and Signature Form, dated 3/25/14, directed the staff to apply a mepilex (foam dressing) to R21's left shin open area every three days and as needed. If draining present moisten with wound cleanser before removing. The order further directed the staff to keep the area open to air for one hour before changing the dressing.	F 441		

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F 441	Continued From page 76 On 4/10/14, at 10:35 a.m. registered nurse (RN)-C entered R21's room, donned gloves, opened a package of 4 x 4 gauze and applied wound wash solution to the gauze. RN-C then washed an exposed wound on R21's left shin. RN-C left the gloves on as he prepared R21's fresh dressing. RN-C reached into his pocket, removed a pen and wrote "4/10/14" on R21's new dressing, applied the dressing and walked out of the room. RN-C approached the medication cart, removed gloves and began gathering dressing supplies for R16. RN-C was not observed to change gloves or wash hands between cleansing the wound and application of the new dressing. RN-C was not observed to remove his gloves and wash his hands prior to leaving R21's room. The quarterly MDS dated 2/7/14, identified R16 as an alert and oriented resident and indicated R16 was receiving application of non-surgical dressings. The Physican's Order dated 3/20/14, directed the staff to cleanse the open area on the right side of R16's forehead with wound cleanser and apply a 2 x 2 wet gauze with normal saline to the inside of the wound. The staff were then to apply Vaseline to the healthy skin around the wound and cover the area with a 4 x 4 gauze and tape twice a day to R16's forehead where a skin cancer (basal cell carcinoma) had been removed. At 10:44 a.m., RN-C entered R16's room and washed hands. RN-C applied gloves and removed a dressing from R16's forehead. The old dressing was observed to have yellow drainage on it. RN-C opened a package of 4 x 4 gauze, applied wound cleanser and washed R16's wound. RN-C applied bacitrain to a q-tip	F 441		

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F 441	Continued From page 77 and applied the bacitracin to R16's wound. RN-C then covered the area with a fresh dressing. At 10:58 a.m. RN-C left the room and removed gloves. RN-C was not observed to wash hands as he began looking in the medication cart to gather supplies for another resident. At 11:00 a.m. RN-C entered the medication room. RN-C confirmed he had not washed his hands in between the washing of R21's wound and applying the new dressing, prior to leaving R21's room, prior to gathering supplies for R16. He confirmed he did not wash his hands in between washing R16's wound and application of the new dressing. RN-C then washed his hands. On 4/10/13, at 2:40 p.m. the director of nurses (DON) confirmed the staff were to wash their hands in-between removal of the dirty dressings and application of a clean dressing. DON stated she would expect the staff to wash hands prior to leaving a resident's room after direct patient contact. The Handwashing/Hand Hygiene policy dated 8/2012, bullet 5.k directed the staff to wash their hands "before and after changing a dressing." During an observation of a blood glucose monitoring on 4/7/14, at 5:29 p.m. for R4 and R29, the registered nurse (RN)-A used the appropriate EPA wipe containing bleach, however, did not keep the surface wet according to the manufacturer recommendations, for 5 minutes.The container direction read, "Use enough wipes to stay visibly wet for 5 minutes." RN-A did not perform hand hygiene after removing gloves and in between testing residents.	F 441		

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F 441	Continued From page 78 During an observation of a blood glucose monitoring on 4/8/14, at 8:00 a.m. for R4, RN-B did not clean the glucometer machine in the bedroom. RN-B put the contaminated machine into the clean lancets, removed gloves and did not perform hand hygiene, walked out of the bedroom to the nursing station to obtain the bin of Clorox wipes to clean the glucometer machine. RN-B wiped off the machine less than a minute and proceded to dry the surface. When asked how long the surface was to remain wet with the bleach RN-B did not know and checked on the policy, which did not specify. A review of the facility policy dated 6/12 and titled, "Blood Glucose Monitor Decontamination" read, "After performing the glucose testing, the nurse wearing gloves will use a Clorox wipe to clean all external parts of the monitor. A second wipe will be used to disinfect the blood glucose monitor. Gloves will be removed and hand hygiene performed." When interviewed on 4/10/14, at 10:00 a.m. the director of nursing verified the surface of the glucometer machine was to be visibly wet for 5 minutes according to the manufacturer recommendations for disinfecting a glucometer machine for HIV and Hepatitis.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	F 456		

