

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



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

Kumalu Fiske Downing

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QU3F

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY	F	Facility ID: 00945	
MEDICARE/MEDICAID PROVIDER N (L1) 245394 2.STATE VENDOR OR MEDICAID NO. (L2) 914342400	0.	3. NAME AND ADI (L3) GOLDEN LI (L4) 471 LYNNHU (L5) SAINT PAUL	VINGCENTER URST AVENUE	- LYNNHU		55104	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 07/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	72 (L18) 72 (L17)	B. Not in Com	equirements	n	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements: 6. Scope of Service 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	tor	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MI	EETS			
18 SNF 18/19 SNF 72 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or	1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	.ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:	
Susanne Reuss,	Unit Superv	isor	07/20/2015	(L19)	<u>Kate Joh</u>	nsTon, Pro	ogram Specialist	08/12/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Part			IPLIANCE WITH O	CIVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)	
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEME BEGINNING I (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00		L30) CARY eet Health/Safety eet Agreement	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L44)		03-Risk of Involu	•	OTHER 07-Provider 00-Active	Status Change	
20. TERMINATION DATE.	20	INTERMEDIA DV/C	(L45)		30. REMARKS				
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NU.		JU. KEMAKKS				
	(L28)	00454		(L31)					
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION (OF APPROVAL DA	TE					
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL		

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245394	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/20/2015
Name of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - LYNNHUR	ST	471 LYNNHURST AVENUE WE SAINT PAUL, MN 55104	ST

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	Correction Completed 07/07/2015	ID Prefix	F0244		Correction Completed 07/07/2015		ID Prefix	F0248		Correction Completed 07/07/2015
Reg. # LSC	483.10(f)(2)		Reg. # LSC	483.15(c)(6)				Reg. # LSC	483.15(f)(1)		<u> </u>
ID Prefix Reg. # LSC	F0249 483.15(f)(2)	Correction Completed 07/07/2015	ID Prefix Reg. # LSC	F0272 483.20(b)(1)		Correction Completed 07/07/2015		ID Prefix Reg. # LSC	F0280 483.20(d)(3),	483.10(l	Correction Completed 07/07/2015
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 07/07/2015	ID Prefix Reg. # LSC	F0311 483.25(a)(2)		Correction Completed 07/07/2015			F0312 483.25(a)(3)		Correction Completed 07/07/2015
ID Prefix Reg. # LSC	F0315 483.25(d)	Correction Completed 07/07/2015	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 07/07/2015			F0431 483.60(b), (d)		Correction Completed 07/07/2015
ID Prefix Reg. # LSC	F0441 483.65	Correction Completed 07/07/2015	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 07/07/2015		ID Prefix Reg. # LSC	483.75(o)(1)		Correction Completed 07/07/2015
Reviewed I		iewed By	Date:	Signature	of Sur	•				Date:	
State Agen	, 010		07/31/201				022				20/2015
CMS RO	By Rev	iewed By	Date:	Signature	ot Sur	veyor:				Date:	
Followup t	o Survey Comple 6/4/2015			Check for any Uncorrected					Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245394	(Y2) Multiple Construction A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 06/12/2015	ID Prefix		Correction Completed 06/12/2015	ID Prefix		Correction Completed
	NFPA 101			NFPA 101		5 "		
LSC	K0018		LSC	K0050		LSC		_
		Correction			Correction			Correction
ID Drofiv		Completed	ID Drofiv		Completed	ID Drofiv		Completed
Reg. # LSC			Reg. # LSC		<u> </u>	Reg. # LSC		
		Correction			Correction			Correction
ID Duefin		Completed	ID Duefix		Completed	ID Drafin		Completed
Reg. # LSC			Reg. # LSC			Reg. #		
		Correction			Correction			Correction
ID Profiv		Completed	ID Profix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
LSC			LSC		<u> </u>	LSC		
		Correction			Correction			Correction
ID Profix		Completed	ID Profix		Completed	ID Profix		Completed
Reg. #								<u> </u>
			LSC			LSC		
Reviewed E	By Revi	ewed By	Date:	Signature of	Surveyor:	-I	Date:	
State Agen	PS/	kfd	07/31/201	5	12	2424	07/1	10/2015
Reviewed E	By Revi	ewed By	Date:	Signature of	Surveyor:		Date:	
Followup t	o Survey Complet	ed on:				iencies. Was a Sur		
	6/3/2015			Uncorrected D	eficiencies (CM	S-2567) Sent to the	Facility? YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QU3F

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY	I	Facility ID: 00945	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245394 2.STATE VENDOR OR MEDICAID NO. (L2) 914342400).	3. NAME AND ADD (L3) GOLDEN LI (L4) 471 LYNNHU (L5) SAINT PAUI	VINGCENTER URST AVENUE	- LYNNHU		55104	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006		7. PROVIDER/SUF	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint	
6. DATE OF SURVEY 06/04/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	72 (L18) 72 ^(L17)	X B. Not in Com	equirements Based On:	n	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	6. Scope of Servi 7. Medical Direc 8. Patient Room 9. Beds/Room	tor	
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY ME	EETS			
18 SNF 18/19 SNF 72	19 SNF	ICF	IID		1861 (e) (1) or 1	1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:	
Sheryl Reed, F	IFE NE II		07/09/2015	(L19)	Kate Joh	nsTon, Pr	ogram Specialis	07/17/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particular to Parti	cipate		IPLIANCE WITH (HTS ACT:	CIVIL	2. C		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	A-1513)	
2. Facility is not Eligible	(L21)								
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25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI	of Admissions:	(L44)		03-Risk of Involur 04-Other Reason f		OTHER 07-Provider 00-Active	Status Change	
, ,	B. Rescind Sus	pension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS				
		00454							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE	Posted 07/	17/2015 Co.			
	(L32)			(L33)	DETERMINA	TION APPRO	VAL		



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

Golden Livingcenter - Lynnhurst June 22, 2015 Page 2

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

Golden Livingcenter - Lynnhurst June 22, 2015 Page 3

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

Golden Livingcenter - Lynnhurst June 22, 2015 Page 4 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:

Golden Livingcenter - Lynnhurst June 22, 2015 Page 5

> 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

PRINTED: 06/22/2015

FORM APPROVED

<u> </u>	<u>NO.</u>	0938-0	23
(X3) D.	ATE S	URVEY	

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCT A. BUILDING

COMPLETED

245394

B. WING

COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION

06/04/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY

471 LYNNHURST AVENUE WEST

GOLDEN LIVINGCENTER - I YNNHUBST

OLDEN	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 COR	(X5) MPLETION DATE
F 000	INITIAL COMMENTS	F 00	0	
	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. 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 160	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

JULY 2, 2015

EXECUTIVE DIRECTOR

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

s	TATEL ACTOR		(X1) PROVIDED OURSE (X1)	1		OMB	MB NO. 0938-039	
A	ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
L			245394	B. WING				
ı		(EACH DEFICIENC	IURST ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION	06/04/2015 (X5) COMPLETION DATE	
		conference in May an about it. I sink to the rit really hurts my body. R37's quarterly Minim 5/5/15, indicated R37 was dependent with a (ADL's). During an interview wisocial service designe 10:30 a.m., both verific grievance policy syste a concern on 5/13/15, not receive a resolutio 6/2/15, when the surve mattress replacement. A said the mattress wo immediately. A review of the facility Guideline, dated 1/19/7 Resolution of grievance timely manner-within 5 the Grievance Form, it employee hearing the grown and submit it for for 483.15(c)(6) LISTEN/A GRIEVANCE/RECOMM	d nothing has been done middle of that mattress and to lay on it." um Data Set (MDS) dated had intact cognition and ctivities of daily living. th the administrator and the e (SSD)-A on 6/3/15, at ed there was a break in the m and R37 who expressed at the care conference, did in to the mattress issue until eyor questioned the The SSD-und be replaced policy titled, Grievance 15, read, Investigation and es shall be completed in a working days of receipt of is the responsibility of the grievance to complete the pollow-up and resolution. CT ON GROUP MENDATION ily group exists, the facility and act upon the nendations of residents	F 24	F166 Resident #37 has documinterview of grievances a follow up. Residents have the potence be affected if expressed grievances are not resolvitimely Staff have been educated regarding living center grievance process. Monthly audit of grievance Tracking Log to ensure grievances resolved with business days ED is responsible Results of these audits we reviewed at the facility Quimeeting for further recommendation. Completion date is July 1 2015.	nd ntial to red d e in 5		

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	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
GOLDEN LIVINGCENTER - LYNNHURST X41 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			245394	B. WING_			06	INA/2015
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	GOLDEN (X4) ID	LIVINGCENTER - LYNNI	TATEMENT OF DEFICIENCIES		47 S.	71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION		(X5)
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		REGULATORY OR	LSC IDENTIFYING INFORMATION)		Χ	CROSS-REFERENCED TO THE APPROPRI	E ATE	COMPLÉTION DATE
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 prove		This REQUIREMENT by: Based on interview a facility failed to act up resident council for 4 (R30, R6, R37, R73), resident council meets. Findings include: Review of Resident Council on each of the two un president presiding or 2015 meeting was he minutes identified that lights was brought up nothing specific regar problem and/or resoluted under the section for voiced concerns about answered in a timely in the resident council in was held only on first business issues were March 2015, meetings identified no old or new Review of the, April 20 identified that the old I not a concern. New buresidents had concern returned. On 6/02/15 at 3:15 p.m. stated that some resid concerns that their call answered on time. R3	and document review the con concerns voiced at the of 4 residents interviewed who regularly attended the tings. Council minutes identified if meeting was generally held hits monthly with one wer the group. The January old only on first floor. The the old business of call, however, there was ding the call lights and the ution was not identified. In the held business, 4 residents at call lights not being manner. Ineetings for February 2015 floor and no old or new identified. Review of the, is on first and second floor we business issues. In the business of call lights was usiness of call lights was usiness indicated 2 of 4 is with laundry not being also stated that laundry is	F 2	244	 Residents #6, 30, 37, 73- hadocumented interviews and follow up of grievances and resolution. Residents have the potential be affected if expressed grievances are not resolved timely. Staff to be educated on grievance and follow up on issues identified at the reside council meetings. Resolution grievances during resident of family groups will be followed on at next resident or family council meeting Monthly audit of resident countinutes to ensure group grievances addressed and followed up on by next reside 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, 	ent n of r d up incil	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245394	B. WING			0.	S/04/204E	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	IURST	•	471	REET ADDRESS, CITY, STATE, ZIP CODE 1 LYNNHURST AVENUE WEST NINT PAUL, MN 55104		6/04/2015	
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	and don't always com a.m., R6, R37 and R3 agreed the issues with and call lights not being be an on going problem of addressed or rescall therview with the ass (AA)-A on 6/02/15 at resident council concand/or resolved, AA-A identified one month wat the next month so up on or resolved. On 6/04/15 at 11:22 anew to the position of council. AA-A explained take place whenever in the resident council be filled out with the cogoes to the department a plan, put it in place a month it should be adway the residents known addressed. On 6/04/15 at 12:51 p who was being transition representative role sing interviewed. The Active resident council role with the administrator explained that AA-A have resident council processed.	they go down to laundry, the back. On 6/04/15 at 11:14 73 were interviewed and the laundry not being returned and she laundry not being returned and answered continued to the and stated the facility had colved the issues. Sistant activities director 3:22 p.m., regarding the erns not being addressed and explained that issues the issues were not followed the processes that should a concern was brought forther the day, who will formulate and then the following dressed at the council. That we their concerns are being the issues were not following dressed at the council that we their concerns are being the interest of the social service concerns are being the interest of the social service concerns are being the interest of the social service concerns are being the interest of the social service concerns are being the interest of the social service concerns are lead, and and been trained on the second procedure for resident the procedure for resident the interest of the social service concerns are lead, and and been trained on the second procedure for resident the procedure for resident the social service concerns are lead, and and been trained on the second procedure for resident the social service concerns are lead, and and been trained on the second procedure for resident the social service concerns are lead, and and been trained on the second procedure for resident the social service concerns are service to second procedure for resident the social service the social service to second procedure for resident the social service the social service the second procedure for resident the social service the social se	F	244				
	Altnough a policy and council was requested	procedure for resident , it was not available for						

