MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245394
August 12, 2015

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

Dear Mr. Carlson:

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 July 7, 2015 the above facility is certified for or recommended for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 31, 2015

Mr. Michael Carlson, Administrator
Golden LivingCenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5394026

Dear Mr. Carlson:

On June 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 4, 2015. 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 July 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2015 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 June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective July 7, 2015 and therefore remedies outlined in our letter to you dated June 22, 2015, 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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QU3F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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 **07/20/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(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
07/17/2015
(L33)

DETERMINATION APPROVAL

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245394	A. Building B. Wing	7/20/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **07/07/2015**
ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/07/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/07/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/07/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/07/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/07/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **07/07/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/kfd	07/31/2015	16022	07/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/4/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245394	A. Building B. Wing **01 - MAIN BUILDING 01**	7/10/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0018	**06/12/2015**	ID Prefix Reg. # **NFPA 101** LSC K0050	**06/12/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 07/31/2015	**Signature of Surveyor:** 12424	**Date:** 07/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/3/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QU3F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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 **06/04/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **72** (L18)

13.Total Certified Beds 72 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sheryl Reed, HFE NE II — 07/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(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
Posted 07/17/2015 Co.
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1833
June 22, 2015

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5394026

Dear Mr. Carlson:

On June 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2015, 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 July 14, 2015 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 September 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and 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. 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.	
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 unresolved grievances were acted on for 1 of 1 resident (R37) reviewed who voiced concerns of an uncomfortable mattress to the facility staff. Findings include: During an observation on 6/1/15, at 6:30 p.m. of R37's mattress, there was a visible indentation in the middle section of the mattress. When interviewed on 6/1/15, at 6:30 p.m. R37 expressed concern about the mattress on the bed and stated, "I told them about it at the care	F 166	7/9/15 SER	

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

EXECUTIVE DIRECTOR | JULY 2, 2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 166	Continued From page 1 conference in May and nothing has been done about it. I sink to the middle of that mattress and it really hurts my body to lay on it." R37's quarterly Minimum Data Set (MDS) dated 5/5/15, indicated R37 had intact cognition and was dependent with activities of daily living (ADL's). During an interview with the administrator and the social service designee (SSD)-A on 6/3/15, at 10:30 a.m., both verified there was a break in the grievance policy system and R37 who expressed a concern on 5/13/15, at the care conference, did not receive a resolution to the mattress issue until 6/2/15, when the surveyor questioned the mattress replacement. The SSD-A said the mattress would be replaced immediately. A review of the facility policy titled, Grievance Guideline, dated 1/19/15, read, Investigation and Resolution of grievances shall be completed in a timely manner-within 5 working days of receipt of the Grievance Form, it is the responsibility of the employee hearing the grievance to complete the form and submit it for follow-up and resolution.	F 166	F166 • Resident #37 has documented interview of grievances and follow up. • Residents have the potential to be affected if expressed grievances are not resolved timely • Staff have been educated regarding living center grievance process. • Monthly audit of grievance Tracking Log to ensure grievances resolved within 5 business days • ED is responsible • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	
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 grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		

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F 244	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to act upon concerns voiced at the resident council for 4 of 4 residents interviewed (R30, R6, R37, R73), who regularly attended the resident council meetings. Findings include: Review of Resident Council minutes identified that a resident council meeting was generally held on each of the two units monthly with one president presiding over the group. The January 2015 meeting was held only on first floor. The minutes identified that the old business of call lights was brought up, however, there was nothing specific regarding the call lights and the problem and/or resolution was not identified. Under the section for new business, 4 residents voiced concerns about call lights not being answered in a timely manner. The resident council meetings for February 2015 was held only on first floor and no old or new business issues were identified. Review of the, March 2015, meetings on first and second floor identified no old or new business issues. Review of the, April 2015, meeting at 1:00 p.m. identified that the old business of call lights was not a concern. New business indicated 2 of 4 residents had concerns with laundry not being returned. On 6/02/15 at 3:15 p.m., during interview, R30 stated that some residents on first floor still had concerns that their call lights were not being answered on time. R30 also stated that laundry is not being returned and explained that when new	F 244	F244 • Residents #6, 30, 37, 73- have documented interviews and follow up of grievances and resolution. • Residents have the potential to be affected if expressed grievances are not resolved timely. • Staff to be educated on grievance and follow up on issues identified at the resident council meetings. Resolution of grievances during resident or family groups will be followed up on at next resident or family council meeting • Monthly audit of resident council minutes to ensure group grievances addressed and followed up on by next resident council meeting • ED is responsible • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	

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F 244	Continued From page 3 clothes are received, they go down to laundry, and don't always come back. On 6/04/15 at 11:14 a.m., R6, R37 and R73 were interviewed and agreed the issues with laundry not being returned and call lights not being answered continued to be an on going problem and stated the facility had not addressed or resolved the issues. Interview with the assistant activities director (AA)-A on 6/02/15 at 3:22 p.m., regarding resident council concerns not being addressed and/or resolved, AA-A explained that issues identified one month were not always addressed at the next month so the issues were not followed up on or resolved. On 6/04/15 at 11:22 a.m., AA-A explained being new to the position of activities and resident council. AA-A explained the processs that should take place whenever a concern was brought forth in the resident council, stating that a form should be filled out with the concern and then the form goes to the department head, who will formulate a plan, put it in place and then the following month it should be addressed at the council. That way the residents know their concerns are being addressed. On 6/04/15 at 12:51 p.m., the Activities Director, who was being transitioned into the social service representative role since November 2014 was interviewed. The Activities Director stated that the resident council role was turned over to AA-A, with the administrator taking over as lead, and explained that AA-A had been trained on the resident council process. Although a policy and procedure for resident council was requested, it was not available for	F 244		

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F 244	Continued From page 4 review.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not provide an individualized program of activities for 2 of 3 residents (R83 and R62) reviewed for activities. Findings include: R83 was not comprehensively assessed for a program of activities. During observation in stage one of the survey, R83 did not participate in recreational activities in the facility. During record review, an assessment for recreational activities could not be located in the resident's record. When interviewed at 9:41 a.m. on 6/4/15, the current director of activities for the facility stated that a recreational activities assessment had not been completed for R83 and explained that since late in 2014 being transitioned into another position in the facility and stated that another director of activities had not been officially	F 248	F248 • Residents #62 and 83 have been reassessed for activity preferences/individualized programs. • Residents have the potential to be effected if individualized activities are not provided. • Activities Staff have been educated on providing activities to meet residents preferences, individual needs. • Audits to be completed at quarterly care conferences on individualized activity programming. • Activities Director/designee is responsible • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	

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F 248	Continued From page 5 appointed. The current director of activities explained that during this transition period some of the the tasks of the activities department had not been completed. R62 was not comprehensively assessed for a program of activities. During observation in stage one of the survey and on 6/2/15 R62 was not observed participating in recreational activities in the facility. On 6/3/15 at 10:20 a.m. activities were being offered in the second floor dining area, however R62 was laying on her bed. When interviewed at on 6/4/15 at 9:30 a.m., the director of activities verified a recreational assessment had not been completed for R62.	F 248		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by:	F 249	F249 • Activities program is directed by a qualified professional. • All residents have the potential to be effected. • Activities Staff to be educated on providing activities to meet residents preferences, individual needs • ED/designee is responsible • Activity program will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	

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F 249	Continued From page 6 Based on interview and document review, the facility failed to provide a qualified activity director. This had the potential to affect all 68 of 68 residents residing in the facility. Findings include: On 6/4/15 at 9:30 a.m. the social services representative/Director of Activities (DOA)indicated being hired in May 2014 as the Director of Activities for the facility and explained that as of November 2014 and had been transitioning into a social services representative role for 2nd floor of the facility. The DOA stated had not worked in an activity department in a health care setting prior to this facility and as of November 2014 another staff person had been transitioning into the assistant activity director for the facility. A review of the DOA's application identified DOA had a bachelor of arts degree in psychology and lacked documentation of certifications or work experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting. When interviewed at 12:30 p.m. on 6/4/15, the administrator was asked if the current director of activities had qualifications for the position, the administrator replied that the current director of activities probably was not qualified because the director of activities had a degree in another discipline and had only worked several months in the activities department of this facility.	F 249		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		

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F 272	Continued From page 7 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on obsservation, interview and document	F 272	F272 • Residents 83 and 62, have been reassessed for activities. • All residents have the potential to be affected if activities preferences are not assessed • Reeducation on providing care per care plan communicating when there is a change in residents function per care plan • DNS/designee to do random weekly audits of cares being provided per care plan. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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F 272	Continued From page 8 review, the facility did not complete a comprehensive assessment for 2 of 3 residents (R83, R62) who were reviewed for activities. Findings include: R83 was not comprehensively assessed for a program of activities. During observation in stage one of the survey, R83 did not participate in recreational activities in the facility. During record review, an assessment for recreational activities could not be located in the resident's record. When interviewed at 9:41 a.m. on 6/4/15, the current director of activities for the facility stated that a recreational activities assessment had not been completed for R83 and explained that late in 2014 being transitiond into another position in the facility and that some of the tasks of the activities department had not been completed. R62 did not have a comprehensive assessment for activities. During stage one of the survey R62 was not observed attending any recreational activities. On 6/3/15 at 10:20 a.m., activities were held on the second floor dining area, however, R62 was in bed and no staff asked R62 about attending the activity. During a family interview on 6/2/15, at 12:39 p.m., family member (F)-M indicated R62 loved activities and felt R62 did not attend enough activities.	F 272		

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F 272	Continued From page 9 A review of the medical record on 6/4/15 revealed there was no comprehensive assessment for recreational activities. On 6/4/15 at 9:49 the Director of Activities verified that a comprehensive assessment had not been completed for R62.	F 272	F280 • Resident 48 care plan has been reviewed and revised as indicated regarding transfers and falls. Resident 19 care plan updated to reflect current pain interventions including non pharmacological interventions. Resident 71 care plan updated to reflect change in toileting, care refusals and interventions for toileting and grooming. • All residents have potential to be affected if care plans are not updated to reflect current needs. • Education on staff to update care plans with current interventions, Review system of updating care plans during transfer from one unit to another. • DNS/designee to complete random weekly audits of care plan and interventions to ensure that proper updates are accurate and concise. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	
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 revise the plan of care for 3 of 5 residents (R71, R48, R19) who required	F 280		

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F 280	Continued From page 10 revisons be made to direct staff of current interventions for activities of daily living, accidents and/or interventions for pain. Findings include: R71's care plan was not revised to include a change in toileting, refusal of cares and interventions for toileting and grooming. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed. R71 was wearing open toed slippers and the toe nails to both feet were observed to be long and curled over the ends of the toes reaching down to the slipper surface. The second and third toe nails of both feet had the nails bending over the toes to the surface of the slipper at which point they were now curving out to the side an additional 1/2 inch forming a check mark appearance. There was a blue green substance smeared on R71's toes. A strong odor of urine was detected in R71's room. During interview on 6/2/15, at 10:26 a.m., R71 was not aware of an odor when asked if R71 detected an odor in the room. R71 talked about both feet being uncomfortable and that is why R71 put the, "ointment" on the toes. During an interview on 6/2/15, at 2:00 p.m., activities assistant (AA)-A explained that R71 often refused cares if staff did not use the, "right approach" and it was not unusual for R71 to go two months without a bath or grooming with nail care. AA-A confirmed there were certain techniques required for R71 to accept cares and the staff would need to learn how to get R71 to accept care by talking about the prior work history	F 280		