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F 456	Continued From page 79 by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 walk-in freezer was maintained in good repair, for safe operating conditions. This had the potential to affect 60 of the 61 residents who resided in the facility. Findings include: During observation of the kitchen on 4/11/14, at 10:55 a.m. the exterior temperature gauge on the large walk-in freezer read 25 degrees Fahrenheit (F), with the interior thermometer reading 20 degrees F. No build up of ice was evident and the fans appeared to be working. The temperature logs for the large walk-in freezer for the last four days ranged from 24 to 29 degrees. Freezer temperatures were checked and logged daily. During interview on 4/11/14, at 10:55 a.m. the certified director manager (CDM) verified the freezer temperatures were too high and indicated the staff are to inform her when the temperatures are too high. The CDM immediately notified maintenance and checked all the food in the freezer. 2 boxes of ice cream cups (48 cups) were soft and 2 boxes of ice cream sandwiches (24 sandwiches) were soft. The rest of the food remained frozen. 8 packages of cured bacon and a whole, fully cooked boneless ham were soft and not frozen, however, the CDM indicated the meet came in yesterday and although it should be frozen by now they were ok because the temperature inside the freezer was 20 degrees. The bacon and ham were moved to the smaller freezer. At 11:05 a.m. maintenance (M)-A arrived and indicated the freezer was in the defrost cycle and	F 456	F456 -The walk-in freezer is set between 0 and 10 degrees Fahrenheit and is monitored daily. If temperatures are above the high acceptable range, the staff report the discrepancies to the Director of Dietary and to the Director of Maintenance. -All residents have the potential to be affected by the deficient practice. -All dietary staff have been educated on the requirements to monitor freezer temps daily and to notify the Dietary manager and Director of Maintenance if temperatures fall outside the recommended ranges. -Random weekly audits will be conducted to ensure walk-in freezer maintains acceptable freezing range. Results will be reviewed at QAPI and action planned as needed. -DSM or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 456	Continued From page 80 said the ice cream should not be soft during the defrost cycle. M-A stated the temperatures were too high and switched the cycle from defrost to regular cycle. At 11:08 a.m. the temperature outside the freezer read 29 degrees. Maintenance called the repair person. Interview with cook (C)-A on 4/11/14 at 11:27 a.m. about the temperature. She agreed the temperature was too high and said to the CDM, "I thought you were aware because the temperatures were high the other day." The CDM said she was not aware and should have been told. On 4/11/14 at 4:25 p.m. M-A was interviewed regarding routine checking of the freezer temperatures and indicated he routinely does not check the freezer temperatures. He knows the staff do it daily and should be notifying maintenance with any problems. The policy and procedure titled, Storage of Frozen Foods, dated 2011, indicated freezer thermostats are set at -0 to -10 degrees to help maintain frozen food. The policy and procedure directed the staff to report unacceptable temperatures to the the director immediately and also to maintenance.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		

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F 463	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident call lights were functioning for 2 of 35 residents (R7, R48) reviewed for functioning call lights. Findings include: The residents call systems were observed and checked with nursing assistant (NA)-L on 4/8/14 at 1:45 p.m. The call systems in R48 and R7's rooms were not functioning. At 1:55 p.m. the director of nursing (DON) was notified of the non functioning call systems. At 2:00 p.m. the DON pushed the call light twice for R48 and was able to get it to work. For R7 the DON was able to get it to work sporadically. The DON removed the call system from R7 and asked the NA to sit with R7 while she paged maintenance to come and replace the system. At 2:05 p.m. maintenance came and replaced the call light cords. During an interview on 4/9/14, at 9:30 a.m., the environmental director (ED) indicated there was not a system to check each residents' call light on a routine basis for functionability but there was a random audit of one or two rooms quarterly. A review of the document titled, "Nurse Call Check Procedure," indicated it is a random audit tool and does not address every residents room on a quartely basis for inspection of the call light system.	F 463	F463 -Res. #48 call light system is in working order. Although there is no resident listed as R7 on the Stage 2 Sample Resident List, the call light system for the entire facility is in working order. -All residents capable of using the call light system have the potential to be affected by the deficient equipment. -Maintenance staff have been educated to conduct routine testing of the call light system to ensure proper function. Staff have been educated on the use of the "Building Engines" system in order to log in maintenance issues to be repaired. -Random weekly audits will be conducted to ensure completion of work orders for identified maintenance issues. Results will be reviewed at QAPI and action planned as needed. -ED or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