	TO THE CONTRACT OF	INEDIO/ND OLIVIOLO				<u> MR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	((X3) DATE S COMPL	
		245394	B. WING_			06/0	4/2015
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COLDEN	10/010000000000000000000000000000000000		l	471 LYNNHURST AVENUE WEST			
GOLDEN	LIVINGCENTER - LYNNH	IURST					
				SAINT PAUL, MN 55104			
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F 244	Continued From page	e 4	F 2	44			
	review.						
SS=D I	INTERESTS/NEEDS	OF EACH RES	F 2	48 F248 ■ Residents #62 and 83 been reassessed for			
	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.			preferences/individual programs. Residents have the pube effected if individual activities are not provue. Activities Staff have be	alized ootential t alized vided.	to	
				educated on providing to meet residents preindividual needs. • Audits to be completed quarterly care confered individualized activity programming.	g activitie ferences ed at ences on	1	
				 Activities Director/des responsible Results of these audit reviewed at the facility meeting for further recommendation. Completion date is June 2015 	ts will be y QA		
	During record review, recreational activities or resident's record.	ing record review, an assessment for reational activities could not be located in the dent's record.		2015.			
	current director of activate that a recreational acti	and stated that another					

STATEMEN	OF DEFICIENCIES	(X4) PROMPERIOR				OMB	NO. 0938-0391	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF		245394	B. WING			,	06/04/2015	
	PROVIDER OR SUPPLIER I LIVINGCENTER - LYNNH	IURST ATEMENT OF DEFICIENCIES		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		00/04/2013	
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F 248	appointed. The curre explained that during of the the tasks of the not been completed. R62 was not compreh program of activities. During observation in on 6/2/15 R62 was not recreational activities. On 6/3/15 at 10:20 a. offered in the second R62 was laying on her when interviewed at odirector of activities veassessment had not b 483.15(f)(2) QUALIFIC PROFESSIONAL The activities program qualified professional who is lice applicable, by the State eligible for certification specialist or as an activities or recreational program of which was full-time in program in a health can occupational therapist assistant; or has compleapproved by the State.	this transition period some activities department had activities department in the facility. In activities were being activities were being activities were being activities acti	F 2	49	 F249 Activities program is directed a qualified professional. All residents have the potent to be effected. Activities Staff to be educate on providing activities to meer residents preferences, individued in the providing activities of the providing activities activities activities activities activiti	ial d		
	This REQUIREMENT i by:	s not met as evidenced						

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	·	245394	B. WING				6/04/204E
	PROVIDER OR SUPPLIER LIVINGCENTER - LYNN	HURST		471	REET ADDRESS, CITY, STATE, ZIP CODE 1 LYNNHURST AVENUE WEST NINT PAUL, MN 55104	<u> </u>	6/04/2015
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F 249	Based on interview facility failed to provi This had the potentia residents residing in Findings include: On 6/4/15 at 9:30 a.r representative/Direct (DOA) indicated beindirector of Activities that as of November transitioning into a scrole for 2nd floor of thad not worked in an health care setting provided in the facility. A review of the DOA' had a bachelor of artilacked documentation experience in a social within the last 5 years a patient activities prosetting. When interviewed at administrator was askactivities had qualification.	and document review, the de a qualified activity director. al to affect all 68 of 68 the facility. m. the social services tor of Activities g hired in May 2014 as the for the facility and explained 2014 and had been ocial services representative the facility. The DOA stated activity department in a crior to this facility and as of ther staff person had been assistant activity director for application identified DOA and of certifications or work and or or recreational program in a health care	F	249			
F 272 SS=D	administrator replied activities probably wa director of activities had discipline and had only the activities departments departments. (a) COMPR ASSESSMENTS	that the current director of s not qualified because the ad a degree in another y worked several months in ent of this facility. EHENSIVE uct initially and periodically	F 27	72			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245394	B. WING		06/04/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNN	HURST		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	
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F 272	reproducible assess functional capacity. A facility must make assessment of a res resident assessment by the State. The as least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior psychosocial well-be Physical functioning Continence; Disease diagnosis at Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and	a comprehensive ident's needs, using the tinstrument (RAI) specified seessment must include at mographic information; patterns; sing; and structural problems; and structural problems; all status; mmary information regarding sment performed on the care e completion of the Minimum	F 27	 Residents 83 and 62, have reassessed for activities. All residents have the potent to be affected if activities preferences are not assessed. Reeducation on providing of per care plan communicating when there is a change in residents function per care. DNS/designee to do randor weekly audits of cares bein provided per care plan. Results of these audits will reviewed at the facility QA meeting for further recommendation. Completion date is July 14, 2015 	ed eare ng plan m g
	by:	is not met as evidenced			

STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DA	<u>IO. 0938-0391</u> FE SURVEY MPLETED	
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	review, the facility of comprehensive ass (R83, R62) who we Findings include: R83 was not compared program of activities. During observation R83 did not participate facility. During record revies recreational activities resident's record. When interviewed a current director of a that a recreational activities facility and that some department had not record that a recreational activities. During stage one of observed attending 6/3/15 at 10:20 a.m. second floor dining	did not complete a sessment for 2 of 3 residents are reviewed for activities. The rehensively assessed for a session of the survey, pate in recreational activities in the session of the survey. The rehensively assessed for a session of the survey, pate in recreational activities in the session of the survey. The rehensively assessed for a session of the survey, pate in recreational activities in the session of the session of the survey. The rehensively assessed for a session of the survey, pate in stage one of the survey, pate in session of the sessio	F	272				
	family member (F)-N	view on 6/2/15, at 12:39 p.m., // indicated R62 loved /2 did not attend enough						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245394	B. WING_		_	06/04/2015	
GOLDEN	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH			STREET ADDRESS, CITY, STA 471 LYNNHURST AVENUE V SAINT PAUL, MN 55104	WEST	00/04/2013	
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F 272	Continued From page		F2	272			
	there was no compre- recreational activities.	al record on 6/4/15 revealed hensive assessment for		F280			
F 280 SS=D	that a comprehensive completed for R62. 483.20(d)(3), 483.10(PARTICIPATE PLANN The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and the comprehensive care within 7 days after the comprehensive assess interdisciplinary team, physician, a registered for the resident, and of disciplines as determinand, to the extent practite resident, the residelegal representative; a	vise found to be ne laws of the State, to a care and treatment or reatment.	F2	reviewed and indicated reg and falls. Re updated to re interventions pharmacolog Resident 71 to reflect chat care refusals for toileting at All residents be affected if updated to re Education on care plans with interventions, updating care transfer from another. DNS/designer andom week	garding transfers esident 19 care pleflect current pair including non gical interventions care plan updated and interventions and interventions and grooming. In a potential to example to current need a staff to update the current plans during one unit to the complete cly audits of care prentions to ensure the current one unit to the current	lan s. d s ot ds.	
	by: Based on observation review, the facility faile	is not met as evidenced , interview and document d to revise the plan of care 1, R48, R19) who required		 accurate and Results of the reviewed at the meeting for fur recommendati Completion day 2015 	se audits will be le facility QA rther ion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06	/04/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST		471	REET ADDRESS, CITY, STATE, ZIP CODE I LYNNHURST AVENUE WEST IINT PAUL, MN 55104	1 00	10-1/2010
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F 280	Continued From page revisons be made to or interventions for active and/or interventions for active reventions for active reventions.	direct staff of current ities of daily living, accidents	F:	280			
	Findings include: R71's care plan was rechange in toileting, reinterventions for toilet	not revised to include a fusal of cares and ing and grooming.					
	During observation or was sitting on the side wearing open toed sli both feet were observover the ends of the to slipper surface. The sboth feet had the nails the surface of the slip now curving out to the forming a check mark blue green substance strong odor of urine we	n 6/2/15, at 10:26 a.m., R71 as of the bed. R71 was appers and the toe nails to red to be long and curled ones reaching down to the econd and third toe nails of a bending over the toes to per at which point they were a side an additional 1/2 inch appearance. There was a smeared on R71's toes. A res detected in R71's room.					
	was not aware of an of detected an odor in the both feet being uncome R71 put the, "ointmen During an interview or activities assistant (AA often refused cares if approach" and it was two months without a care. AA-A confirmed techniques required for the staff would need to	odor when asked if R71 the room. R71 talked about infortable and that is why t" on the toes. In 6/2/15, at 2:00 p.m., A)-A explained that R71 staff did not use the, "right not unusual for R71 to go bath or grooming with nail					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
NAME OF PROVIDED OR GURBLUSE	245394	B. WING		06/	04/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LY			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
technique that hat The active diagnorecord (eMR) face R71 had Alzheim adjustment disord R71's annual Min 4/17/15, indicated cognitive skills withinking. Furthern rejection of care of than daily during G of the MDS indicassistance with an and a 1 person phr R71 was total deproved. When interviewed registered nurse (was not updated to refusal of care and grooming and bate R48 had a history revise the care plate the care plate increase in staff as a activities of dai minimum data set R48 required exteres on for transfer the most current of mobility impairments.	shood, indicating this was the s worked for R71 in the past. Deses from the electronic medical as sheet dated 6/3/15, indentified et's disease, dementia and der with anxiety. Imum Data Set (MDS) dated at R71 had severely impaired the inattention and disorganized more, the MDS indicated occurred 4 to 6 days, but less the assessment period. Section icated R71 required extensive ctivities of daily living (ADL's) mysical assist. Bathing indicated bendence. If on 6/4/15, at 10:01 a.m. RN)-B verified the care plan to include urine incontinece, do interventions for toileting, hing. of falls and the facility failed to an for transfers. If on 6/4/15, at 10:01 a.m. RN)-B verified the care plan to include urine incontinece, do interventions for toileting, hing. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers. If all sand the facility failed to an for transfers.	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	СОМ	E SURVEY IPLETED
2422		
245394 B. WING	1 06	6/04/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
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		