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F 280	Continued From page 11 and the neighborhood, indicating this was the technique that has worked for R71 in the past. The active diagnoses from the electronic medical record (eMR) face sheet dated 6/3/15, indentified R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS) dated 4/17/15, indicated R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. Section G of the MDS indicated R71 required extensive assistance with activities of daily living (ADL's) and a 1 person physical assist. Bathing indicated R71 was total dependence. When interviewed on 6/4/15, at 10:01 a.m. registered nurse (RN)-B verified the care plan was not updated to include urine incontinece, refusal of care and interventions for toileting, grooming and bathing. R48 had a history of falls and the facility failed to revise the care plan for transfers. The comprehensive assessment note, dated 3/10/15 identified R48 had been requiring an increase in staff assistance with transfers as well as activities of daily living (ADLS) The significant minimum data set (MDS) dated 3/6/15 indicated R48 required extensive assistance of one staff person for transfers. The most current care plan indicated R48 had a mobility impairment due to scoliosis and identified R48 as being independent, history of falls and	F 280		

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F 280	Continued From page 12 requires assistance of 1 for ADLS. Interventions on the care plan did not direct staff how to transfer R48. On 6/4/15 at 9:38 a.m,. the MDS registered nurse (RN-C) stated the care plan had not been updated to identify the transferring needs of R48 and was unsure how it could have been overlooked. The facility did not ensure R19 had an updated care plan that identified pain with interventions to include nonpharmacological interventions. R19 was admitted to the facility on 4/16/15 with diagnoses that included chronic ischemic heart disease, anxiety disorder, osteoarthrosis, idiopathic peripheral neuropathy, and polymyalgia rheumatica. The admission orders included the following: 1. morphine sulfate 20 mg/5ml, solution (milligram, milliliter) orally as needed every four hours for general osteoarthrosis. 2. morphine solution, 20 mg/5ml, administer 20 mg orally three times per day at 8:00, 2:00 p.m., 10:00 p.m. for pain, 3. MS Contin (morphine) table extended release, 15 mg, administer 1 tablet three times per day at 7:00 a.m, 1:00 p.m., 9:00 p.m. for pain, 4.Gabapentin (neurotinin) capsule, 400 mg orally twice a day for idiopath peripheral neuropathy. 5. Acetaminophen 325 mg tablet orally as needed every four hours for pain/fever, take 1-2 tablets, maximum acetaminophen: 4 GM (grams)/24 hours	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 280	Continued From page 13 R19 was currently receiving the following medications: 1. Acetaminophen tablet: give 325 mg orally every four hours as needed for pain or fever. Check to see if give 650 mg first. Maximum dose 4 gm every 24 hours., 2. acetaminophen tablet give 650 mg orally every 4 hours as needed for pain or fever., Check to see if give 325 mg first, maximum dose 4 gm /24 hours. 3. Gabapentin capsule give 400 mg orally twice a day related to neuropathy 4. MS Contin tablet extended release 15 mg give 15 mg orally twice a day for pain. The current care plan, dated 4/21/15, was reviewed. There was no focus goal for having pain or for being at risk for pain for R19. The care plan lacked interventions for pain, which included nonpharmacological interventions. On 6/4/15 at 11:11 a.m., the minimum data nurse (RN)-C reviewed the care plan and agreed the care plan did not identify R19's potential pain or identify interventions to direct staff to minimize R19's pain. Review of the policy provided, from the 2012 RAI (Resident Assessment Instrument) manual, directed staff, "the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care."	F 280		

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R57) for activities of daily living (ADL's). Findings include: R57's care plan, dated 11/6/14, directed staff that R57 had physical functional deficits of self-care impairment and directed staff, "I will maintain or improve my current level of physical functioning. Interventions: Personal Hygiene/Grooming: extensive assistance of one ..." On 6/1/15 at 6:20 p.m., during an attempt to interview R57, observations of several facial hairs to the upper lip and the chin area were noted to be approximately one half inch long. R57 was unable to respond to interview questions regarding grooming. On 6/2/15 at 10:20 a.m. R57 was observed to still have numerous facial hairs. During interview with nursing assistant (NA) - B on 6/3/15 at 8:13 a.m., NA-B agreed that R57 was unshaven and explained being busy and not having a chance to shave R57.	F 282	F282 • Resident 57, care plan/care sheets reviewed/ revised as indicated regarding ADLS. • All residents have the potential to be affected if cares are not provided according to the plan of care. • Education to staff provided on cares being given per care plan. • DNS/designee to complete random weekly audits of care being provided per care plan • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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F 282	Continued From page 15 During an interview with director of nursing (DON) on 6/3/15/ at 9:07 a.m., DON stated that shaving facial hair was part of personal grooming. During interview with registered nurse (RN) - B on 6/3/15 at 12:06 p.m. RN-B explained that the expectation is for residents to be shaved if that is the residents wish and that staff need to follow the care plan. RN-B added that shaving was considered part of grooming and the care plan for R57 addressed it.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement consistent ambulation programs to maintain or improve each resident for 1 of 1 resident (R6) reviewed for ambulation. Findings include: During an observation on 6/1/15, at 6:34 pm R6 was seated in a wheel chair by the side of the bed. R6 stated, "They don't walk me to meals and to the bathroom like they are suppose to do." During an interview on 6/1/15, at 6:34 p.m. R6 expressed concern of not walking to meals and the bathroom according to the physician orders and the established restorative program set up by	F 311	F311 • Resident 6 ambulation plan has a documented review of ambulation plan, care plan and care sheet have been updated as indicated. • All resident on restorative plans have potential to be affected if programming is not provided consistently. • DNS/designee to complete random weekly audits that residents are receiving assistance with programs per care plan. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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F 311	Continued From page 16 the therapy department. R6's quarterly Minimum Data Set (MDS) dated, 3/24/15, indicated R6 had intact cognition and was dependent with activities of daily living (ADL's). Document review of the physician order dated 4/30/13 and read, ADL Program. 1. Walk to bathroom with SBA (stand by assist) 2. Will toilet and wipe self. Walk to dining room with 2 wheeled walker and sit in arm chair. Every shift. PT (physical therapy) Resident will walk 50 feet using FWW (front wheeled walker) with assist of 1 BID (twice a day). Follow with wheelchair every day and evening shift to maintain ability to walk. During an observation on 6/2/15, at 8:30 a.m. R6 was seated in the wheel chair at the dining room table and did not walk to the dining room for the meal. During an observation and interview on 6/3/15, at 7:35 a.m. R6 was seated in the wheel chair and stated, "They did not walk me to the bathroom this morning." When interviewed on 6/3/15, at 7:40 a.m. nursing assistant (NA)-A verified R6 did not walk to the bathroom and the process was to walk her in the hallway after breakfast. A review of the untitled document staff referred to as the "aide assignment sheet", directed staff, Restorative walking program see documentation book and ADL sheet in room for cares. During an interview with the director of nursing (DON) on 6/3/15, at 8:00 a.m. DON verified R6	F 311		

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 311	Continued From page 17 was to be walked according to the physician orders to the bathroom, to meals and in the hallway 50 feet twice a day.	F 311		
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 services for 2 of 3 residents (R71, R57) in the sample who were dependent on staff for personal cares. Findings include: R71 was not provided assistance with gromming and bathing. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed, wearing open toed slippers. R71's toe nails on both feet were observed to be long and curled over the ends of the toes reaching down to the slipper surface. The second and third toe nails of both feet had the nails bending over the toes to the surface of the slipper at which point they were now curving out to the side an additional 1/2 inch, forming a check mark appearance. There was a blue green substance smeared on R71's toes (which looked like toothpaste and was later confirmed by	F 312	F312 • Resident 57 and 71 are receiving assistance as needed for personal cares. • All residents needing assistance with personal cares have the potential to be affected. • Documented education of staff on providing care per care plan. • DNS/designee to complete random weekly audits that resident ADL's are being provided per care plan, ie; bathing, shaving, grooming, nail care, etc. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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F 312	Continued From page 18 nursing staff as toothpaste). A strong odor of urine was detected in R71's room. During interview on 6/2/15 at 10:26 a.m. R71 was not aware of any odors in the room. R71 talked about both feet being uncomfortable and that is why R71 applied, "ointment" on the toes. During interview on 6/2/15, at 2:00 p.m., activities assistant (AA)-A verified R71 often refused cares if staff did not use the "right approach" and it was not unusual for R71 to go two months without a bath or grooming with nail care. AA-A confirmed there were certain techniques required for R71 to accept cares and the staff would need to learn how to get R71 to accept care by talking about the prior work history and the neighborhood, which was a technique that worked for R71 in the past. The active diagnosis from the electronic medical record (eMR) face sheet dated 6/3/15, identified R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS), dated 4/17/15, identified R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. This information was not documented on R71's plan of care. When interviewed on 6/4/15, at 10:01 a.m., registered nurse (RN)-B verified the care plan did not addressthat R71 was incontinent of urine and refusal of care interventions.	F 312		

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F 312	Continued From page 19 When interviewed on 6/4/15, at 11:30 a.m., family member (F)-A indicated the urine smell in R71's bedroom and person had been going on a very long time. F-A stated, "Who wants to smell like urine." F-A expressed further frustration and concern that the staff tell F-A that R71 refuses care. F-A stated, "At what point should the staff be expected to figure out how to provide care for [R71] so that [R71] receives the care [R71] needs." Furthermore, F-A expressed dissatisfaction with the staff for not providing nail care for R71 and stated, "I trimmed those toe nails in October because the staff kept saying [R71] refused, it took me an hour and a half. At what point should the staff figure out how to provide care?" When interviewed on 6/4/15 at 1:00 p.m., the director of nursing verified there was not a specific policy regarding re-approaching residents who have refused care. The DON validated the expectation would be for staff to provide the care as soon as possible for the resident or find another staff person who could provide the care for the resident. On 6/1/15 at 6:20 p.m., during an attempt to interview R57, several facial hairs to the upper lip and the chin area approximately one half inch long, were observed. R57 was unable to communicate needs when queried regarding grooming preferences. On 6/2/15 at 10:20 a.m., R57 was observed to still have numerous facial hairs. R57's clinical record noted R57 was admitted to facility on 10/17/14, and had diagnoses, which included bipolar disorder, paralysis agitans,	F 312		