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F 465	Continued From page 82 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an environment that was in good repair for 12 of 35 residents (R2, R4, R21, R25, R37, R55, R62, R67, R73, R76, R8, R26) in the sample reviewed. Findings include: During the initial interviews and observation on 4/7/14 and 4/8/14, there were numerous scratches, and wearing away of the surface on doors exposing bare wood. These areas were observed on the bathroom doors and the main doors to the bedroom for R2, R4, R21, R25, R37, R55, R62, R67, R73, and R76. Furthermore there was unpainted spackling on the wall for R21 & R62. During an interview with the environmental director (|ED) on 4/10/14 at 9:30 a.m. he verified the areas needed to be repaired and painted for a cleanable surface. The ED did not have a system to go through each and every room on a routine basis to identify which areas are in need for repair. A review of the most recent untitled documents listing items in need of repair, none of these areas were addressed and verified by the ED that he would implement a repair list.	F 465	F465 -Repairs, maintenance, and cleaning have been completed in rooms for Resident #'s 4, 21, 25, 37, 55, 62, 67, 73, and 8. Res. #26 is no longer at this facility. Res. #2 and Res. #76 are not included on the Stage 2 Sample Resident List. -All resident have the potential to be affected by the deficient practice. -Maintenance and Housekeeping staff have been educated to keep rooms as a safe, functional, sanitary, and comfortable environment for residents, staff, and the visiting public. Staff have been educated on the use of the "Building Engines" system in order to log in maintenance issues to be repaired. -Random weekly audits will be conducted to ensure completion of identified maintenance issues and to ensure resident rooms and common user areas are a safe, functional, sanitary, and comfortable environment. -ED or designee is the responsible party. -Corrective action will be completed by 5/21/2014.	

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F 465	Continued From page 83 During the morning care observations of R8 on 04/09/2014 at 8:00 a.m. water was seeping through tiles on the floor and collecting on top of the floor. R8 did not ambulate and required a mechanical lift transfer from bed to the wheelchair. On 04/09/2014 at 9:00 a.m. observed R26's room floor to be wet due to underground water seepage through the tile. R26 did not ambulate and required a mechanical lift for transfer from bed to the wheelchair. During an interview with maintenance director on 04/10/14 at 2:45 p.m., he indicated the seepage of water through the tile was due to the rapid melting of the frost on the ground. He added that the problem had started on Monday and they have contacted their engineer staff who have advised him once the floor drys out to test the soil type and based on the soil type a pump could be installed to pump the water away from these rooms. He said the housekeeping staff was instructed to mop these floors frequently to try to keep them dry.	F 465		

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	245337	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Golden Livingcenter Linden was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us	K 000	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** POC ok TS 5-12-14 RECEIVED MAY 12 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-21-14

EXIT: 4-11-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 5/8/14

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

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K 000	Continued From page 1 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. This 2 story building was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	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	K 029	**K 029** • All penetrations in the corridor wall at the A) 1st floor - Maintenance Storage Room across from room 14 has been properly plugged and sealed by our contracted Fire Safety Company. This was done using the proper fire rated sealant and pillows around the conduit. B) 1st floor - Housekeeping Storage Room. has been properly plugged and sealed the penetrations above the fire alarm panel conduits and wires sealed by our contracted Fire Safety Company. This was done using the proper fire rated sealant. All plugging and sealing was done in a approved manner to stop the penetration of any smoke.	

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.3.2.1 and 8.4.1. The deficient practice affected approximately 20 of the 67 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on 04/08/2014, it was observed that penetrations in the corridor wall to hazardous rooms were in the following areas: A) 1st Floor-Maintenance Storage Room across from room 14 has penetrations in the corridor wall around conduit. B) 1st floor - Housekeeping Storage Room has penetrations in the corridor wall around conduit and wires above fire alarm panel. This deficient practice was verified by the Facility Maintenance Director.	K 029	• This work was completed by Nardini Fire Protection Company on April 9, 2014. • The Facility Maintenance Director will continue to monitor for and prevent any reoccurrence and ensure corrections of this deficiently of wall penetrations.	
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	K 033	**K 033** • The door at the 2nd floor Stairway Door by room 131has been repaired by installation of a new positive latching door set. This is a self closing and latching 3/4 hour fire-rated doors to retain the proper wall and door construction fire-rating. • The facility Maintenance Director is responsible for ensuring project completion and for continuous monitoring to prevent a reoccurrence of the deficiency. • Completion date: April 30, 2014	

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K 033	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect 30 of 67 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on 04/08/2014, it was observed that the 2nd floor Stairwell Door by room 131 had the latching device removed from the door and did not positive latch. This deficient practice was verified by the Facility Maintenance Director.	K 033		
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 reports, records and interview,, it was determined that the facility failed to conduct fire drills 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. Findings include:	K 050	**K 050** • Fire Drills will be conducted to be varied throughout the total hours available for the evening shift, as are the drills in the morning shift and N.O.C shifts. • The facility Maintenance Director is responsible for ensuring project completion and for continuous monitoring to prevent a reoccurrence of the deficiency. • Completion date: April 9, 2014 by Set up of a Schedule for tentative drills and times.	

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K 050	Continued From page 4 On facility tour between 09:00 AM and 01:00 PM on 04/08/2014, based on review of available documentation it was reveled that fire drills were not varied throughout the shift during the evening shift. 4 of 5 drills were conducted between 3:00 PM hour. This deficient practice was verified facility Maintenance Director. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 050		