		WINEDIOTAID GERVIOLG				OME	3 NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		DATE SURVEY COMPLETED
		245394	B. WING				06/04/2015
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		00/04/2015
COLDEN	10/000000000000000000000000000000000000			l	LYNNHURST AVENUE WEST		
GOLDEN	LIVINGCENTER - LYN	NHURST		1	NT PAUL, MN 55104		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIES		UA.			
PREFIX		NCY MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5)
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR		COMPLETION DATE
					DEFICIENCY)		
F 280	0						
F 200	- similar i roin pe		F.	280			
		receiving the following					
	medications:	tablet at a OOF					
	every four hours or	tablet: give 325 mg orally					
	Check to see if give	s needed for pain or fever. e 650 mg first. Maximum dose					
	4 gm every 24 hou	re					
		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 caps	sule give 400 mg orally twice a					
	day related to neur	opathy					
	4. MS Contin tablet	extended release 15 mg give					
	15 mg orally twice						
	The current care pl	an, dated 4/21/15, was					
	reviewed. There w	as no focus goal for having					
	pain or for being at	risk for pain for R19. The					
	care plan lacked inf	terventions for pain, which					
	included nonpharm	acological interventions.					
	On 6/4/15 at 11:11	a.m., the minimum data nurse					
	(RN)-C reviewed th	e care plan and agreed the					
	care plan did not ide	entify R19's potential pain or					
	identify intervention	s to direct staff to minimize					
	R19's pain.						
	Review of the policy	provided, from the 2012 RAI					
	(Resident Assessm	ent Instrument) manual,					
	directed staff, "the	comprehensive care plan is					
	an interdisciplinary	communication tool. It must					
	include measurable	objectives and time frames					
	and must describe t	he services that are to be					
		r maintain the resident's					
	highest practicable	physical, mental, and					
	psychosocial well-be	eing. The care plan must be					
	reviewed and revise	ed periodically, and the					
		arranged must be consistent					
	with each resident's	written plan of care "		1			1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			00	6/04/2015
	PROVIDER OR SUPPLIER LIVINGCENTER - LYNNH SUMMARY ST	IURST ATEMENT OF DEFICIENCIES	ID	47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
PRÉFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 282 SS=D	PERSONS/PER CAR The services provided must be provided by accordance with each care. This REQUIREMENT by: Based on observation review, the facility fail accordance with their care for 1 of 3 resider daily living (ADL's). Findings include: R57's care plan, dated R57 had physical fundingairment and direct improve my current le Interventions: Persona extensive assistance of the upper lip and the papproximately one unable to respond to in regarding grooming. On 6/2/15 at 10:20 a.m. have numerous facial During interview with ron 6/3/15 at 8:13 a.m.,	d or arranged by the facility qualified persons in a resident's written plan of is not met as evidenced in, interview and document ed to provide services in esident's written plan of its (R57) for activities of its (R57) for activities of its (R57) for activities of its in a side in a	F	282	 Resident 57, care plan/care sheets reviewed/ revised as indicated regarding ADLS. All residents have the potenti to be affected if cares are not provided according to the plan of care. Education to staff provided or 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 	n n an.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06/	04/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST ATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 282 F 311 SS=D	on 6/3/15/ at 9:07 a.m facial hair was part of During interview with 6/3/15 at 12:06 p.m. Fexpectation is for resithe residents wish anothe care plan. RN-B at	ith director of nursing (DON) in., DON stated that shaving personal grooming. registered nurse (RN) - B on RN-B explained that the dents to be shaved if that is did that staff need to follow idded that shaving was coming and the care plan for MENT/SERVICES TO		282 311 F311 • Resident 6 ambula			
	services to maintain of specified in paragraph. This REQUIREMENT by: Based on observation review, the facility faile ambulation programs resident for 1 of 1 resimbulation. Findings include: During an observation was seated in a wheel bed. R6 stated, "They to the bathroom like the During an interview or expressed concern of the bathroom according	e appropriate treatment and or improve his or her abilities in (a)(1) of this section. is not met as evidenced in, interview and document ed to implement consistent to maintain or improve each indent (R6) reviewed for on 6/1/15, at 6:34 pm R6 in the don't walk me to meals and levy are suppose to do." a 6/1/15, at 6:34 p.m. R6 in the mot walking to meals and in the physician orders storative program set up by		a documented revisambulation plan, care sheet have be as indicated. • All resident on restance potential to be programming is not consistently. • DNS/designee to consistently and residents are received assistance with program assistance with program plan. • Results of these audinesting for further recommendation. • Completion date is a 2015	ew of are plan and een updated orative plan e affected if t provided omplete dits that ving grams per dits will be flity QA	d I s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245394		B. WING			06/04/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST			STREET ADDRESS, CITY, STATE, ZIP COE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	DE	00/	04/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 311	the therapy department of the therapy department of the series of the se	ant. Jum Data Set (MDS) dated, and intact cognition and activities of daily living The physician order dated of Program. 1. Walk to stand by assist) 2. Will toilet of dining room with 2 sit in arm chair. Every shift. A Resident will walk 50 feet eeled walker) with assist of follow with wheelchair every in to maintain ability to walk. The on 6/2/15, at 8:30 a.m. R6 eel chair at the dining room for the company of the walk me to the bathroom 6/3/15, at 7:40 a.m. nursing fied R6 did not walk to the cess was to walk her in the set. d document staff referred to eat sheet", directed staff, rogram see documentation	F 3	11			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245394	B. WING		06/04/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST	4	STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
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. 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	F 311		ance e taff lan.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245394		B. WING			06/04/2015		
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNI	HURST		471	REET ADDRESS, CITY, STATE, ZIP CODE Lynnhurst avenue west Int Paul, Mn 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	urine was detected in During interview on 6 not aware of any odd about both feet being why R71 applied, "oil During interview on 6 assistant (AA)-A verifit staff did not use the not unusual for R71 to bath or grooming with there were certain ted accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept cares and the how to get R71 to accept care and all standard the care accept care of the car	apaste). A strong odor of a R71's room. 6/2/15 at 10:26 a.m. R71 was ors in the room. R71 talked a uncomfortable and that is intment" on the toes. 6/2/15, at 2:00 p.m., activities fied R71 often refused cares a "right approach" and it was o go two months without a in nail care. AA-A confirmed chniques required for R71 to staff would need to learn cept care by talking about and the neighborhood, he that worked for R71 in the from the electronic medical eet dated 6/3/15, identified disease, dementia and with anxiety. In Data Set (MDS), dated 1 had severely impaired attention and disorganized attention and disorganized attention and disorganized attention and disorganized attention and confirmed A to 6 days, but less assessment period. This ocumented on R71's plan of 6/4/15, at 10:01 a.m., B verified the care plan did was incontinent of urine and	F	312				

STATEMENT	OF DEFICIENCIES	I	- ₁				OMB N	<u> 0938-0391</u>	
AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245394	B. WING				06	/04/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNI SLIMMARY ST		ID	471	REET ADDRESS, CITY, STATE, ZIP CODE Lynnhurst avenue west Int Paul, Mn 55104		- 00	104/2013	
PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	: TE	(X5) COMPLETION DATE	
	member (F)-A indicated bedroom and person long time. F-A stated urine." F-A expressed concern that the staff care. F-A stated, "At be expected to figure [R71] so that [R71] reneeds." Furthermore, dissatisfaction with the care for R71 and stated nails in October becated [R71] refused, it took what point should the provide care?" When interviewed on director of nursing very specific policy regarding who have refused care expectation would be as soon as possible for another staff person we for the resident. On 6/1/15 at 6:20 p.m. interview R57, several and the chin area applong, were observed. It communicate needs we grooming preferences On 6/2/15 at 10:20 a.m. still have numerous factors.	ied the urine smell in R71's had been going on a very "Who wants to smell like difurther frustration and itell F-A that R71 refuses what point should the staff out how to provide care for aceives the care [R71] F-A expressed e staff for not providing nailed, "I trimmed those toe use the staff kept saying me an hour and a half. At staff figure out how to 6/4/15 at 1:00 p.m., the iffied there was not a ng re-approaching residents e. The DON validated the for staff to provide the care or the resident or find who could provide the care or the resident of find staff inch R57 was unable to when queried regarding in., R57 was observed to cial hairs.	F	312					
1	facility on 10/17/14, an included bipolar disord	d had diagnoses, which							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA	(2/0) 1411	CONSTRUCTION	OMB N	<u>10. 0938-0391</u>	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILD	ING _	CON	MPLETED	
		245394	B. WING			.	610.410.04 F
NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	6/04/2015
GOLDEN	LIVINGCENTER - LYNNH	IIIPST			71 LYNNHURST AVENUE WEST		
					AINT PAUL, MN 55104		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	- 1	(EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION
		·	1/40	'	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 312	minaga i rom page		F	312			
	dementia w/behavior	disturbances and					
	dysphagia. Medication	n that included Klonopin,					
	Sinemet, and Clozapi	ne.					
	R57's quarterly Minim	um Data Set (MDS) dated					
	4/21/15, identified R5	7 required extensive assist					
	with bed mobility, tran	sfers, dressing, toileting and					
	personal hygiene nee	ds. In addition, R57 required					
	total assist with bathin	ig activity.					
	The care plan dated	11/6/14, identified R57 had					
	physical functional def	ficits of self-care impairment					
	and directed staff, "I w	vill maintain or improve my					
	current level of physic	al functioning. Interventions:					
	Personal Hygiene/Gro	oming: extensive					
	assistance of one"						
	During interview with r	nursing assistant (NA) - B					
	on 6/3/15 at 8:13 a.m.,	NA-B verified that R57					
	was unshaven and exp	plained being busy and not					
	having a chance to sha	ave R57.					
	During interview with a	lirector of nursing (DON) on					
	6/3/15 at 9:07 a.m., DO	ON stated that shaving					
	facial hair was part of p	personal grooming.					
	During interview with re	egistered nurse (RN) - B on					
	6/3/15 at 12:06 p.m., R	N-B indicated the					
	that shaving was consi	iff to follow the care plan,					
	grooming and R57's ca	re plan addressed this					1
	Policy and procedure ti	Ited shaving the resident					
	uated 1/26/15, reads, "	To remove facial hair and					
	inhiove the resident's	appearance and morale."					
	Policy and procedure tit	tled, shaving the resident					
	dated 1/26/15, directed	staff, "Care plan					
(documentation guidelin	es Problem: Identify the					