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F 312	Continued From page 20 dementia w/behavior disturbances and dysphagia. Medication that included Klonopin, Sinemet, and Clozapine. R57's quarterly Minimum Data Set (MDS) dated 4/21/15, identified R57 required extensive assist with bed mobility, transfers, dressing, toileting and personal hygiene needs. In addition, R57 required total assist with bathing activity. The care plan, dated 11/6/14, identified R57 had physical functional deficits of self-care impairment and directed staff, "I will maintain or improve my current level of physical functioning. Interventions: Personal Hygiene/Grooming: extensive assistance of one ..." During interview with nursing assistant (NA) - B on 6/3/15 at 8:13 a.m., NA-B verified that R57 was unshaven and explained being busy and not having a chance to shave R57. During interview with director of nursing (DON) on 6/3/15 at 9:07 a.m., DON stated that shaving facial hair was part of personal grooming. During interview with registered nurse (RN) - B on 6/3/15 at 12:06 p.m., RN-B indicated the expectation was for staff to follow the care plan, that shaving was considered to be part of grooming and R57's care plan addressed this. Policy and procedure tilted shaving the resident dated 1/26/15, reads, "To remove facial hair and improve the resident's appearance and morale." Policy and procedure titled, shaving the resident dated 1/26/15, directed staff, "Care plan documentation guidelines Problem: Identify the	F 312		

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F 312	Continued From page 21 appropriate problem under which to list shaving as an approach. Consider listing possible risks and complications. Goal: List measurable goal(s) to be accomplished. List target date. Approaches: List responsible discipline for each approach. list instructions unique to this resident. list necessary monitoring and observation of the underlying condition. list appropriate preventive skin care." Policy and procedure for RAI and care planning dated July 2012, directed staff, "As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care."	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F315 • Resident 27, 71 toileting/incontinence care plans have been reviewed and revised as indicated • All resident with incontinent needs have the potential to be affected. • Documented education of staff to provide toileting/incontinence cares per care plans and to communicate to nursing when a resident has a change in bladder/bowel function. • DNS/designee to complete random weekly audits that cares are being provided for toileting/incontinence cares per care plan. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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 315	Continued From page 22 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) who was identified as incontinent of urine, received the necessary care and services to manage incontinence and 1 of 1 resident (R71) did not receive a toileting plan when assessed as having incontinent episodes. Findings includes: R27's quarterly minimum data set (MDS) dated 3/20/15, was reviewed and identified R27's BIMS score as 15 (congnitively intact). The MDS identified that R27 required extensive assist of one with transfers, dressing, toileting, personal hygiene and total assist of one with bathing activities. R27's toileting needs addressed R27 as being frequently incontinent with bladder and always continent with bowel. During a random observation on 6/01/15 at 5:12 p.m., a strong odor of urine was detected from R27's room. R27 was observed lying flat on the bed, soaked with urine that penetrated R27's shirt and pants. R27 expressed being embarrassed and anxious because of wet clothes. R27 explained the call light had been put on, a staff person came into the room and informed R27 of being busy and would be back. R27 attempted to cover wet clothes while conversing with surveyor. At 5:14 p.m., licensed practical nurse (LPN)-C and nursing assistant (NA)-C, was informed of R27's incontinent situation and both indicated the matter would be addressed. Follow up with R27 on 6/1/15 at 5:56 p.m., R27 smiled and stated, "I would like to say thank you and God is good to send you."	F 315		

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F 315	Continued From page 23 Activities of daily living care area assessment (CAA) dated 1/8/15, identified: resident requires extensive assist with dressing, toileting. In addition, the urinary incontinence and indwelling catheter CAA dated 1/8/15, reads, "Resident is frequently incontinent of urine. Staff assists with toileting, changing and pericare following incontinent episodes. R27's care plan, reviewed by the facility on 3/3/15, revealed, "..... limited assist of staff with toileting, transfers on/off toilet PRN (as needed). Occasional incontinence of bowel and bladder without pattern. Symptoms of urge incontinence. Does not wear incontinence products. Able to request assist with changing soiled clothing and hygiene PRN. Goals: I will maintain my current level of urinary continence. Interventions: Assist with clothing and pericare PRN. Changes in color, odor, or consistency of urine, dysuria, frequency, fever, pain. Provide assist with toileting as needed." During an interview with director of nursing (DON) on 6/2/15 at 3:25 p.m., DON stated the expectation for answering call lights is that when staff see a resident's call light on, it should be answered and if the staff person cannot assist the resident, based on the level of care, the staff person should alert the nursing staff of the resident's needs. During an interview with registered nurse (RN)-B on 6/3/15 at 12:16 p.m., RN-B's expectation was that if R27 put the call light on to be toileted R27, nursing staff should assist R27 to the toilet. The facility Policy and Procedure titled	F 315		

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 315	Continued From page 24 incontinence care, dated 1/26/15, reads, "Procedure purpose: To keep skin clean, dry, free of irritation and odor, to identify skin problems as soon as possible so treatment can be started to prevent skin breakdown to prevent infection" Policy and procedure titled incontinence management/bladder function guideline dated 1/19/15, reads, "Prevent skin problems such as pressure areas and excoriation Improve the morale of the resident Restore the resident's dignity Manage urinary incontinence, restore or maintain as much normal bladder function as possible. Observe and record the resident's voiding pattern and revise the toileting scheduled to meet the residents toileting needs" R71 did not receive a toileting plan when assessed as having incontinent episodes. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed and a strong odor of urine was detected coming from R71's person. During an interview on 6/2/15, at 10:26 a.m., R71 was not aware of a body odor when asked if R71 detected any body odor or urine type odors in the room. R71 commented of being informed, "You stink." The active diagnoses from the electronic medical record (eMR) face sheet dated 6/3/15, indicated R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS) dated	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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F 315	Continued From page 25 4/17/15, indicated R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS dated 4/17/15, indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. R71's plan of care dated 2/12/15, identified R71 as being continent of bowel and bladder. Urinates on bathroom floor and in heating vents due to dementia. Supervision/set up only provided with toileting. The MDS bladder assessment dated 4/17/15, identified R71 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding. Furthermore, the MDS indicated no trial of a toileting program (scheduled toileting, prompted voiding, or bladder training) had been attempted since urinary incontinence was noted in this facility. When interviewed on 6/4/15, at 10:01 a.m., registered nurse (RN)-B verified the care plan did not address R71 as incontinent of urine and did not address refusal of care interventions. RN-B thought R71 was continent of urine, realized there was a urine odor in the room and explained that sometimes R71 has body odor because R71 has gone as long as 2 months without a bath due to refusing to take a bath or shower. RN-B verified a toileting plan had not been developed for R71 because RN-B thought R71 was continent of urine. RN-B verified the voiding pattern for R71 was not assessed. When interviewed on 6/4/15, at 11:30 a.m., family member (F)-A indicated the urine smell in R71's bedroom and person had been going on a very long time. F-A stated, "Who wants to smell like	F 315		

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 315	Continued From page 26 urine." F-A expressed further frustration and concern that the staff tell him R71 refuses care. F-A stated, "At what point should the staff be expected to figure out how to provide care for [R71] so that [R71] receives the care [R71] needs." When interviewed on 6/4/14 at 1:00 p.m., the director of nursing stated there was not a specific policy regarding re-approaching residents who refuse care. The DON informed surveyor the expectation would be for staff to provide the care as soon as possible for the resident or find another staff person who could provide the care for the resident.	F 315		
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	F 329	F329 • Resident 19 pain medication regiment has been reviewed and is receiving pain management per residents satisfaction including non-pharmacological pain interventions. • Residents experiencing pain have the potential to be affected if non-pharmacological interventions are not identified. • Education to staff on including non-pharmacological pain management interventions, as well as documenting effectiveness with pharmacological and non-pharmacological interventions. • DNS/designee to complete random weekly audits that pain medication/management includes non-pharmacological interventions. Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 329	Continued From page 27 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 (R19) resident's care plan incorporated pharmacological and nonpharmacological interventions for pain. Findings include: R19 was admitted to the facility on 4/16/15 with diagnoses that included chronic ischemic heart disease, anxiety disorder, osteoarthrosis, idiopathic peripheral neuropathy, and polymyalgia rheumatica. The admission orders included the following: 1. morphine sulfate 20 mg/5ml, solution (milligram, milliliter) orally as needed every four hours for general osteoarthrosis. 2. morphine solution, 20 mg/5ml, administer 20 mg orally three times per day at 8:00, 2:00 p.m., 10:00 p.m. for pain, 3. MS Contin (morphine) table extended release, 15 mg, administer 1 tablet three times per day at 7:00 a.m, 1:00 p.m., 9:00 p.m. for pain, 4.Gabapentin (neurotinin) capsule, 400 mg orally twice a day for idiopath peripheral neuropathy. 5. Acetaminophen 325 mg tablet orally as needed every four hours for pain/fever, take 1-2 tablets, maximum acetaminophen: 4 GM (grams)/24 hours Currently the resident was receiving:	F 329		

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 329	Continued From page 28 1. Acetaminophen tablet: give 325 mg orally every four hours as needed for pain or fever. Check to see if give 650 mg first. Maximum dose 4 gm every 24 hours., 2. acetaminophen tablet give 650 mg orally every 4 hours as needed for pain or fever., Check to see if give 325 mg first, maximum dose 4 gm /24 hours. 3. Gabapentin capsule give 400 mg orally twice a day related to neuropathy 4. MS Contin tablet extended release 15 mg give 15 mg orally twice a day for pain. The current care plan, dated 4/21/15 was reviewed. There was no focus goal for having pain or for being at risk for pain for R19. On 6/4/15 at 11:11 a.m., the minimum data nurse (RN)-C reviewed the care plan and agreed the care plan had not been developed to identify R19's risk of pain.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	F431 • Med room refrigerators are being maintained at proper temperatures. • All residents receiving refrigerated medication have the potential to be affected. • Temperature schedule has been placed on med room refrigerators. Licensed staff have been educated on taking temps and documentation and proper ranges. • DNS/designee to complete random weekly audits of fridge temps. • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015	

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 431	Continued From page 29 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, document review, and interview, the facility did not maintain proper temperature controls for refrigerated medications in 2 of 2 medication rooms reviewed, which had the potential to affect the residents in the facility who used insulin, Tuberculin testing solution, Xalatan eye drops, and influenza vaccine. Findings include: During observation of the first floor medication room refrigerator, at 3:26 p.m. on 6/2/15, the thermometer inside the refrigerator read 28 degrees Fahrenheit. The thermometer was shown to licensed practical nurse (LPN)-B nearby who stated, "It is in the 20's, that can't be right." The temperature log on the refrigerator showed	F 431		

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 431	Continued From page 30 that the temperature in this medication refrigerator was read as 32 degrees Fahrenheit on 5/31/15, and no refrigerator temperatures had been recorded since that date. This refrigerator contained Tuberculin purified protein testing solution opened 5/19/15, Xalatan eye drops for two separate residents, gentamicin liquid for the emergency kit, two FlexTouch insulin pens, a vial of Humulin regular insulin, and bisacodyl suppositories. The insulins were for two separate residents. The heading on the refrigerator temperature log read, "Refrigerator (med) (Acceptable range of 36-46*F)." Immediately following this observation, the nurse manager for the first floor was notified of the temperature in the medication refrigerator and asked if anyone in the facility had been notified of the temperature and if there was a work order or process in place to correct the situation. She stated that she would check. During observation of the medication refrigerator in the second floor medication room, at 3:42 p.m. on 6/2/15, the thermometer inside the refrigerator read 32 degrees Fahrenheit. The thermometer was immediately shown to the nearby nursing supervisor. The nurse manager for the second floor was shown the thermometer inside the medication refrigerator, and while he was looking inside the refrigerator he stated, "Who turned this up? The temp control in here is turned all the way up." The medication refrigerator contained 12 vials of FluLaval influenza vaccine, ten doses each vial, with the expiration date of June 2015. The refrigerator also contained Tuberculin purified protein testing solution, insulin pens, and bisacodyl suppositories.	F 431		

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F 431	Continued From page 31 During interview at 9:45 a.m. on 6/3/15, the nurse manager for first floor was asked if she needed to destroy any of the medications in the first floor medication refrigerator, and she stated that she destroyed and ordered new insulins and new Tuberculin. She also stated that she could not find a work order or documentation for resolving the 32 degree temperature that had been recorded on the refrigerator temperature log in the first floor medication room. During interview at 2:00 p.m. on 06/03/2015, the nurse manager for the second floor was asked if he needed to destroy any of the medications in the second floor medication refrigerator, and he stated that he threw away everything in the med room refrigerator, except the bisacodyl suppositories, and ordered new meds and vaccines. He stated that he adjusted the temperature controls in the second floor medication refrigerator, checked the refrigerator temperature on 6/3/15 and it was 40 degrees. A surveyor requested of the director of nursing policies and procedures regarding the maintenance of the medication refrigerator temperatures 6/4/15 and none was provided.	F 431	F441 • Staff have been educated on infection control with emphasis regarding the cleaning up of bodily fluids, water dispensing unit and cleaning routines. • All residents have the potential to be effected if infection control measures are not followed. • Staff have been educated on infection control measures including cleaning up of hazardous waste- urine, blood, emesis, etc. Housekeeping staff have been educated on bathroom cleaning, patient room cleaning, and complete room cleaning procedures. • Audit of cleaning systems, interview staff on procedures weekly • ED/designee is responsible • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	
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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 441	Continued From page 32 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to use standard infection control practices during floor sanitation and to prevent cross contamination during the clean up process. This had the potential to affect residents who came into contact with the urine spill and potential to affect the 4 residents who shared one bathroom, of the 68 residents who resided in the	F 441		

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 441	Continued From page 33 facility. Findings include: During an observation on 6/1/15, at 5:28, a registered nurse (RN)-A informed housekeeper (H)-A a puddle of urine needed to be cleaned up in the dining room. There was a 12 inch by 15 inch puddle according to the 12 inch by 12 inch floor tiles. H-A proceeded to clean up the urine using a microfiber 4 inch by 15 inch thin non-absorbent mop. There was too much urine to absorb and H-A spread the wetness out to a 60 by 60 inch area. Then, H-A picked up the thin micro fiber mopping strip and walked out to the housekeeping cart in the hallway, dripped wetness out to the cart and using a gloved hand removed the micro strip mop from the Velcro base and put the micro mop into a plastic bag. H-A removed the contaminated gloves and was going to take the housekeeping cart back to the storage area. Surveyor intervened and asked the H-A what was the procedure for cleaning up urine spills. When interviewed on 6/1/15, at 5:35 p.m. H-A was not sure of the cleaning procedure for urine but stated, "The solution the facility uses starts to cut down the urine right away." H-A was informed the mop dripped the urine out into the hallway and now the area contaminated extends out into the hallway where the housekeeping cart was set along the north wall. H-A did not know about handwashing after removing the urine saturated mop with the gloves because H-A thought the gloves were a protection. H-A agreed the area should be re-sanitized with a new mop. When interviewed on 6/3/15, at 1:58 p.m. the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 director of nursing (DON) validated nursing should have used a mop and bucket to clean up the first spill of body fluid and then housekeeping should come along and sanitize the area. According to the DON, the facility does not have a policy and procedure for cleaning up of body fluids. Furthermore, the DON verified the housekeeping department are expected to wash hands after removing gloves as a standard of practice. During several observations on 6/1/15, during the evening meal, on 6/2/15, before breakfast and at 10:00 a.m., the 5 gallon bottled water dispensing unit in the first floor dining room, several residents/visitors were observed to be utilizing the spigot to obtain water. There was dust accumulated on the top of the dispenser and there were small pea size to dime size brown and black stains noted on and about the spigot. When interviewed on 6/2/15, at 3:15 p.m., H-A verified the housekeeping department did not clean the water dispenser and validated it needed to be cleaned. Furthermore, H-A verified the empty bottles should not be on the floor and the stored bottles were not on a moveable cart so that the area could be sanitized by the housekeeping department. The facility did not have any cleaning documents for the water dispenser and were not aware of the manufacturer recommendations for sanitizing the water dispensing spigot. During observations on 6/1/15 at 5:15 p.m., 6/2/15 at 9:00 a.m., and on 6/3/15 at 1:58 p.m., a bathroom shared by 4 residents in rooms 114 and 116, had a yellow, brown stained, elevated	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35	F 441		

plastic toilet seat stored on the floor next to the toilet. There was a urine odor to this toilet seat. There was a resident care basin on the floor on the other side of the toile and a used toothbrush and a partial tube of toothpaste on the shelf above the sink.

When interviewed on 6/3/15, at 1:58 p.m., nursing assistant (NA)-A and the DON both verified they did not think any of the 4 residents were using the elevated toilet seat and validated the toilet seat needed to be cleaned and removed from the floor. NA-A and the DON validated the basin was not to be stored on the floor in the bathroom and the toothbrush and tooth paste was not to be left on the sink shelf, not knowing who it belonged to. NA-A and the DON verified the standard for infection control was breached.

The facility did not have a policy or procedure for storage of resident care items in the bathroom.

During an observation of H-B cleaning the bathroom, shared by 4 residents in rooms 114 and 116, on 6/3/15, at 2:15 p.m., H-B used a microfiber cloth to wipe off the toilet after spraying a solution on the toilet. H-B cleaned from the most contaminated rim of the toilet out and down the less contaminated base of the toilet.

When interviewed on 6/3/15, at 2:18 p.m., H-B indicated being finished cleaning the bathroom and took the spray bottle and cloth supplies to leave the room. When questioned about the raised toilet seat being on the floor, the basin on the floor, and what about cleaning of the sink and floor H-B indicated difficulty understanding English and would get the supervisor. H-A verified H-B had difficulty with English and the company

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	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 441	Continued From page 36 would further evaluate the cleaning practice of H-B, According to H-A there was not an official cleaning routine written at this time, but the expectation would be to wash and sanitize the mirror, sink, toilet and bathroom floor each day. H-A verified a strong urine smell remained in the bathroom.	F 441	F465 • Residents #11, 16 and 20 wheelchairs have been cleaned and worn areas replaced. Repairs in rooms 112, 114, 200, 202, 203, 218 have been completed. Building ventilation system has been assessed and repairs begun by licensed HVAC company. Resident rooms have been inspected and repairs completed as needed. • All residents have the potential to be effected if not provided a sanitary and safe environment. • Staff to be educated on system to identify as needing repair • Random weekly audits of 2 rooms per week to ensure any needed repairs have been completed. Room and equipment inspections per deep cleaning schedule Q 60 days to ensure rooms are in repair • ED/designee is responsible • Negative results of these audits/inspections will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 and interview, the facility did not maintain a sanitary and orderly environment, and did not keep resident equipment in good repair. This had the potential to affect 3 residents (R11, R16, R20) who had soiled and worn wheelchairs and had the potential to affect 6 residents, who resided in rooms 112, 114, 200, 202, 203, 218, of the 68 residents who resided in the facility. Findings include: During environmental tour observation at 10 a.m. on 6/4/15, the upholstery of R11's wheelchair was nearly completely worn off the edges of the arms of the wheelchair and the resident stated that the wheelchair stank. No odor was noticeable at that time. The wheelchair of R16 had a brown clump	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 465	Continued From page 37 of matter on a left lower rail. The upholstery on the back of the wheelchair of R20 was heavily cracked and peeling. The first floor tub room had a stale odor and when the vent in that room was checked for function by the maintenance director, no air was being drawn through the vent. The wall near the air conditioner in room 112 had a large area of unpainted and rough surface. The bathroom ceiling in room 114 contained large areas of peeling paint. The grout around the toilet in that same bathroom was dark and rough, and the paint on the lower door frame was peeling and rough with a rust-colored material. The heat register under the window and behind the bed in room 200 was a dark brown color with drip marks covering the entire surface. The chair near the window in room 200 had a large blue drip mark on the back support section and the paint was gouged on the wall behind the bed near the window. There was a large unpainted and rough area on the ceiling near the air conditioner in room 202. The window curtains in room 203 were partially detached from the curtain rod. The wall near the air conditioner in room 218 contained a large unpainted, white, and rough area. During the tour the maintenance director stated that he had difficulty completing plaster and painting tasks in the facility because residents could not be in the room when some tasks are done and at times the residents refuse to allow the work to be done or there is no other place in the facility for the resident to go while the work is being done.	F 465		
F 520	483.75(o)(1) QAA	F 520		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520 SS=F	Continued From page 38 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a process to assure areas of concern, related to cleanliness of residents, cleanliness of environment, odors and infection control practices were followed through with and revisted at Quality Assessment and Performance Improvement (QAPI) meetings and also failed to conduct the QAPI meetings quarterly. This had the potential to adversely	F 520	F520 • QAPI meetings are scheduled quarterly for the year. • All residents have the potential to be effected if QAPI meeting is not conducted quarterly to follow through on areas of concern. • Staff have been educated on QAPI requirements. • Quarterly audit of QAPI meeting minutes. • ED/designee is responsible • Results of these audits will be reviewed at the facility QA meeting for further recommendation. • Completion date is July 14, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	06/04/2015

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F 520	Continued From page 39 affect all residents who resided in the facility. Findings include: The facility QAPI program lacked a process for in depth analysis, improvement activities and action plans to address identified areas of concern related to cleanliness and infection control. On 6/04/15 at 11:51 a.m., the director of nursing (DON) as chairperson of the QAPI committee, was interviewed about quality issues identified, regarding cleanliness of residents, environment and infection control concerns. The DON indicated being aware of odors and cleanliness of residents and said that this was brought forth in the February and March QAPI meetings. The QAPI Performance Improvement Plan log for February identified the concern as, "direct patient care, dressing, bathing, grooming etc., improvement", as areas to work on and the status of the action plan was identified as being, "in progress." The DON did not identify what the action plan was or what, "in progress" meant. The DON explained being in the current position since February and was unsure what had happened prior to that time. The DON stated that the ongoing issues of direct patient care, dressing, bathing, grooming etc., improvement, had been identified in February and March and a plan was formulated, however in April the same issues were not identified as a concern. The DON was unaware of why the ongoing issues had not been addressed in the QAPI committee in April and could not recall what had been discussed in the May. It was also noted that a QAPI meeting had been	F 520		