OTATEMENT OF PERSONNELLAND SERVICES				OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	B. WING_		06/04/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST		URST		STREET ADDRESS, CITY, STATE, ZIP COI 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	DE
(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 CO	ON SHOULD BE COMPLETION E APPROPRIATE DATE
	appropriate problem to as an approach. Consum and complications. Go to be accomplished. Last responsible disciplinatructions unique to monitoring and observed and procedure dated July 2012, directors and procedure dated July 2012, directors and must describe the furnished to attain or include measurable of and must describe the furnished to attain or inhighest practicable phesychosocial well-being reviewed and revised services provided or a with each resident's resident who enters the indwelling catheter is resident's clinical condicatheterization was newho is incontinent of bit reatment and services infections and to restor function as possible.	ander which to list shaving sider listing possible risks pal: List measurable goal(s) ist target date. Approaches: pline for each approach. list this resident. list necessary vation of the underlying late preventive skin care." for RAI and care planning sted staff, "As required at 42 prehensive care plan is an aunication tool. It must plectives and time frames a services that are to be maintain the resident's sysical, mental, and lag. The care plan must be periodically, and the rranged must be consistent ritten plan of care." TER, PREVENT UTI,	F 31	F315 Resident 27, 71 toileting/incontinence have been reviewed as indicated All resident with inconneeds have the poter affected. Documented education	and revised ntinent ntial to be on of staff continence and to ing when a e in n. nplete s that cares r cares per s will be

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES			OMB	VO. 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245394	B. WING _			S/04/204E	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNI	HURST		STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		6/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	ΠΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 315	Based on observation review, the facility fail (R27) who was ident received the necessary manage incontinent end id not receive a toile having incontinent end in the findings includes: R27's quarterly minimally 3/20/15, was reviewed score as 15 (congnitive identified that R27 recone with transfers, drawing in the first property	on, interview and document led to ensure 1 of 1 resident iffied as incontinent of urine, ary care and services to e and 1 of 1 resident (R71) eting plan when assessed as pisodes. The MDS dated d and identified R27's BIMS vely intact). The MDS quired extensive assist of essing, toileting, personal ist of one with bathing ing needs addressed R27 as intinent with bladder and	F3	15			
	p.m., a strong odor of R27's room. R27 was bed, soaked with urinand pants. R27 expreand anxious because explained the call ligh person came into the being busy and would cover wet clothes while At 5:14 p.m., licensed and nursing assistant R27's incontinent situater would be addressed.	t had been put on, a staff room and informed R27 of be back. R27 attempted to le conversing with surveyor. practical nurse (LPN)-C (NA)-C, was informed of ation and both indicated the lessed.					

SERVICES				OMB I	NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		245394	B. WING_			06/04/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST		STREET ADDRESS, CITY, STATE, ZIP (471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	CODE	070472013
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 315	Continued From page	23	F3	315		
	(CAA) dated 1/8/15, ic extensive assist with caddition, the urinary ir catheter CAA dated 1/8 frequently incontinent toileting, changing and incontinent episodes. R27's care plan, review 3/3/15, revealed, " toileting, transfers on/o Occasional incontinen without pattern. Symptobes not wear incontine without pattern. Symptobes not wear incontine request assist with changiene PRN. Goals: I level of urinary contine with clothing and peric	wed by the facility on limited assist of staff with off toilet PRN (as needed). ce of bowel and bladder toms of urge incontinence. nence products. Able to anging soiled clothing and will maintain my current ence. Interventions: Assist are PRN. Changes in color, furine, dysuria, frequency.				
	on 6/2/15 at 3:25 p.m., expectation for answer staff see a resident's care	ing call lights is that when all light on, it should be aff person cannot assist the level of care, the staff				
	on 6/3/15 at 12:16 p.m.	n registered nurse (RN)-B , RN-B's expectation was ight on to be toileted R27, sist R27 to the toilet.				
•	The facility Policy and F	Procedure titled				

STATEMENT	OF DEFICIENCIES	(X4) PROMESTICATION				OM	IB NO. 0938-0391	
AND PLAN OF CORRECTION (A1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245394	B. WING					
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST			•	471	EET ADDRESS, CITY, STATE, ZIP CODE LYNNHURST AVENUE WEST NT PAUL, MN 55104		06/04/2015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF CORRECTIO IX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 315	incontinence care, da "Procedure purpose: of irritation and odor, soon as possible so t		F3	315				
	1/19/15, reads, "Prev pressure areas and e morale of the residen dignity Manage urinal maintain as much nor possible. Observe and	function guideline dated ent skin problems such as xcoriation Improve the t Restore the resident's ry incontinence, restore or mal bladder function as d record the resident's evise the toileting scheduled						
	was sitting on the side odor of urine was dete person. During an interview on	6/2/15, at 10:26 a.m., R71 of the bed and a strong acted coming from R71's						
	was not aware of a boodetected any body odd room. R71 commented stink." The active diagnoses frecord (eMR) face shee	dy odor when asked if R71 or urine type odors in the d of being informed, "You rom the electronic medical et dated 6/3/15, indicated						
6	R71 had Alzheimer's d adjustment disorder wit R71's annual Minimum	isease, dementia and th anxiety. Data Set (MDS) dated						

	OF DEFICIENCIES F CORRECTION			MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING				V0.4/0.4.5	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	IURST		471	REET ADDRESS, CITY, STATE, ZIP CODE LYNNHURST AVENUE WEST INT PAUL, MN 55104	1 06	6/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	cognitive skills with in thinking. Furthermore indicated rejection of but less than daily dure R71's plan of care dat as being continent of on bathroom floor and dementia. Supervision toileting. The MDS bladder assidentified R71 was free (7 or more episodes of at least one episodes of at least one episode of Furthermore, the MDS toileting program (schevoiding, or bladder traisince urinary incontine facility. When interviewed on 6 registered nurse (RN)-not address R71 as incontine address refusal of thought R71 was continued as a urine odor in the sometimes R71 has begone as long as 2 mon refusing to take a bath toileting plan had not be because RN-B thought urine. RN-B verified the was not assessed.	1 had severely impaired attention and disorganized, the MDS dated 4/17/15, care occurred 4 to 6 days, ring the assessment period. Ited 2/12/15, identified R71 bowel and bladder. Urinates in heating vents due to n/set up only provided with essment dated 4/17/15, quently incontinent of urine f urinary incontinence, but if continent voiding. Sindicated no trial of a eduled toileting, prompted ining) had been attempted ence was noted in this essentially and care interventions. RN-B nent of urine, realized there a room and explained that body odor because R71 has of this without a bath due to or shower. RN-B verified a een developed for R71 are room and explainent of evoiding pattern for R71	F	315				
1	member (F)-A indicated bedroom and person h	/4/15, at 11:30 a.m., family d the urine smell in R71's ad been going on a very Who wants to smell like						

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING _		06/04/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	IURST ATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 315	urine." F-A expressed concern that the staff F-A stated, "At what p	I further frustration and tell him R71 refuses care. point should the staff be thow to provide care for	F 3	15		
	director of nursing state policy regarding re-aperefuse care. The DON expectation would be as soon as possible for another staff person of for the resident. 483.25(I) DRUG REGUNNECESSARY DRUE Each resident's drug runnecessary drugs. Adrug when used in exception of the resident of the resident, the facility may be a compreheresident, the facility may be a compreheresident, the facility may be a diagnosed and doctrecord; and residents of the resident of the	IMEN IS FREE FROM JGS egimen must be free from an unnecessary drug is any cessive dose (including for excessive duration; or itoring; or without adequate or in the presence of s which indicate the dose discontinued; or any asons above. Insive assessment of a just ensure that residents tipsychotic drugs are not less antipsychotic drug or treat a specific condition umented in the clinical who use antipsychotic dose reductions, and	F 32	 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 affect 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 	ted d. g s	

		MEDICAID SERVICES				OMB I	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245394	B. WING				6/04/2015
	PROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page drugs.	2 7	FS	329			
	by: Based on interview a facility failed to ensure	is not met as evidenced nd document review, the e 1 of 5 (R19) resident's d pharmacological and nterventions for pain.					
	Findings include:						
	diagnoses that include disease, anxiety disore	he facility on 4/16/15 with ed chronic ischemic heart der, osteoarthrosis, europathy, and polymyalgia					
	hours for general oster 2. morphine solution, 2 mg orally three times properties of 10:00 p.m. for pain, 3. MS Contin (morphin 15 mg, administer 1 tat 7:00 a.m., 1:00 p.m., 9: 4. Gabapentin (neurotir twice a day for idiopath 5. Acetaminophen 325 every four hours for path maximum acetaminophen such services of the ser	mg/5ml, solution ally as needed every four parthrosis. 20 mg/5ml, administer 20 per day at 8:00, 2:00 p.m., e) table extended release, blet three times per day at 00 p.m. for pain, nin) capsule, 400 mg orally a peripheral neuropathy. mg tablet orally as needed in/fever, take 1-2 tablets, nen: 4 GM (grams)/24					
	Currently the resident v	vas receiving:					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06/04/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH			STREET ADDRESS, CITY, STATE 471 LYNNHURST AVENUE WE SAINT PAUL, MN 55104		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI D TO THE APPROPRIA ICIENCY)		
F 329	every four hours as n Check to see if give 6 4 gm every 24 hours. 2. acetaminophen tab 4 hours as needed fo see if give 325 mg firs hours. 3. Gabapentin capsul day related to neurop 4. MS Contin tablet ex 15 mg orally twice a continuous The current care plan reviewed. There was pain or for being at ris On 6/4/15 at 11:11 a. (RN)-C reviewed the	plet: give 325 mg orally eeded for pain or fever. 350 mg first. Maximum dose blet give 650 mg orally every r pain or fever., Check to st, maximum dose 4 gm /24 e give 400 mg orally twice a athy extended release 15 mg give day for pain. , dated 4/21/15 was no focus goal for having	F	F431 • Med room refri being maintain temperatures. • All residents refrigerated me	gerators are ed at proper eceiving	the	
F 431 SS=E	483.60(b), (d), (e) DR LABEL/STORE DRUCT The facility must empty a licensed pharmacist of records of receipt a controlled drugs in suraccurate reconciliation records are in order a controlled drugs is mareconciled.	doy or obtain the services of who establishes a system and disposition of all efficient detail to enable an an account of all wintained and periodically used in the facility must be with currently accepted and cautionary	F4	potential to be Temperature s placed on med refrigerators. L have been edu temps and doc proper ranges. DNS/designee random weekly temps. Results of thes reviewed at the meeting for fur recommendation Completion day 2015	chedule has been and incensed staff incensed staff incented on taking to complete and audits of fridgue audits will be a facility QA ther on.	g d	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DAT	FE SURVEY MPLETED
		245394	B. WING	-		00	6/04/2015
	ROVIDER OR SUPPLIER	URST		471	EET ADDRESS, CITY, STATE, ZIP CODE LYNNHURST AVENUE WEST INT PAUL, MN 55104	1 00	0/04/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	applicable. In accordance with St facility must store all clocked compartments controls, and permit of have access to the ke. The facility must provipermanently affixed controlled drugs listed Comprehensive Drug Control Act of 1976 ar abuse, except when the package drug distribution.	ate and Federal laws, the drugs and biologicals in under proper temperature nly authorized personnel to ys. de separately locked, compartments for storage of in Schedule II of the	F	431			
	by: Based on observatior interview, the facility d temperature controls f in 2 of 2 medication ro the potential to affect t who used insulin, Tube Xalatan eye drops, and Findings include: During observation of troom refrigerator, at 3: thermometer inside the degrees Fahrenheit. T shown to licensed practices and the stated, "It is in the	or refrigerated medications oms reviewed, which had the residents in the facility erculin testing solution, d influenza vaccine. The first floor medication 26 p.m. on 6/2/15, the erefrigerator read 28					