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F 520	Continued From page 40 held in September 2014 but no meeting was held in December. When interviewed on 6/4/15 at 2:00 p.m., the administrator identified the meetings are to held quarterly and that the December meeting had been missed. A policy and procedure for QAPI was requested, however was not provided.	F 520		

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

F5394023

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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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 Living Center Lynnhurst was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POC OK BR 7 JULY 15 RECEIVED JUN - 7 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 6-4-15 DC: 7/14/15

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

EXECUTIVE DIRECTOR | JULY 2, 2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Living Center Lynnhurst is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected 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 72 beds and had a census of 69 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245394	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/03/2015

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:00 AM and 01:00 PM on 06/03/2015, it was observed that the corridor door to the 1st floor Clean Linen Room, had 2 3/8	K 018	K018 COMPLETED • two 3/8 inch penetrations were filled on June 12th with fire barrier caulk. • Maintenance Director is responsible	

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K 018	Continued From page 3 inch penetrations in the door from an old latch that was replaced. This deficient practice was verified by the Maintenance Director (JB), at the time of discovery.	K 018		
K 050 SS=C	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: On facility tour between 09:00 AM and 01:00 PM on 06/03/2015, based on review of available documentation it was reveled that the facility had no documentation for fire drills conducted 1) during the Night shift of the 1st quarter 2015 and 3rd quarter 2014. 2) During the Evening shift of the 4th quarter 2014.	K 050	K050 • monthly schedule created with fire drills scheduled for all shifts once per quarter • quarterly audit of fire drill documentation • ED/designee is responsible COMPLETED 6/12/15	

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K 050	Continued From page 4 This deficiency was verified by the facility Maintenance Director (JB) at the time of discovery.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1833
June 22, 2015

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5394026

Dear Mr. Carlson:

The above facility was surveyed on June 1, 2015 through June 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St Paul MN, 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 1, 2, 3, 4, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to:	2 000 7/9/15 SER	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: JULY 2, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	06/04/2015

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2 000	Continued From page 1 Minnesota Department of Health, Health Regulation Division, Licensing and Certification P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 255	Continued From page 2 assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a process to assure areas of concern, related to cleanliness of residents, cleanliness of environment, odors and infection control practices were followed through with and revisted at Quality Assessment and Performance Improvement (QAPI) meetings and also failed to conduct the QAPI meetings quarterly. This had the potential to adversely affect all residents who resided in the facility. Findings include: The facility QAPI program lacked a process for in depth analysis, improvement activities and action plans to address identified areas of concern related to cleanliness and infection control. On 6/04/15 at 11:51 a.m., the director of nursing (DON) as chairperson of the QAPI committee, was interviewed about quality issues identified, regarding cleanliness of residents, environment and infection control concerns. The DON indicated being aware of odors and cleanliness of residents and said that this was brought forth in the February and March QAPI meetings. The QAPI Performance Improvement Plan log for February identified the concern as, "direct patient	2 255		

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	00945	A. BUILDING: _____ B. WING _____	06/04/2015

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2 255	Continued From page 3 care, dressing, bathing, grooming etc., improvement", as areas to work on and the status of the action plan was identified as being, "in progress." The DON did not identify what the action plan was or what, "in progress" meant. The DON explained being in the current position since February and was unsure what had happened prior to that time. The DON stated that the ongoing issues of direct patient care, dressing, bathing, grooming etc., improvement, had been identified in February and March and a plan was formulated, however in April the same issues were not identified as a concern. The DON was unaware of why the ongoing issues had not been addressed in the QAPI committee in April and could not recall what had been discussed in the May. It was also noted that a QAPI meeting had been held in September 2014 but no meeting was held in December. When interviewed on 6/4/15 at 2:00 p.m., the administrator identified the meetings are to held quarterly and that the December meeting had been missed. A policy and procedure for QAPI was requested, however was not provided. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing could assure that Quality Assessment and Performance Improvement meetings are held quarterly and that areas of concern are identified, analyzed, improvement plans developed and monitored to assure residents are provided appropriate care, that the environment in which	2 255		

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2 255	Continued From page 4 the residents live is clean, free from odors. The administrator, director of nursing and/or designee could also train staff approprate approaches to assure residents are clean, environment is clean and odor free and that staff use appropriate infection control techniques to minimize the risk for infections. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 255		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees	2 302		

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2 302	Continued From page 5 trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provided required training for nursing facility staff who serve persons with Alzheimer's Disease. The had to potential to affect 16 of 16 persons with the diagnoses of Alzheimer's Disease. Findings included: On 6/4/15 at approximately 9:00 a.m. the administrator provided a breakdown of what newly hired staff had attended alzheimer's training. The following staff were hired within the 12 months and did not receive the required training: Registered Nurse (RN)-G was hired on 8/12/14, and Licensed Practical Nurse (LPN)-E was hired 8/12/14. Certified Nursing Assistant (CNA)-E was hired on 3/26/15, CNA-F was hired 12/19/14, CNA -G was hired 4/28/14, and CNA-H was hired 4/28/15. The Activity Director, currently assigned to work as a social service representative on the 2nd floor of the facility was hired 5/19/14 and did not have the required Alzheimer's Disease training upon hire. On 6/4/15 at approximately 9:10 a.m. the administrator and the director of nursing (DON) verified these findings. The DON indicated there has been a change and recent new hires have	2 302		

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2 302	Continued From page 6 had the required training. SUGGESTED METHOD OF CORRECTION: The director of nursing could assure that the required training is provided for nursing facility staff who serve persons with Alzheimer's Disease. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements;	2 540		

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2 540	Continued From page 7 F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on obsservation, interview and document review, the facility did not complete a comprehensive assessment for 2 of 3 residents (R83, R62) who were reviewed for activities. Findings include: R83 was not comprehensively assessed for a program of activities. During observation in stage one of the survey, R83 did not participate in recreational activities in the facility. During record review, an assessment for recreational activities could not be located in the resident's record. When interviewed at 9:41 a.m. on 6/4/15, the current director of activities for the facility stated that a recreational activities assessment had not been completed for R83 and explained that late in 2014 being transitiond into another position in the facility and that some of the tasks of the activities department had not been completed. R62 did not have a comprehensive assessment	2 540		

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2 540	Continued From page 8 for activities. During stage one of the survey R62 was not observed attending any recreational activities. On 6/3/15 at 10:20 a.m., activities were held on the second floor dining area, however, R62 was in bed and no staff asked R62 about attending the activity. During a family interview on 6/2/15, at 12:39 p.m., family member (F)-M indicated R62 loved activities and felt R62 did not attend enough activities. A review of the medical record on 6/4/15 revealed there was no comprehensive assessment for recreational activities. On 6/4/15 at 9:49 the Director of Activities verified that a comprehensive assessment had not been completed for R62. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could develop and iplement policies and procedures related to assessments for residents. The DON or designee, could provide training for all nursing staff related to the completion of assessments. The quality assessment and assusrance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 540		

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2 565	Continued From page 9	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced 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 3 residents (R57) for activities of daily living (ADL's). Findings include: R57's care plan, dated 11/6/14, directed staff that R57 had physical functional deficits of self-care impairment and directed staff, "I will maintain or improve my current level of physical functioning. Interventions: Personal Hygiene/Grooming: extensive assistance of one ..." On 6/1/15 at 6:20 p.m., during an attempt to interview R57, observations of several facial hairs to the upper lip and the chin area were noted to be approximately one half inch long. R57 was unable to respond to interview questions regarding grooming. On 6/2/15 at 10:20 a.m. R57 was observed to still have numerous facial hairs. During interview with nursing assistant (NA) - B on 6/3/15 at 8:13 a.m., NA-B agreed that R57	2 565		

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2 565	Continued From page 10 was unshaven and explained being busy and not having a chance to shave R57. During an interview with director of nursing (DON) on 6/3/15/ at 9:07 a.m., DON stated that shaving facial hair was part of personal grooming. During interview with registered nurse (RN) - B on 6/3/15 at 12:06 p.m. RN-B explained that the expectation is for residents to be shaved if that is the residents wish andt that staff need to follow the care plan. RN-B added that shaving was considered part of grooming and the care plan for R57 addressed it. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised 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,	2 570		

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2 570	Continued From page 11 and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 3 of 5 residents (R71, R48, R19) who required revisons be made to direct staff of current interventions for activities of daily living, accidents and/or interventions for pain. Findings include: R71's care plan was not revised to include a change in toileting, refusal of cares and interventions for toileting and grooming. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed. R71 was wearing open toed slippers and the toe nails to both feet were observed to be long and curled over the ends of the toes reaching down to the slipper surface. The second and third toe nails of both feet had the nails bending over the toes to the surface of the slipper at which point they were now curving out to the side an additional 1/2 inch forming a check mark appearance. There was a blue green substance smeared on R71's toes. A strong odor of urine was detected in R71's room. During interview on 6/2/15, at 10:26 a.m., R71 was not aware of an odor when asked if R71 detected an odor in the room. R71 talked about	2 570		

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2 570	Continued From page 12 both feet being uncomfortable and that is why R71 put the, "ointment" on the toes. During an interview on 6/2/15, at 2:00 p.m., activities assistant (AA)-A explained that R71 often refused cares if staff did not use the, "right approach" and it was not unusual for R71 to go two months without a bath or grooming with nail care. AA-A confirmed there were certain techniques required for R71 to accept cares and the staff would need to learn how to get R71 to accept care by talking about the prior work history and the neighborhood, indicating this was the technique that has worked for R71 in the past. The active diagnoses from the electronic medical record (eMR) face sheet dated 6/3/15, indentified R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS) dated 4/17/15, indicated R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. Section G of the MDS indicated R71 required extensive assistance with activities of daily living (ADL's) and a 1 person physical assist. Bathing indicated R71 was total dependence. When interviewed on 6/4/15, at 10:01 a.m. registered nurse (RN)-B verified the care plan was not updated to include urine incontinece, refusal of care and interventions for toileting, grooming and bathing. R48 had a history of falls and the facility failed to revise the care plan for transfers.	2 570		

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2 570	Continued From page 13 The comprehensive assessment note, dated 3/10/15 identified R48 had been requiring an increase in staff assistance with transfers as well as activities of daily living (ADLS) The significant minimum data set (MDS) dated 3/6/15 indicated R48 required extensive assistance of one staff person for transfers. The most current care plan indicated R48 had a mobility impairment due to scoliosis and identified R48 as being independent, history of falls and requires assistance of 1 for ADLS. Interventions on the care plan did not direct staff how to transfer R48. On 6/4/15 at 9:38 a.m,. the MDS registered nurse (RN-C) stated the care plan had not been updated to identify the transferring needs of R48 and was unsure how it could have been overlooked. The facility did not ensure R19 had an updated care plan that identified pain with interventions to include nonpharmacological interventions. R19 was admitted to the facility on 4/16/15 with diagnoses that included chronic ischemic heart disease, anxiety disorder, osteoarthrosis, idiopathic peripheral neuropathy, and polymyalgia rheumatica. The admission orders included the following: 1. morphine sulfate 20 mg/5ml, solution (milligram, milliliter) orally as needed every four hours for general osteoarthrosis. 2. morphine solution, 20 mg/5ml, administer 20 mg orally three times per day at 8:00, 2:00 p.m., 10:00 p.m. for pain,	2 570		