STATEMENT	OF DEFICIENCIES	I		-		OMB N	<u>10. 0938-0391</u>
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		245394	B. WING			١ ,	6/04/2015
	PROVIDER OR SUPPLIER	HURST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		0/04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	on 5/31/15, and no rebeen recorded since contained Tuberculin solution opened 5/19/two separate resident emergency kit, two Fl of Humulin regular insuppositories. The inresidents. The heading temperature log read, (Acceptable range of Immediately following manager for the first fit temperature in the measked if anyone in the the temperature and it process in place to costated that she would During observation of in the second floor meon 6/2/15, the thermoread 32 degrees Fahrowas immediately show supervisor. The nurse floor was shown the themedication refrigerator lup? The temp control way up." The medication refrigerator lay up. The medication refrigerator also control way up. The medication refrigerator also control refri	in this medication as 32 degrees Fahrenheit efrigerator temperatures had that date. This refrigerator purified protein testing /15, Xalatan eye drops for ts, gentamicin liquid for the exTouch insulin pens, a vial sulin, and bisacodyl sulins were for two separate ng on the refrigerator "Refrigerator (med) 36-46*F)." this observation, the nurse cloor was notified of the edication refrigerator and e facility had been notified of f there was a work order or rrect the situation. She check. the medication refrigerator edication room, at 3:42 p.m. meter inside the refrigerator enheit. The thermometer on to the nearby nursing e manager for the second elermometer inside the r, and while he was looking the stated, "Who turned this in here is turned all the ion refrigerator contained fluenza vaccine, ten doses iration date of June 2015. Contained Tuberculin solution, insulin pens, and	F	431			

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		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245394	B. WING		06	6/04/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNH (X4) ID SUMMARY ST.	IURST ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 PROVIDER'S PLAN OF COR			
PREFIX (EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION COROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
manager for first floor destroy any of the me medication refrigerate destroyed and ordere Tuberculin. She also find a work order or destroyed on the refrigerate the first floor medication. During interview at 2: nurse manager for the he needed to destroy the second floor medicated that he threw a room refrigerator, excessuppositories, and ordered to temperature controls in medication refrigerato temperature on 6/3/15. A surveyor requested policies and procedure maintenance of the medication refrigerator temperatures 6/4/15 at 483.65 INFECTION CESPREAD, LINENS The facility must establinfection Control Prografe, sanitary and comto help prevent the devordisease and infection (a) Infection Control Programs and infection Control Programs	45 a.m. on 6/3/15, the nurse was asked if she needed to edications in the first floor or, and she stated that she do new insulins and new stated that she could not ocumentation for resolving rature that had been lerator temperature log in on room. 200 p.m. on 06/03/2015, the esecond floor was asked if any of the medications in cation refrigerator, and he way everything in the med lept the bisacodyl dered new meds and that he adjusted the in the second floor or, checked the refrigerator of and it was 40 degrees. Of the director of nursing less regarding the ledication refrigerator and none was provided. ONTROL, PREVENT	F 4	 Staff have been eductinfection control with exegarding the cleaning bodily fluids, water distunit and cleaning rout All residents have the to be effected if infect measures are not follow. Staff have been eductinfection control measured including cleaning up hazardous waster uring emesis, etc. Houseke staff have been educated bathroom cleaning, pacileaning, and compleaders in a staff and compleaders. 	emphasis g up of spensing tines. e potential cion control owed. ated on sures of ne, blood, eeping ated on atient room te room ems, cedures onsible ts will be y QA		

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06/04/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNI	HURST		47	REET ADDRESS, CITY, STATE, ZIP CODE 1 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	1 0	0/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what proshould be applied to (3) Maintains a record actions related to infection for the control of the control	rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection Control Program ident needs isolation to infection, the facility must erohibit employees with a se or infected skin lesions the residents or their food, if ismit the disease. Equire staff to wash their ct resident contact for which atted by accepted	F	441			
	by: Based on observatior review, the facility faile control practices durin prevent cross contami process. This had the who came into contact potential to affect the	is not met as evidenced a, interview and document ed to use standard infection g floor sanitation and to nation during the clean up potential to affect residents with the urine spill and residents who shared one sidents who resided in the					

OLIVILI	OT ON WEDICARE &	WEDICAID SERVICES			OMB	NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245394	B. WING _			06/04/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST		STREET ADDRESS, CITY, STATE, ZIP 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	(H)-A a puddle of urinin the dining room. Thinch puddle according floor tiles. H-A proceed using a microfiber 4 in non-absorbent mop. The absorb and H-A spread by 60 inch area. Then micro fiber mopping so thousekeeping cart in the wetness out to the car removed the micro stream base and put the micro H-A removed the contagoing to take the house storage area. Surveyon H-A what was the processills. When interviewed on 6 was not sure of the cleich but stated, "The solution."	a on 6/1/15, at 5:28, a -A informed housekeeper e needed to be cleaned up ere was a 12 inch by 15 to the 12 inch by 12 inch eded to clean up the urine tich by 15 inch thin There was too much urine to d the wetness out to a 60 the hellway, dripped t and using a gloved hand ip mop from the Velcro o mop into a plastic bag, aminated gloves and was ekeeping cart back to the r intervened and asked the cedure for cleaning up urine 6/1/15, at 5:35 p.m. H-A teaning procedure for urine on the facility uses starts to	F	141			
	the mop dripped the un and now the area cont the hallway where the along the north wall. H handwashing after rem mop with the gloves be	noving the urine saturated ecause H-A thought the on. H-A agreed the area with a new mop.					

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245394 B. WING 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 34 F 441 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

		T TOTAL OLIVIOLO				OWR V	<u>10. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	B. WING _		-	0	6/04/2015
NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVINGCENTER - LYNN	UU DOT			LYNNHURST AVENUE WEST		
GOLDEN	LIVINGCENTER - LYNN	IHURSI			NT PAUL, MN 55104		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From page 35		F4	141			
		ored on the floor next to the	•	` ' '			
	toilet. There was a u	urine odor to this toilet seat.					
	There was a resider	nt care basin on the floor on					
		toile and a used toothbrush					
	and a partial tube of	toothpaste on the shelf					
	above the sink.	,					
	When interviewed o	n 6/3/15, at 1:58 p.m.,					
	nursing assistant (N	A)-A and the DON both					
	verified they did not	think any of the 4 residents					
	were using the eleva	ated toilet seat and validated					
	the tollet seat needs	ed to be cleaned and removed					
	hasin was not to be	and the DON validated the					
	hathroom and the to	stored on the floor in the otherwish and tooth paste was					
	not to be left on the	sink shelf, not knowing who it					
	belonged to, NA-A a	and the DON verified the					
	standard for infection	n control was breached.					
	The facility did not h	ave a policy or procedure for					
	storage of resident care items in the bathroom.						
	During an observation	on of H-B cleaning the					
	bathroom, shared by	4 residents in rooms 114			·		
	and 116, on 6/3/15, a	at 2:15 p.m., H-B used a		.			
	microfiber cloth to wi	pe off the toilet after spraying					
	a solution on the toil	et. H-B cleaned from the					
		im of the toilet out and down					
	the less contaminate	d base of the toilet.					
	When interviewed or	n 6/3/15, at 2:18 p.m., H-B					
	indicated being finish	ned cleaning the bathroom					
	and took the spray be	ottle and cloth supplies to					
	leave the room. Whe	n questioned about the					
	raised toilet seat beir	ng on the floor, the basin on			•	İ	
	the floor, and what al	bout cleaning of the sink and					
	moor H-B indicated di	fficulty understanding				1	
	Linguish and would ge	et the supervisor. H-A verified					
	n-B nad difficulty with	n English and the company		1		I	1

0747514515		T DIONID OLIVIOLS			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245394	B. WING		06/04/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2013
COLDEN	1 IV/INOCENTED INC.			471 LYNNHURST AVENUE WEST	
GOLDEN	LIVINGCENTER - LYNN	HURST		SAINT PAUL, MN 55104	*
(X4) ID	STIMMADY C	FATEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 441	o o numbed i form pag	e 36 te the cleaning practice of	F 44	1	
	According to H-A the cleaning routine writt expectation would be mirror, sink, toilet and H-A verified a strong bathroom. 483.70(h) SAFE/FUNCTIONAL E ENVIRON The facility must provisanitary, and comfort residents, staff and the same and the staff and the same and	en at this time, but the a to wash and sanitize the dibathroom floor each day, urine smell remained in the dibathroom floor each day, urine smell remained in the dibathroom floor each day, urine smell remained in the dibathroom floor each day, urine smell remained in the dibathroom floor each floor	F 465	F465 Residents #11, 16 and 20 wheelchairs have been clear and worn areas replaced. Repairs in rooms 112, 114, 202, 203, 218 have been completed. Building ventilar system has been assessed repairs begun by licensed HVAC company. Resident rooms have been inspected repairs completed as needer and repairs completed as needer epairs completed as needer and and safe environme. Staff to be educated on system to identify as needing repair. Random weekly audits of 2 rooms per week to ensure an 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.	200, tion and and d. tial I a ent. em
	wheelchair stank. No	odor was noticeable at that of R16 had a brown clump		recommendation. • Completion date is July 14, 2015.	