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2 570	Continued From page 14 3. MS Contin (morphine) table extended release, 15 mg, administer 1 tablet three times per day at 7:00 a.m, 1:00 p.m., 9:00 p.m. for pain, 4.Gabapentin (neurotinin) capsule, 400 mg orally twice a day for idiopath peripheral neuropathy. 5. Acetaminophen 325 mg tablet orally as needed every four hours for pain/fever, take 1-2 tablets, maximum acetaminophen: 4 GM (grams)/24 hours R19 was currently receiving the following medications: 1. Acetaminophen tablet: give 325 mg orally every four hours as needed for pain or fever. Check to see if give 650 mg first. Maximum dose 4 gm every 24 hours., 2. acetaminophen tablet give 650 mg orally every 4 hours as needed for pain or fever., Check to see if give 325 mg first, maximum dose 4 gm /24 hours. 3. Gabapentin capsule give 400 mg orally twice a day related to neuropathy 4. MS Contin tablet extended release 15 mg give 15 mg orally twice a day for pain. The current care plan, dated 4/21/15, was reviewed. There was no focus goal for having pain or for being at risk for pain for R19. The care plan lacked interventions for pain, which included nonpharmacological interventions. On 6/4/15 at 11:11 a.m., the minimum data nurse (RN)-C reviewed the care plan and agreed the care plan did not identify R19's potential pain or identify interventions to direct staff to minimize R19's pain. Review of the policy provided, from the 2012 RAI (Resident Assessment Instrument) manual,	2 570		

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2 570	Continued From page 15 directed staff, "the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An	2 840		

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2 840	Continued From page 16 incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) who was identified as incontinent of urine, received the necessary care and services to manage incontinence and 1 of 1 resident (R71)	2 840		

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2 840	Continued From page 17 did not receive a toileting plan when assessed as having incontinent episodes. Findings includes: R27's quarterly minimum data set (MDS) dated 3/20/15, was reviewed and identified R27's BIMS score as 15 (congnitively intact). The MDS identified that R27 required extensive assist of one with transfers, dressing, toileting, personal hygiene and total assist of one with bathing activities. R27's toileting needs addressed R27 as being frequently incontinent with bladder and always continent with bowel. During a random observation on 6/01/15 at 5:12 p.m., a strong odor of urine was detected from R27's room. R27 was observed lying flat on the bed, soaked with urine that penetrated R27's shirt and pants. R27 expressed being embarrassed and anxious because of wet clothes. R27 explained the call light had been put on, a staff person came into the room and informed R27 of being busy and would be back. R27 attempted to cover wet clothes while conversing with surveyor. At 5:14 p.m., licensed practical nurse (LPN)-C and nursing assistant (NA)-C, was informed of R27's incontinent situation and both indicated the matter would be addressed. Follow up with R27 on 6/1/15 at 5:56 p.m., R27 smiled and stated, "I would like to say thank you and God is good to send you." Activities of daily living care area assessment (CAA) dated 1/8/15, identified: resident requires extensive assist with dressing, toileting. In addition, the urinary incontinence and indwelling catheter CAA dated 1/8/15, reads, "Resident is	2 840		

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2 840	Continued From page 18 frequently incontinent of urine. Staff assists with toileting, changing and pericare following incontinent episodes. R27's care plan, reviewed by the facility on 3/3/15, revealed, "..... limited assist of staff with toileting, transfers on/off toilet PRN (as needed). Occasional incontinence of bowel and bladder without pattern. Symptoms of urge incontinence. Does not wear incontinence products. Able to request assist with changing soiled clothing and hygiene PRN. Goals: I will maintain my current level of urinary continence. Interventions: Assist with clothing and pericare PRN. Changes in color, odor, or consistency of urine, dysuria, frequency, fever, pain. Provide assist with toileting as needed." During an interview with director of nursing (DON) on 6/2/15 at 3:25 p.m., DON stated the expectation for answering call lights is that when staff see a resident's call light on, it should be answered and if the staff person cannot assist the resident, based on the level of care, the staff person should alert the nursing staff of the resident's needs. During an interview with registered nurse (RN)-B on 6/3/15 at 12:16 p.m., RN-B's expectation was that if R27 put the call light on to be toileted R27, nursing staff should assist R27 to the toilet. The facility Policy and Procedure titled incontinence care, dated 1/26/15, reads, "Procedure purpose: To keep skin clean, dry, free of irritation and odor, to identify skin problems as soon as possible so treatment can be started to prevent skin breakdown to prevent infection" Policy and procedure titled incontinence	2 840		

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2 840	Continued From page 19 management/bladder function guideline dated 1/19/15, reads, "Prevent skin problems such as pressure areas and excoriation Improve the morale of the resident Restore the resident's dignity Manage urinary incontinence, restore or maintain as much normal bladder function as possible. Observe and record the resident's voiding pattern and revise the toileting scheduled to meet the residents toileting needs" R71 did not receive a toileting plan when assessed as having incontinent episodes. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed and a strong odor of urine was detected coming from R71's person. During an interview on 6/2/15, at 10:26 a.m., R71 was not aware of a body odor when asked if R71 detected any body odor or urine type odors in the room. R71 commented of being informed, "You stink." The active diagnoses from the electronic medical record (eMR) face sheet dated 6/3/15, indicated R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS) dated 4/17/15, indicated R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS dated 4/17/15, indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. R71's plan of care dated 2/12/15, identified R71 as being continent of bowel and bladder. Urinates	2 840		

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2 840	Continued From page 20 on bathroom floor and in heating vents due to dementia. Supervision/set up only provided with toileting. The MDS bladder assessment dated 4/17/15, identified R71 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding. Furthermore, the MDS indicated no trial of a toileting program (scheduled toileting, prompted voiding, or bladder training) had been attempted since urinary incontinence was noted in this facility. When interviewed on 6/4/15, at 10:01 a.m., registered nurse (RN)-B verified the care plan did not address R71 as incontinent of urine and did not address refusal of care interventions. RN-B thought R71 was continent of urine, realized there was a urine odor in the room and explained that sometimes R71 has body odor because R71 has gone as long as 2 months without a bath due to refusing to take a bath or shower. RN-B verified a toileting plan had not been developed for R71 because RN-B thought R71 was continent of urine. RN-B verified the voiding pattern for R71 was not assessed. When interviewed on 6/4/15, at 11:30 a.m., family member (F)-A indicated the urine smell in R71's bedroom and person had been going on a very long time. F-A stated, "Who wants to smell like urine." F-A expressed further frustration and concern that the staff tell him R71 refuses care. F-A stated, "At what point should the staff be expected to figure out how to provide care for [R71] so that [R71] receives the care [R71] needs." When interviewed on 6/4/14 at 1:00 p.m., the	2 840		

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2 840	Continued From page 21 director of nursing stated there was not a specific policy regarding re-approaching residents who refuse care. The DON informed surveyor the expectation would be for staff to provide the care as soon as possible for the resident or find another staff person who could provide the care for the resident. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment and services. The director of nursing or designee (s) could develop a system to conduct random audits of the delivery of care to ensure appropriate care and serves are implemented. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 840		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet;	2 915		

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2 915	Continued From page 22 (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement consistent ambulation programs to maintain or improve each resident for 1 of 1 resident (R6) reviewed for ambulation. Findings include: During an observation on 6/1/15, at 6:34 pm R6 was seated in a wheel chair by the side of the bed. R6 stated, "They don't walk me to meals and to the bathroom like they are suppose to do." During an interview on 6/1/15, at 6:34 p.m. R6 expressed concern of not walking to meals and the bathroom according to the physician orders and the established restorative program set up by the therapy department. R6's quarterly Minimum Data Set (MDS) dated, 3/24/15, indicated R6 had intact cognition and was dependent with activities of daily living (ADL's). Document review of the physician order dated 4/30/13 and read, ADL Program. 1. Walk to bathroom with SBA (stand by assist) 2. Will toilet and wipe self. Walk to dining room with 2 wheeled walker and sit in arm chair. Every shift. PT (physical therapy) Resident will walk 50 feet	2 915		

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2 915	Continued From page 23 using FWW (front wheeled walker) with assist of 1 BID (twice a day). Follow with wheelchair every day and evening shift to maintain ability to walk. During an observation on 6/2/15, at 8:30 a.m. R6 was seated in the wheel chair at the dining room table and did not walk to the dining room for the meal. During an observation and interview on 6/3/15, at 7:35 a.m. R6 was seated in the wheel chair and stated, "They did not walk me to the bathroom this morning." When interviewed on 6/3/15, at 7:40 a.m. nursing assistant (NA)-A verified R6 did not walk to the bathroom and the process was to walk her in the hallway after breakfast. A review of the untitled document staff referred to as the "aide assignment sheet", directed staff, Restorative walking program see documentation book and ADL sheet in room for cares. During an interview with the director of nursing (DON) on 6/3/15, at 8:00 a.m. DON verified R6 was to be walked according to the physician orders to the bathroom, to meals and in the hallway 50 feet twice a day. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review all residents needing staff assistance to complete activities of daily living to assure they are receiving the necessary treatment and services. The director of nursing or designee (s) could develop a system to conduct random audits of the delivery of care to ensure appropriate care and serves are implemented.	2 915		

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2 915	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services for 2 of 3 residents (R71, R57) in the sample who were dependent on staff for personal cares. Findings include: R71 was not provided assistance with gromming and bathing. During observation on 6/2/15, at 10:26 a.m., R71 was sitting on the side of the bed, wearing open toed slippers. R71's toe nails on both feet were observed to be long and curled over the ends of the toes reaching down to the slipper surface. The second and third toe nails of both feet had the nails bending over the toes to the surface of the slipper at which point they were now curving	2 920		

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2 920	Continued From page 25 out to the side an additional 1/2 inch, forming a check mark appearance. There was a blue green substance smeared on R71's toes (which looked like toothpaste and was later confirmed by nursing staff as toothpaste). A strong odor of urine was detected in R71's room. During interview on 6/2/15 at 10:26 a.m. R71 was not aware of any odors in the room. R71 talked about both feet being uncomfortable and that is why R71 applied, "ointment" on the toes. During interview on 6/2/15, at 2:00 p.m., activities assistant (AA)-A verified R71 often refused cares if staff did not use the "right approach" and it was not unusual for R71 to go two months without a bath or grooming with nail care. AA-A confirmed there were certain techniques required for R71 to accept cares and the staff would need to learn how to get R71 to accept care by talking about the prior work history and the neighborhood, which was a technique that worked for R71 in the past. The active diagnosis from the electronic medical record (eMR) face sheet dated 6/3/15, identified R71 had Alzheimer's disease, dementia and adjustment disorder with anxiety. R71's annual Minimum Data Set (MDS), dated 4/17/15, identified R71 had severely impaired cognitive skills with inattention and disorganized thinking. Furthermore, the MDS indicated rejection of care occurred 4 to 6 days, but less than daily during the assessment period. This information was not documented on R71's plan of care. When interviewed on 6/4/15, at 10:01 a.m., registered nurse (RN)-B verified the care plan did	2 920		