AND PLAN	o. comeonon	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING				
NAME OF	PROVIDER OR SUPPLIER		J. WING		TREET ADDRESS, CITY, STATE, ZIP CODE		06/04/2015
GOLDE	N LIVINGCENTER - LYNNH			471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 465	of matter on a left low the back of the wheele cracked and peeling. The first floor tub room when the vent in that if function by the mainted being drawn through the air conditioner in room unpainted and rough stoceiling in room 114 compeeling paint. The grossame bathroom was dipaint on the lower door rough with a rust-color register under the wind covering the entire sur window in room 200 was a dark the covering the entire sur window in room 200 had on the back support seguiged on the wall betwindow. There was a larea on the ceiling near room 202. The window were partially detached wall near the air condition contained a large unpainted and at the had difficulty compainting tasks in the fact could not be in the room done and at times the retter work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the work to be done or the service of the service of the work to be done or the service of t	chair of R20 was heavily In had a stale odor and room was checked for mance director, no air was he vent. The wall near the state of surface. The bathroom maintained large areas of out around the toilet in that ark and rough, and the reframe was peeling and led material. The heat dow and behind the bed in prown color with drip marks face. The chair near the large blue drip mark loction and the paint was mind the bed near the large unpainted and rough or the air conditioner in vocurtains in room 203. If from the curtain rod. The oner in room 218 inted, white, and rough one the curtain plaster and sility because residents on when some tasks are	F	465			
F 520	being done. 483.75(o)(1) QAA	gee dio work is	F 52	0			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	USURVEY
		is a vivial vivi	A. BUILDI	NG _		COM	PLETED
NAME OF B	DOI 10 D D D D D D D D D D D D D D D D D D	245394	B. WING			06	/04/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	IURST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
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F 520 SS=F	COMMITTEE-MEMB QUARTERLY/PLANS A facility must mainta assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activiti develops and impleme action to correct ident A State or the Secret disclosure of the reco except insofar as such compliance of such co requirements of this so	in a quality assessment and a consisting of the director of hysician designated by the other members of the east quarterly to identify which quality assessment less are necessary; and ents appropriate plans of iffed quality deficiencies. ary may not require rds of such committee in disclosure is related to the committee with the	F	520	 F520 QAPI meetings are schedul quarterly for the year. All residents have the potento be effected if QAPI meetinot conducted quarterly to furthrough on areas of concernstant Staff have been educated of QAPI requirements. Quarterly audit of QAPI meetinutes. ED/designee is responsible Results of these audits will reviewed at the facility QA meeting for further recommendation. Completion date is July 14, 2015. 	ntial ng is ollow n. n	
	by: Based on interview ar facility failed to develo areas of concern, relai residents, cleanliness infection control practi with and revisted at Qu	ted to cleanliness of of environment, odors and ces were followed through uality Assessment and ment (QAPI) meetings and the QAPI meetings					

STATEMEN	T OF DEFICIENCIES	(X4) PROMPER PROMPER	<u> </u>			OMB	NO. 0938-03	9
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) E	OATE SURVEY OMPLETED	<u>-</u>
		245394	B. WING					
ĺ	PROVIDER OR SUPPLIER I LIVINGCENTER - LYNNH	HURST	<u> </u>	.	STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		06/04/2015	
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	affect all residents where a status of the action plan was or what DON explained being improvement, as area status of the action plan was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unsuprior to that time. The Dongoing issues of direct bathing, grooming etc., identified in February and was unaware of why the ongoing addressed in the QAPI occuld not recall what hall and way.	pram lacked a process for invernent activities and action tified areas of concern and infection control. I.m., the director of nursing of the QAPI committee, equality issues identified, of residents, environment concerns. The DON of odors and cleanliness of a this was brought forth in the QAPI meetings. The concern as, "direct patient as, grooming etc., as to work on and the news identified as being, N did not identify what the transport of the current position since are what had happened don stated that the transport patient care, dressing, improvement, had been and March and a plan was April the same issues concern. The DON was loing issues had not been committee in April and dispendent of the process of the committee in April and dispendent of the committee in	F	520				
	was also noted that a	QAPI meeting had been						

STATEMENT	OF DEFICIENCIES	(X4) PROVIDED (VICES				OMB NO. 0938-039	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245394	B. WING				
GOLDEN	PROVIDER OR SUPPLIER I LIVINGCENTER - LYNNH			STR 471	REET ADDRESS, CITY, STATE, ZIP CODE LYNNHURST AVENUE WEST INT PAUL, MN 55104		06/04/2015
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F 520	held in September 20 in December. When ir p.m., the administrato to held quarterly and thad been missed.	14 but no meeting was held nterviewed on 6/4/15 at 2:00 r identified the meetings are that the December meeting	F	520	DEFICIENCY)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5394023 PRINTED: 06/22/2015 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245394 B WING 06/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 | INITIAL COMMENTS K 000 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. -7 2015PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION **HEALTH CARE FIRE INSPECTIONS** STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE EXECUTIVE DIRECTOR JULY 2, 2015

Any deliciency statement ending with an asteriek (*) 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 program participation.

L CENTED	S FUR WEDICARE &	VEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06	/03/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
GOLDEN	LIVINGCENTER - LYNNH	URST			71 LYNNHURST AVENUE WEST		
				9	SAINT PAUL, MN 56104		
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K 000	Continued From page	11	к	000			
	Marian.Whitney@stat Angela.Kappenman@						
	THE PLAN OF CORE DEFICIENCY MUST I FOLLOWING INFORI	NCLUDE ALL OF THE					
	A description of whom to correct the deficient	at has been, or will be, done cy.					- the second sec
	2. The actual, or prope	osed, completion date.					
	The name and/or till responsible for correct prevent a reoccurrence	tion and monitoring to					
	constructed at 2 differ building was construct determined to be of Ty 1967, an addition was northeast and was det	pasement. The building was entitimes. The original ed in 1962 and was the II (222) construction. In constructed to the ermined to be of Type					
	II(222) construction, Band the 1 addition mee allowed for existing but surveyed as one buildi	ecause the original building at the construction type ildings, the facility was ng.					
	with smoke detection li open to the corridors to automatic fire departm	has a fire alarm system the corridors and spaces					
	The requirement at 42	CFR, Subpart 483.70(a) is					

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

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245394	B. WING		, n	3/03/2015
1	ROVIDER OR SUPPLIER LIVINGCENTER - LYNNH	URST		STREET ADDRESS, CITY, STATE, ZIP COD 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 65104		¥03/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE	(XS) COMPLETION DATE
K 000 K 018 SS=D	NOT MET as evidence NFPA 101 LIFE SAFE Doors protecting corrivered enclosures on hazardous areas are stitused constructed of 1 wood, or capable of reminutes. Doors in spring required to resist the provided with a methodoor closed. Duto are permitted. 19.3.	ed by: ETY CODE STANDARD dor openings in other than f vertical openings, exits, or substantial doors, such as % inch solid-bonded core esisting fire for at least 20 inklered buildings are only bassage of smoke. There is closing of the doors. Doors eans suitable for keeping h doors meeting 19.3.6.3.6 6.3		000 O18 KO18 Two 3/8 inch penetrat filled on June 12th with barrier caulk. Maintenance Director responsible	tions were	
	did not have a comidor requirements of NFPA 19.3.6.3.2. This deficient safety of the residents compartment. Findings include: On facility tour between on 06/03/2015, it was o	and interview, the facility door that meets the 101 LSC (00) Section In practice could affect the				

	TO LOCK DICTION OF DE	MEDIONIO GENVICES				OMP IN	J. UBSB-USBT
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01		SURVEY PLETED
		245394	D. WING		And the date of the control of the specific of	06	/03/2015
	ROVIDER OR SUPPLIER	URST		47	rreet address, city, state, zip code 71 Lynnhurst avenue west Aint Paul, MN 56104		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
K 018 K 050 SS=C	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. 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.			050	K050 monthly schedule created w fire drills scheduled for all stonce per quarter quarterly audit of fire drill documentation		
	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			• ED/designee is responsible COMPLETED 6/13/15		,	
	Based on review of re interview,, it was deter to conduct fire drills in LSC (00) Section 19.7	ot met as evidenced by: ports, records and mined that the facility failed accordance with NFPA 101 .1.2. This deficient practice react in the event of a fire.			0/13/13		
	Findings include:						
	on 06/03/2015, based documentation it was r no documentation for f 1) during the Night shi and 3rd quarter 2014.	eveled that the facility had					

PRINTED: 06/22/2015 FORMAPPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245394 B. WING 06/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST SAINT PAUL, MN 65104 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 050 Continued From page 4 K 050 This deficiency was verified by the facility Maintenance Director (JB) at the time of discovery.



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 <u>only a suggestion</u> 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.

Golden Livingcenter - Lynnhurst June 22, 2015 Page 2

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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING:_ 00945 B. WING 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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 Minnesota Department of Health is Department's staff, visited the above provider and documenting the State Licensing the following correction orders are issued. When Correction Orders using federal software. corrections are completed, please sign and date, Tag numbers have been assigned to make a copy of these orders and return the Minnesota state statutes/rules for Nursing original to: Homes. Minnesota Department of Health

LABORATORY DIRECTOR'S OF RROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE OIR SECTOR 10 STATE FORM

(X8) DATE

LABORATORY DIRECTOR'S OF RROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE OIR SECTOR 11 (X8) DATE

LABORATORY DIRECTOR'S OF RROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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LABORATORY DIRECTOR'S OF RROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE OIR SECTOR 11 (X8) DATE

LABORATORY DIRECTOR 12 (X8) DATE

LABORATOR 12 (X8) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		00945	B. WING		06/04/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
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GOLDEN	I LIVINGCENTER - LY	SAINT PA	AUL, MN 551	104	
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2 000	Continued From pa	age 1	2 000		
2 000	Minnesota Departm	nent of Health, Health , Licensing and Certification		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficient column and replaces the "To Comportion of the correction order. To column also includes the finding are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Metho Correction and the Time Period Forection.	Tag." If the atute/rule cies" Inply" Ithis s which after the as veyors at of
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES OF THE STATES OF THE STATES OF THE SUBMIT A PLAN OF CORRECTION OF THE SUBMIT A PLAN OF CORRECTION OF THE SUBMIT A PLAN OF THE SUBMIT A P	F FO . THIS FO ON FOR
2 255	MN Rule 4658.0070 Assurance Commit	0 Quality Assessment and tee	2 255		
	assessment and as of the administrator services, the medic designated by the n three other membe representing discipl	ust maintain a quality surance committee consisting the director of nursing that director or other physician medical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and			

Minnesota Department of Health

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 255 Continued From page 2 2 2 5 5 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 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

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(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

(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

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2 255	care, dressing, bath improvement", as a status of the action "in progress." The laction plan was or vertical DON explained being February and was uprior to that time. The ongoing issues of deathing, grooming elidentified in February formulated, however were not identified a unaware of why the addressed in the Quantification.	-	2 255			
	held in September 2 in December. Wher p.m., the administra	at a QAPI meeting had been 2014 but no meeting was held interviewed on 6/4/15 at 2:00 tor identified the meetings are d that the December meeting				
	A policy and proced however was not pro	ure for QAPI was requested, ovided.				
· .	The administrator at could assure that Q Performance Improved quarterly and that at analyzed, improvemmonitored to assure	HOD OF CORRECTION: nd the director of nursing uality Assessment and vement meetings are held reas of concern are identified, nent plans developed and residents are provided at the environment in which				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
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2 255	Continued From pa	ge 4	2 255		
	administrator, direc could also train staf assure residents ar and odor free and the	clean, free from odors. The tor of nursing and/or designee if approprate approaches to e clean, environment is clean that staff use appropriate the risk			
2 302	(21) days.	R CORRECTION: Twenty one 44.6503 Alzheimer's disease	2 302		
2 002	or related disorder t		2 302	·	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.				
	Alzheimer's disease or related d segregated or gene care staff	ity serves persons with lisorders, whether in a ral unit, the facility's direct rs must be trained in dementia		·	
	related disorders; (2) assistance with a (3) problem solving and (4) communication s (c) The facility shall written or electronic	of Alzheimer's disease and activities of daily living; with challenging behaviors;			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		SURVEY
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2 302	Continued From pa	ge 5	2 302			
	trained, the frequen topics covered.	document compliance with				
	by: Based on interview facility failed to prov nursing facility staff Alzheimer's Disease affect 16 of 16 pers Alzheimer's Disease	and document review the vided required training for who serve persons with e. The had to potential to ons with the diagnoses of e.				
	Findings included:					
	administrator provid newly hired staff had training. The following staff v	kimately 9:00 a.m. the led a breakdown of what d attended alzheimer's were hired within the 12 receive the required training:				
	and Licensed Pract 8/12/14. Certified N hired on 3/26/15, CI CNA -G was hired 4 4/28/15. The Activit to work as a social s 2nd floor of the faci not have the require training upon hire. On 6/4/15 at approx	(RN)-G was hired on 8/12/14, tical Nurse (LPN)-E was hired lursing Assistant (CNA)-E was NA-F was hired 12/19/14, 1/28/14, and CNA-H was hired by Director, currently assigned service representative on the fility was hired 5/19/14 and did and Alzheimer's Disease				
	verified these finding	he director of nursing (DON) gs. The DON indicated there and recent new hires have				

Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00945	B. WING		06/0	04/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHURST	HURST AVE UL, MN 551			
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2 302	Continued From pa	ge 6	2 302			
	had the required tra	aining.				
	The director of nur required training is	THOD OF CORRECTION: sing could assure that the provided for nursing facility sons with Alzheimer's				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				,
2 540	MN Rule 4658.0400 Resident Assessme	O Subp. 1 & 2 Comprehensive ent	2 540			
	conduct a compreh resident's needs, w capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive resused to develop, recomprehensive plant 4658.0405. Subp. 2. Information comprehensive resinclude at least the A. medically designed.	ment. A nursing home must ensive assessment of each hich describes the resident's n daily life functions and ents in functional capacity. A at conducted according to , section 148.171, subdivision s part of the comprehensive nt. The results of the ident assessment must be view, and revise the resident's n of care as defined in part attention gathered. The ident assessment must following information: fined conditions and prior				
	C. physical andD. sensory and	us measurement; I mental functional status; physical impairments; atus and requirements;				

PRINTED: 07/09/2015 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 540 2 540 Continued From page 7 F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; 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 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

R62 did not have a comprehensive assessment

department had not been completed.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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2 540	Continued From pa	ge 8		2 540			
	for activities.						
	observed attending 6/3/15 at 10:20 a.m second floor dining	f the survey R62 was any recreational activ ., activities were held area, however, R62 v ked R62 about attend	vities. On on the vas in	- 14			
	family member (F)-	rview on 6/2/15, at 12 M indicated R62 loved 62 did not attend enou	i t				·
		dical record on 6/4/15 rehensive assessmen es.					
		ne Director of Activities ve assessment had n					
	The director of nurs develop and ipleme related to assessme or designee, could part staff related to the of the quality assessment.	ETHOD FOR CORRE sing (DON) or designe ent policies and proced ents for residents. The provide training for all completion of assessing ment and assusrance erform random audits to	e, could dures e DON nursing nents.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twe	enty one				

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ 00945 B. WING 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 565 Continued From page 9 2 565 2 565 MN Rule 4658.0405 Subp. 3 Comprehensive 2 565 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 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

During interview with nursing assistant (NA) - B on 6/3/15 at 8:13 a.m., NA-B agreed that R57

have numerous facial hairs.

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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,

PRINTED: 07/09/2015 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST** GOLDEN LIVINGCENTER - LYNNHURST SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 570 2 570 | Continued From page 11 and, to the extent practicable, with the participation of the resident, the resident's legal quardian 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 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

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 570 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

2. morphine solution, 20 mg/5ml, administer 20 mg orally three times per day at 8:00, 2:00 p.m.,

hours for general osteoarthrosis.

10:00 p.m. for pain,

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING _ 06/04/2015 00945 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 570 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.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING_ 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PRÉFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 570 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. 2 840 MN Rule 4658.0520 Subp. 2 B Adequate and 2 840 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

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 840 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)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
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2 840	Continued From pa	ge 17	2 840			
	did not receive a toileting plan when assessed as having incontinent episodes.					
	Findings includes:			,		
	3/20/15, was review score as 15 (congnidentified that R27 rone with transfers, hygiene and total activities. R27's toil	imum data set (MDS) dated wed and identified R27's BIMS itively intact). The MDS required extensive assist of dressing, toileting, personal ssist of one with bathing eting needs addressed R27 as continent with bladder and th 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.					
		on 6/1/15 at 5:56 p.m., R27 'I would like to say thank you send you."				
	(CAA) dated 1/8/15 extensive assist wit addition, the urinary	ing care area assessment , identified: resident requires h dressing, toileting. In r incontinence and indwelling 1/8/15, reads, "Resident is				

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 840 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

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING _ 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 840 2 8 4 0 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

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 840 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

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING_ 06/04/2015 00945 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 840 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 9 1 5 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;

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
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		00945		B. WING		06/0	06/04/2015	
NAME OF	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
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2 915	Continued From pa	ge 22		2 915				
		90 ==						
	(4) eat; and (5) use speech, language, or other functional communication systems; and							
			IG					
	This MAN Demoisses							
	This MN Requirement by:	ent is not met as e	evidenced					
	Based on observati	on interview and o	locument					
	review, the facility fa							
	ambulation progran							
	resident for 1 of 1 re	esident (R6) reviev	ved for					
	ambulation.						-	
	Findings include:							
	During an observati	on on 6/1/15, at 6:	34 pm R6					
	was seated in a who							
	bed. R6 stated, "Th							
	to the bathroom like	they are suppose	to do."					
	During an interview	on 6/1/15 at 6:34	nm P6					
	expressed concern							
	the bathroom accor	_						
	and the established							
	the therapy departm	nent.						
	DOI	D / O / (MD	0) (-				
	R6's quarterly Minin							
	3/24/15, indicated F was dependent with							
	(ADL's).	i activities of dally f	IVIIII					
	(D = 0).							
	Document review o							
	4/30/13 and read, A	<u> </u>						
	bathroom with SBA							
	and wipe self. Walk							
	wheeled walker and PT (physical therap				·			
	i i (priysical trierap	y) ivesidelit will wa	air ou ieel					

6899

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 915 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)

and serves are implemented.

could develop a system to conduct random audits of the delivery of care to ensure appropriate care

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMP	LETED
		00945	B. WING		06/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRST		NUE WEST		
		SAINT PA	UL, MN 551			
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2010	·	R CORRECTION: Twenty one				
2 920	920 MN Rule 4658.0525 Subp. 6 B Rehab - ADLs		2 920			
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility for	ent is not met as evidenced ion, interview and document ailed to provide services for 2, R57) in the sample who were for personal cares.				
	Findings include:					
	R71 was not provid and bathing.	ed assistance with gromming				
	was sitting on the s toed slippers. R71's observed to be long the toes reaching d The second and thi the nails bending or	on 6/2/15, at 10:26 a.m., R71 ide of the bed, wearing open is toe nails on both feet were grand curled over the ends of own to the slipper surface. In the toes to the surface of point they were now curving				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 06/04/2015 00945 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 920 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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00945	B. WING		06/0	04/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551			
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2 920	not addressthat R7 refusal of care inter When interviewed of member (F)-A indicated bedroom and persolong time. F-A state urine." F-A expressed concern that the state care. F-A stated, "A be expected to figure [R71] so that [R71] needs." Furthermore dissatisfaction with care for R71 and stanails in October bed [R71] refused, it too what point should the provide care?" When interviewed of director of nursing was soon as possible another staff persore for the resident. On 6/1/15 at 6:20 puinterview R57, severand the chin area along, were observed.	1 was incontinent of urine and ventions. on 6/4/15, at 11:30 a.m., family ated the urine smell in R71's on had been going on a very d, "Who wants to smell like ed further frustration and aff tell F-A that R71 refuses t what point should the staff re out how to provide care for receives the care [R71] e, F-A expressed the staff for not providing nail ated, "I trimmed those toe cause the staff kept saying ok me an hour and a half. At the staff figure out how to provide the care are. The DON validated the per for staff to provide the care of the resident or find an who could provide the care. on 6/4/15 at 1:00 p.m., the perified there was not a reding re-approaching residents are. The DON validated the per for staff to provide the care of the resident or find an who could provide the care. on 6/4/15 at 1:00 p.m., the perified there was not a reding re-approaching residents are. The DON validated the per for staff to provide the care. The DON validated the care are for the resident or find an who could provide the care are for the resident or find an who could provide the care. The DON validated the care are for the resident or find an who could provide the care are for the resident or find an who could provide the care are for the resident or find an who could provide the care.	2 920	DETIMENOT)		
	On 6/2/15 at 10:20 a still have numerous	a.m., R57 was observed to facial hairs.				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 920 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00945		B. WING		06/0	04/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		-
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2 920	dated 1/26/15, direct documentation guid appropriate problem as an approach. Co and complications, to be accomplished List responsible disinstructions unique monitoring and obscondition, list appropriate July 2012, directly and procedu dated July 2012, directly and procedu dated July 2012, directly and must describe furnished to attain thighest practicable psychosocial well-breviewed and revises services provided owith each resident's are receiving the neservices. The directly and serves are important of the delivery of calculations and serves are important of the delivery of calculations.	cted staff, "Care delines Problem under which to insider listing problem is to this resident to this resident ervation of the priate prevention of the priate prevention of the priate prevention to the services that it is the services that it is the services that it is in maintain the physical, mention to end periodically, it is a written plan of the services that it is in the priodically, it is in the priodical periodically, it is in the services that it is in the priodical periodically, it is in the priodical periodically, it is in the priodical periodical periodic	n: Identify the to list shaving ossible risks surable goal(s) te. Approaches: approach. list list necessary underlying we skin care." care planning a required at 42 tare plan is an ol. It must ditime frames at are to be resident's al, and plan must be and the st be consistent for care." CORRECTION: lesignee, could staff assistance to assure they nent and or designee (s) trandom audits propriate care	2 920			
	(21) days.						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - LY	NNHIIRST	NHURST AVE NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 29	21375			
21375	5 MN Rule 4658.0800 Subp. 1 Infection Control; Program		21375			
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observation review, the facility facontrol practices duprevent cross contaprocess. This had the who came into contapotential to affect the	on, interview and document ailed to use standard infection uring floor sanitation and to amination during the clean up he potential to affect residents act with the urine spill and are 4 residents who shared one a residents who resided in the				
	registered nurse (R (H)-A a puddle of ur in the dining room. inch puddle accordi floor tiles. H-A produsing a microfiber 4 non-absorbent mop absorb and H-A spr by 60 inch area. The micro fiber mopping housekeeping cart i wetness out to the cremoved the microbase and put the mid H-A removed the control of	ion on 6/1/15, at 5:28, a N)-A informed housekeeper rine needed to be cleaned up There was a 12 inch by 15 ng to the 12 inch by 12 inch reeded to clean up the urine inch by 15 inch thin There was too much urine to read the wetness out to a 60 en, H-A picked up the thin g strip and walked out to the in the hallway, dripped cart and using a gloved hand strip mop from the Velcro icro mop into a plastic bag. Interpretation of the contaminated gloves and was pussekeeping cart back to the				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21375 Continued From page 30 21375 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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:				E SURVEY PLETED	
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PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
clean the water display to be cleaned. Furth empty bottles should stored bottles were that the area could housekeeping department of the water dispersion of the tolet. There was a reside the other side of the and a partial tube of above the sink. When interviewed of the water dispersion of the tolet seat needs from the floor. NA-A basin was not to be bathroom and the tonot to be left on the belonged to. NA-A a standard for infection. The facility did not he storage of resident.	eeping department did not penser and validated it needed hermore, H-A verified the ld not be on the floor and the not on a moveable cart so be sanitized by the artment. have any cleaning documents as a rand were not aware of the mmendations for sanitizing the	21375			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	1
٠		00945	B. WING		06/04/2015	5
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21375	bathroom, shared band 116, on 6/3/15, microfiber cloth to valso a solution on the toil most contaminated the less contaminated. When interviewed condicated being finisiand took the spray leave the room. What raised toilet seat be the floor, and what floor H-B indicated English and would generated to the floor, and what floor H-B indicated English and would generated to the floor, and what floor H-B indicated English and would generated to the floor, and what floor H-B indicated English and would generate the floor, and what floor H-B indicated English and would generate the floor, and what floor H-B indicated English and would generate the floor, and what floor H-B indicated English and would generate the floor, and floor H-B indicated English and would generate the floor, and generated the floor H-B indicated English and would generate the floor H-B indicated English and would generate the floor H-B indicated English and would generate the floor, and generated the floor H-B indicated English and would generate the floor, and generated the floor H-B indicated English and would generate the floor, and generated the floor H-B indicated English and would generate the floor H-B indicated English and would generate the floor H-B indicated English and would generated the floor H-B indicated English and	at 2:15 p.m., H-B used a vipe off the toilet after spraying ilet. H-B cleaned from the rim of the toilet out and down ted base of the toilet. On 6/3/15, at 2:18 p.m., H-B shed cleaning the bathroom bottle and cloth supplies to the new floor, the basin on about cleaning of the sink and difficulty understanding get the supervisor. H-A verified ith English and the company attention at this time, but the set of wash and sanitize the nd bathroom floor each day. It is gurine smell remained in the set of nursing (DON) and the could review and revise ures for infection control. It could be educated as portance of correct cleaning stematerials. The ousekeeping director could so on a regular basis to ensure	21375			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21435 MN Rule 4658.0900 Subp. 1 Activity and 21435 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 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