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2 920	Continued From page 26 not addressthat R71 was incontinent of urine and refusal of care interventions. When interviewed on 6/4/15, at 11:30 a.m., family member (F)-A indicated the urine smell in R71's bedroom and person had been going on a very long time. F-A stated, "Who wants to smell like urine." F-A expressed further frustration and concern that the staff tell F-A that R71 refuses care. F-A stated, "At what point should the staff be expected to figure out how to provide care for [R71] so that [R71] receives the care [R71] needs." Furthermore, F-A expressed dissatisfaction with the staff for not providing nail care for R71 and stated, "I trimmed those toe nails in October because the staff kept saying [R71] refused, it took me an hour and a half. At what point should the staff figure out how to provide care?" When interviewed on 6/4/15 at 1:00 p.m., the director of nursing verified there was not a specific policy regarding re-approaching residents who have refused care. The DON validated the expectation would be for staff to provide the care as soon as possible for the resident or find another staff person who could provide the care for the resident. On 6/1/15 at 6:20 p.m., during an attempt to interview R57, several facial hairs to the upper lip and the chin area approximately one half inch long, were observed. R57 was unable to communicate needs when queried regarding grooming preferences. On 6/2/15 at 10:20 a.m., R57 was observed to still have numerous facial hairs.	2 920		

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2 920	Continued From page 27 R57's clinical record noted R57 was admitted to facility on 10/17/14, and had diagnoses, which included bipolar disorder, paralysis agitans, dementia w/behavior disturbances and dysphagia. Medication that included Klonopin, Sinemet, and Clozapine. R57's quarterly Minimum Data Set (MDS) dated 4/21/15, identified R57 required extensive assist with bed mobility, transfers, dressing, toileting and personal hygiene needs. In addition, R57 required total assist with bathing activity. The care plan, dated 11/6/14, identified R57 had physical functional deficits of self-care impairment and directed staff, "I will maintain or improve my current level of physical functioning. Interventions: Personal Hygiene/Grooming: extensive assistance of one ..." During interview with nursing assistant (NA) - B on 6/3/15 at 8:13 a.m., NA-B verified that R57 was unshaven and explained being busy and not having a chance to shave R57. During interview with director of nursing (DON) on 6/3/15 at 9:07 a.m., DON stated that shaving facial hair was part of personal grooming. During interview with registered nurse (RN) - B on 6/3/15 at 12:06 p.m., RN-B indicated the expectation was for staff to follow the care plan, that shaving was considered to be part of grooming and R57's care plan addressed this. Policy and procedure tilted shaving the resident dated 1/26/15, reads, "To remove facial hair and improve the resident's appearance and morale." Policy and procedure titled, shaving the resident	2 920		

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2 920	Continued From page 28 dated 1/26/15, directed staff, "Care plan documentation guidelines Problem: Identify the appropriate problem under which to list shaving as an approach. Consider listing possible risks and complications. Goal: List measurable goal(s) to be accomplished. List target date. Approaches: List responsible discipline for each approach. list instructions unique to this resident. list necessary monitoring and observation of the underlying condition. list appropriate preventive skin care." Policy and procedure for RAI and care planning dated July 2012, directed staff, "As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review all residents dependent on staff assistance to complete activities of daily living to assure they are receiving the necessary treatment and services. The director of nursing or designee (s) could develop a system to conduct random audits of the delivery of care to ensure appropriate care and serves are implemented. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 920		

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21375	Continued From page 29	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to use standard infection control practices during floor sanitation and to prevent cross contamination during the clean up process. This had the potential to affect residents who came into contact with the urine spill and potential to affect the 4 residents who shared one bathroom, of the 68 residents who resided in the facility. Findings include: During an observation on 6/1/15, at 5:28, a registered nurse (RN)-A informed housekeeper (H)-A a puddle of urine needed to be cleaned up in the dining room. There was a 12 inch by 15 inch puddle according to the 12 inch by 12 inch floor tiles. H-A proceeded to clean up the urine using a microfiber 4 inch by 15 inch thin non-absorbent mop. There was too much urine to absorb and H-A spread the wetness out to a 60 by 60 inch area. Then, H-A picked up the thin micro fiber mopping strip and walked out to the housekeeping cart in the hallway, dripped wetness out to the cart and using a gloved hand removed the micro strip mop from the Velcro base and put the micro mop into a plastic bag. H-A removed the contaminated gloves and was going to take the housekeeping cart back to the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

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21375	Continued From page 30 storage area. Surveyor intervened and asked the H-A what was the procedure for cleaning up urine spills. When interviewed on 6/1/15, at 5:35 p.m. H-A was not sure of the cleaning procedure for urine but stated, "The solution the facility uses starts to cut down the urine right away." H-A was informed the mop dripped the urine out into the hallway and now the area contaminated extends out into the hallway where the housekeeping cart was set along the north wall. H-A did not know about handwashing after removing the urine saturated mop with the gloves because H-A thought the gloves were a protection. H-A agreed the area should be re-sanitized with a new mop. When interviewed on 6/3/15, at 1:58 p.m. the director of nursing (DON) validated nursing should have used a mop and bucket to clean up the first spill of body fluid and then housekeeping should come along and sanitize the area. According to the DON, the facility does not have a policy and procedure for cleaning up of body fluids. Furthermore, the DON verified the housekeeping department are expected to wash hands after removing gloves as a standard of practice. During several observations on 6/1/15, during the evening meal, on 6/2/15, before breakfast and at 10:00 a.m., the 5 gallon bottled water dispensing unit in the first floor dining room, several residents/visitors were observed to be utilizing the spigot to obtain water. There was dust accumulated on the top of the dispenser and there were small pea size to dime size brown and black stains noted on and about the spigot. When interviewed on 6/2/15, at 3:15 p.m., H-A	21375		

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21375	Continued From page 31 verified the housekeeping department did not clean the water dispenser and validated it needed to be cleaned. Furthermore, H-A verified the empty bottles should not be on the floor and the stored bottles were not on a moveable cart so that the area could be sanitized by the housekeeping department. The facility did not have any cleaning documents for the water dispenser and were not aware of the manufacturer recommendations for sanitizing the water dispensing spigot. During observations on 6/1/15 at 5:15 p.m., 6/2/15 at 9:00 a.m., and on 6/3/15 at 1:58 p.m., a bathroom shared by 4 residents in rooms 114 and 116, had a yellow, brown stained, elevated plastic toilet seat stored on the floor next to the toilet. There was a urine odor to this toilet seat. There was a resident care basin on the floor on the other side of the toile and a used toothbrush and a partial tube of toothpaste on the shelf above the sink. When interviewed on 6/3/15, at 1:58 p.m., nursing assistant (NA)-A and the DON both verified they did not think any of the 4 residents were using the elevated toilet seat and validated the toilet seat needed to be cleaned and removed from the floor. NA-A and the DON validated the basin was not to be stored on the floor in the bathroom and the toothbrush and tooth paste was not to be left on the sink shelf, not knowing who it belonged to. NA-A and the DON verified the standard for infection control was breached. The facility did not have a policy or procedure for storage of resident care items in the bathroom. During an observation of H-B cleaning the	21375		

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21375	Continued From page 32 bathroom, shared by 4 residents in rooms 114 and 116, on 6/3/15, at 2:15 p.m., H-B used a microfiber cloth to wipe off the toilet after spraying a solution on the toilet. H-B cleaned from the most contaminated rim of the toilet out and down the less contaminated base of the toilet. When interviewed on 6/3/15, at 2:18 p.m., H-B indicated being finished cleaning the bathroom and took the spray bottle and cloth supplies to leave the room. When questioned about the raised toilet seat being on the floor, the basin on the floor, and what about cleaning of the sink and floor H-B indicated difficulty understanding English and would get the supervisor. H-A verified H-B had difficulty with English and the company would further evaluate the cleaning practice of H-B, According to H-A there was not an official cleaning routine written at this time, but the expectation would be to wash and sanitize the mirror, sink, toilet and bathroom floor each day. H-A verified a strong urine smell remained in the bathroom. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for infection control. Housekeeping staff could be educated as necessary to the importance of correct cleaning proceedures of waste materials. The administrator and housekeeping director could audit resident areas on a regular basis to ensure a compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not provide an individualized program of activities for 2 of 3 residents (R83 and R62) reviewed for activities. Findings include: R83 was not comprehensively assessed for a program of activities. During observation in stage one of the survey, R83 did not participate in recreational activities in the facility. During record review, an assessment for recreational activities could not be located in the resident's record. When interviewed at 9:41 a.m. on 6/4/15, the current director of activities for the facility stated	21435		

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21435	Continued From page 34 that a recreational activities assessment had not been completed for this resident and explained that since late in 2014 being transitioned into another position in the facility and stated that another director of activities had not been officially appointed. The current director of activities explained that during this transition period some of the the tasks of the activities department had not been completed. R62 was not comprehensively assessed for a program of activities. During observation in stage one of the survey and on 6/2/15 R62 was not observed participating in recreational activities in the facility. On 6/3/15 at 10:20 a.m. activities were being offered in the second floor dining area, however R62 was laying on her bed. When interviewed at on 6/4/15 at 9:30 a.m., the director of activities verified a recreational assessment had not been completed for R62. A SUGGESTED METHOD FOR CORRECTION: The administrator or designee, could review and revise policies and procedures related to ensuring organized activities are based on individual resident's interests. The administrator or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are completing comprehensive assessments on residents participating in recreational activities. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21435		

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21445	Continued From page 35	21445		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a qualified activity director. This had the potential to affect all 68 of 68 residents residing in the facility. Findings include: On 6/4/15 at 9:30 a.m. the social services representative/Director of Activities (DOA)indicated being hired in May 2014 as the Director of Activities for the facility and explained that as of November 2014 and had been transitioning into a social services representative role for 2nd floor of the facility. The DOA stated had not worked in an activity department in a health care setting prior to this facility and as of November 2014 another staff person had been transitioning into the assistant activity director for the facility. A review of the DOA's application identified DOA had a bachelor of arts degree in psychology and lacked documentation of certifications or work experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting. When interviewed at 12:30 p.m. on 6/4/15, the administrator was asked if the current director of activities had qualifications for the position, the	21445		

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21445	Continued From page 36 administrator replied that the current director of activities probably was not qualified because the director of activities had a degree in another discipline and had only worked several months in the activities department of this facility. A SUGGESTED METHOD FOR CORRECTION: The administrator or designee, could review and revise policies and procedures related to ensuring an Activity Director meets the qualifications necessary to direct organized activities and recreation in a health care setting. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21445		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	21535		

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21535	Continued From page 37 Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 (R19) resident's care plan incorporated pharmacological and nonpharmacological interventions for pain. Findings include: R19 was admitted to the facility on 4/16/15 with diagnoses that included chronic ischemic heart disease, anxiety disorder, osteoarthrosis, idiopathic peripheral neuropathy, and polymyalgia rheumatica. The admission orders included the following: 1. morphine sulfate 20 mg/5ml, solution (milligram, milliliter) orally as needed every four hours for general osteoarthrosis. 2. morphine solution, 20 mg/5ml, administer 20 mg orally three times per day at 8:00, 2:00 p.m., 10:00 p.m. for pain, 3. MS Contin (morphine) table extended release, 15 mg, administer 1 tablet three times per day at 7:00 a.m, 1:00 p.m., 9:00 p.m. for pain, 4.Gabapentin (neurotinin) capsule, 400 mg orally twice a day for idiopath peripheral neuropathy. 5. Acetaminophen 325 mg tablet orally as needed every four hours for pain/fever, take 1-2 tablets,	21535		

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21535	Continued From page 38 maximum acetaminophen: 4 GM (grams)/24 hours Currently the resident was receiving: 1. Acetaminophen tablet: give 325 mg orally every four hours as needed for pain or fever. Check to see if give 650 mg first. Maximum dose 4 gm every 24 hours., 2. acetaminophen tablet give 650 mg orally every 4 hours as needed for pain or fever., Check to see if give 325 mg first, maximum dose 4 gm /24 hours. 3. Gabapentin capsule give 400 mg orally twice a day related to neuropathy 4. MS Contin tablet extended release 15 mg give 15 mg orally twice a day for pain. The current care plan, dated 4/21/15 was reviewed. There was no focus goal for having pain or for being at risk for pain for R19. On 6/4/15 at 11:11 a.m., the minimum data nurse (RN)-C reviewed the care plan and agreed the care plan had not been developed to identify R19's risk of pain. A SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could work with the consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of developing interventions for uncessary medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place.	21535		

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	00945	A. BUILDING: _____ B. WING _____	06/04/2015

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21535	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not maintain proper temperature controls for refrigerated medications in 2 of 2 medication rooms reviewed, which had the potential to affect the residents in the facility who used insulin, Tuberculin testing solution, Xalatan eye drops, and influenza vaccine. Findings include: During observation of the first floor medication room refrigerator, at 3:26 p.m. on 6/2/15, the thermometer inside the refrigerator read 28 degrees Fahrenheit. The thermometer was shown to licensed practical nurse (LPN)-B nearby who stated, "It is in the 20's, that can't be right." The temperature log on the refrigerator showed that the temperature in this medication refrigerator was read as 32 degrees Fahrenheit on 5/31/15, and no refrigerator temperatures had been recorded since that date. This refrigerator contained Tuberculin purified protein testing solution opened 5/19/15, Xalatan eye drops for two separate residents, gentamicin liquid for the emergency kit, two FlexTouch insulin pens, a vial	21610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21610	Continued From page 40 of Humulin regular insulin, and bisacodyl suppositories. The insulins were for two separate residents. The heading on the refrigerator temperature log read, "Refrigerator (med) (Acceptable range of 36-46*F)." Immediately following this observation, the nurse manager for the first floor was notified of the temperature in the medication refrigerator and asked if anyone in the facility had been notified of the temperature and if there was a work order or process in place to correct the situation. She stated that she would check. During observation of the medication refrigerator in the second floor medication room, at 3:42 p.m. on 6/2/15, the thermometer inside the refrigerator read 32 degrees Fahrenheit. The thermometer was immediately shown to the nearby nursing supervisor. The nurse manager for the second floor was shown the thermometer inside the medication refrigerator, and while he was looking inside the refrigerator he stated, "Who turned this up? The temp control in here is turned all the way up." The medication refrigerator contained 12 vials of FluLaval influenza vaccine, ten doses each vial, with the expiration date of June 2015. The refrigerator also contained Tuberculin purified protein testing solution, insulin pens, and bisacodyl suppositories. During interview at 9:45 a.m. on 6/3/15, the nurse manager for first floor was asked if she needed to destroy any of the medications in the first floor medication refrigerator, and she stated that she destroyed and ordered new insulins and new Tuberculin. She also stated that she could not find a work order or documentation for resolving the 32 degree temperature that had been recorded on the refrigerator temperature log in	21610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21610	Continued From page 41 the first floor medication room. During interview at 2:00 p.m. on 06/03/2015, the nurse manager for the second floor was asked if he needed to destroy any of the medications in the second floor medication refrigerator, and he stated that he threw away everything in the med room refrigerator, except the bisacodyl suppositories, and ordered new meds and vaccines. He stated that he adjusted the temperature controls in the second floor medication refrigerator, checked the refrigerator temperature on 6/3/15 and it was 40 degrees. A surveyor requested of the director of nursing policies and procedures regarding the maintenance of the medication refrigerator temperatures 6/4/15 and none was provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of storing medications at the proper temperature. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use	21665		

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21665	Continued From page 42 personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not maintain a sanitary and orderly environment, and did not keep resident equipment in good repair. This had the potential to affect 3 residents (R11, R16, R20) who had soiled and worn wheelchairs and had the potential to affect 6 residents, who resided in rooms 112, 114, 200, 202, 203, 218, of the 68 residents who resided in the facility. Findings include: During environmental tour observation at 10 a.m. on 6/4/15, the upholstery of R11's wheelchair was nearly completely worn off the edges of the arms of the wheelchair and the resident stated that the wheelchair stank. No odor was noticeable at that time. The wheelchair of R16 had a brown clump of matter on a left lower rail. The upholstery on the back of the wheelchair of R20 was heavily cracked and peeling. The first floor tub room had a stale odor and when the vent in that room was checked for function by the maintenance director, no air was being drawn through the vent. The wall near the air conditioner in room 112 had a large area of unpainted and rough surface. The bathroom ceiling in room 114 contained large areas of peeling paint. The grout around the toilet in that same bathroom was dark and rough, and the paint on the lower door frame was peeling and rough with a rust-colored material. The heat register under the window and behind the bed in room 200 was a dark brown color with drip marks	21665		

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GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 43 covering the entire surface. The chair near the window in room 200 had a large blue drip mark on the back support section and the paint was gouged on the wall behind the bed near the window. There was a large unpainted and rough area on the ceiling near the air conditioner in room 202. The window curtains in room 203 were partially detached from the curtain rod. The wall near the air conditioner in room 218 contained a large unpainted, white, and rough area. During the tour the maintenance director stated that he had difficulty completing plaster and painting tasks in the facility because residents could not be in the room when some tasks are done and at times the residents refuse to allow the work to be done or there is no other place in the facility for the resident to go while the work is being done. SUGGESTIVE METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights	21870		

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21870	Continued From page 44 Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to act upon concerns voiced at the resident council for 4 of 4 residents interviewed (R30, R6, R37, R73), who regularly attended the resident council meetings. Findings include: Review of Resident Council minutes identified that a resident council meeting was generally held on each of the two units monthly with one president presiding over the group. The January 2015 meeting was held only on first floor. The minutes identified that the old business of call lights was brought up, however, there was nothing specific regarding the call lights and the problem and/or resolution was not identified. Under the section for new business, 4 residents voiced concerns about call lights not being answered in a timely manner. The resident council meetings for February 2015 was held only on first floor and no old or new business issues were identified. Review of the, March 2015, meetings on first and second floor identified no old or new business issues. Review of the, April 2015, meeting at 1:00 p.m. identified that the old business of call lights was not a concern. New business indicated 2 of 4 residents had concerns with laundry not being returned.	21870		

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21870	Continued From page 45 On 6/02/15 at 3:15 p.m., during interview, R30 stated that some residents on first floor still had concerns that their call lights were not being answered on time. R30 also stated that laundry is not being returned and explained that when new clothes are received, they go down to laundry, and don't always come back. On 6/04/15 at 11:14 a.m., R6, R37 and R73 were interviewed and agreed the issues with laundry not being returned and call lights not being answered continued to be an on going problem and stated the facility had not addressed or resolved the issues. Interview with the assistant activities director (AA)-A on 6/02/15 at 3:22 p.m., regarding resident council concerns not being addressed and/or resolved, AA-A explained that issues identified one month were not always addressed at the next month so the issues were not followed up on or resolved. On 6/04/15 at 11:22 a.m., AA-A explained being new to the position of activities and resident council. AA-A explained the processs that should take place whenever a concern was brought forth in the resident council, stating that a form should be filled out with the concern and then the form goes to the department head, who will formulate a plan, put it in place and then the following month it should be addressed at the council. That way the residents know their concerns are being addressed. On 6/04/15 at 12:51 p.m., the Activities Director, who was being transitioned into the social service representative role since November 2014 was interviewed. The Activities Director stated that the resident council role was turned over to AA-A, with the administrator taking over as lead, and	21870		

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21870	Continued From page 46 explained that AA-A had been trained on the resident council process. Although a policy and procedure for resident council was requested, it was not available for review. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that residents concerns are listened to and acted upon timely. The director of nursing or designee could review policy and procedures, train staff, monitor systems, interview residents and evaluate the process to assure the facility acts upon resident council grievances, specifically related to food concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older	21880		

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21880	Continued From page 47 Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unresolved grievances were acted on for 1 of 1 resident (R37) reviewed who voiced concerns of an uncomfortable mattress to the facility staff. Findings include: During an observation on 6/1/15, at 6:30 p.m. of	21880		

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21880	Continued From page 48 R37's mattress, there was a visible indentation in the middle section of the mattress. When interviewed on 6/1/15, at 6:30 p.m. R37 expressed concern about the mattress on the bed and stated, "I told them about it at the care conference in May and nothing has been done about it. I sink to the middle of that mattress and it really hurts my body to lay on it." R37's quarterly Minimum Data Set (MDS) dated 5/5/15, indicated R37 had intact cognition and was dependent with activities of daily living (ADL's). During an interview with the administrator and the social service designee (SSD)-A on 6/3/15, at 10:30 a.m., both verified there was a break in the grievance policy system and R37 who expressed a concern on 5/13/15, at the care conference, did not receive a resolution to the mattress issue until 6/2/15, when the surveyor questioned the mattress replacement. The SSD-A said the mattress would be replaced immediately. A review of the facility policy titled, Grievance Guideline, dated 1/19/15, read, Investigation and Resolution of grievances shall be completed in a timely manner-within 5 working days of receipt of the Grievance Form, it is the responsibility of the employee hearing the grievance to complete the form and submit it for follow-up and resolution. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that residents concerns are listened to and acted	21880		

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21880	Continued From page 49 upon timely. The director of nursing or designee could review policy and procedures, train staff, monitor systems, interview residents and evaluate the process to assure the facility acts upon resident council grievances, specifically related to food concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		