PRINTED: 07/09/2015 **FORM APPROVED** Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21435 Continued From page 34 21435 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.

(21) days.

TIME PERIOD FOR CORRECTION: Twenty one

Minneso	ta Department of He	ealth			FURIM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	IHURST AVE .UL, MN 551			
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21445	Continued From pa	ge 35	21445			
21445	MN Rule 4658.0900 Recreation Program	O Subp. 3 Activity and	21445			
	Subp. 3. Activity and red be a person who is direct the activity ar program at that nur. This MN Requiremed by: Based on interview facility failed to prov. This had the potent residents residing in Findings include: On 6/4/15 at 9:30 a representative/Director of Activities that as of November (DOA) indicated bein Director of Activities that as of November transitioning into a strole for 2nd floor of had not worked in a health care setting. November 2014 and transitioning into the facility. A review of the DOA had a bachelor of a lacked documentative experience in a soot within the last 5 years a patient activities presented.	and recreation program director. It reation program director must trained or experienced to and recreation staff and sing home. The social services are the facility. The social services are the facility and explained are 2014 and had been social services representative the facility. The DOA stated an activity department in a prior to this facility and as of other staff person had been assistant activity director for the same are assistant activity director for the same are assistant activity director for the same are assistant activity director for the same are assistant activity director for the same assistant activity director for the same and the same are assistant activity director for the same are assistant activity director.				
	administrator was a	at 12:30 p.m. on 6/4/15, the sked if the current director of cations for the position, the				

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		00945	B. WING		06/04/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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GOLDLIN	I LIVINGOLINTER - LI	SAINT PA	UL, MN 551	04		
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21445	Continued From pa	ge 36	21445			
	administrator replie activities probably v director of activities	d that the current director of was not qualified because the had a degree in another only worked several months in				
	The administrator of revise policies and an Activity Director	ETHOD FOR CORRECTION: or designee, could review and procedures related to ensuring meets the qualifications organized activities and th care setting.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preser which indicate the discontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Re	al. A resident's drug regimen innecessary drugs. An sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or note of adverse consequences lose should be reduced or trug regimen review required in the nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	·	IDENTIFICATION NUMBER.	A. BUILDING:		CONIF	LETED
		00945	B. WING		06/0	04/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - LY	NNHURST	IHURST AVE .UL, M N 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From pa	ae 37	21535			
21000	Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is incompared available through the system and the State subject to frequent This MN Requirement by: Based on interview facility failed to ensure plan incorpora	Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan the Law Library. It is not	21000			
	diagnoses that includisease, anxiety disidiopathic periphera rheumatica. The admission orded 1. morphine sulfate (milligram, milliliter) hours for general or 2. morphine solution mg orally three times 10:00 p.m. for pain, 3. MS Contin (morph 15 mg, administer 17:00 a.m, 1:00 p.m. 4. Gabapentin (neur twice a day for idiop 5. Acetaminophen 3	n, 20 mg/5ml, administer 20 es per day at 8:00, 2:00 p.m., hine) table extended release, tablet three times per day at				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		06/0	04/2015
	PROVIDER OR SUPPLIER	NNHURST 471 LYNN	DRESS, CITY, IHURST AVE			
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21535	maximum acetamir hours Currently the reside 1. Acetaminophen to every four hours as Check to see if give 4 gm every 24 hour 2. acetaminophen to 4 hours as needed see if give 325 mg to hours. 3. Gabapentin caps day related to neuro 4. MS Contin tablet 15 mg orally twice at The current care play reviewed. There was pain or for being at Con 6/4/15 at 11:11 (RN)-C reviewed the care plan had not book R19's risk of pain. A SUGGESTED ME The Director of Nurswork with the consumedications were reinterventions and mensure the staff were of developing interventions. The Directors. The Directors and mensure the staff were of developing interventions. The Directors and directors. The Directors and directors. The Directors and directors and directors and directors. The Directors and direct	ent was receiving: rablet: give 325 mg orally needed for pain or fever. e 650 mg first. Maximum dose s., ablet give 650 mg orally every for pain or fever., Check to first, maximum dose 4 gm /24 sule give 400 mg orally twice a opathy extended release 15 mg give	21535			

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00945	B. WING		06/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 39	21535			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21610	MN Rule 4658.1340 and Preparation Are	O Subp. 1 Medicine Cabinet ea;Storage	21610			
	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.					
	by: Based on observati interview, the facility temperature contro in 2 of 2 medication the potential to affe who used insulin, T	on, document review, and y did not maintain proper ls for refrigerated medications rooms reviewed, which had ct the residents in the facility uberculin testing solution, and influenza vaccine.				
	Findings include:					
	room refrigerator, a thermometer inside degrees Fahrenheit shown to licensed p who stated, "It is in The temperature lot that the temperature refrigerator was rea on 5/31/15, and no been recorded sinc contained Tuberculi solution opened 5/1 two separate reside	of the first floor medication t 3:26 p.m. on 6/2/15, the the refrigerator read 28 t. The thermometer was practical nurse (LPN)-B nearby the 20's, that can't be right." g on the refrigerator showed in this medication as 32 degrees Fahrenheit refrigerator temperatures had that date. This refrigerator in purified protein testing 9/15, Xalatan eye drops for ents, gentamicin liquid for the FlexTouch insulin pens, a vial				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21610 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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMF	PLETED
		00945	B. WING		06/0	04/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
COLDEN	I LIVINGCENTER - LY	ANNUIDST 471 LYNN	IHURST AVE	NUE WEST		
GOLDEN	I LIVINGCENTER - LT	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 41	21610			
	the first floor medic	ation room.				
	During interview at nurse manager for the needed to destrothe second floor mestated that he threw room refrigerator, esuppositories, and evaccines. He stated temperature control medication refrigeratemperature on 6/3/A surveyor requested policies and proced maintenance of the	2:00 p.m. on 06/03/2015, the the second floor was asked if by any of the medications in edication refrigerator, and he waway everything in the med except the bisacodyl ordered new meds and d that he adjusted the ls in the second floor ator, checked the refrigerator was 40 degrees.				
	administrator, direct consulting pharmace policies and proced medications. Nursing necessary to the immedications at the portion of designee, along a audit medications of compliance.	proper temperature. The DON with the pharmacist, could in a regular basis to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400) Physical Environment	21665			
	functional, comforta	ust provide a safe, clean, able, and homelike physical ng the resident to use				

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING_ 06/04/2015 00945 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21665 21665 Continued From page 42 personal belongings to the extent possible. This MN Requirement is not met as evidenced 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00945	B. WING	·	06/0	4/2015
	PROVIDER OR SUPPLIER	NNHURST 471 LYNN	DRESS, CITY, S HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	window in room 200 on the back support gouged on the wall window. There was area on the ceiling room 202. The winter wall near the air concontained a large under an area. During the tour the that he had difficulty painting tasks in the could not be in the done and at times the work to be done the facility for the rebeing done. SUGGESTIVE METHOD The director of nurse educate staff regard clean, functional and DON or designee, comaintenance and heriodic audits of an ensure a safe, clean environment is main	ge 43 surface. The chair near the had a large blue drip mark to section and the paint was behind the bed near the sa large unpainted and rough near the air conditioner in dow curtains in room 203 hed from the curtain rod. The nditioner in room 218 npainted, white, and rough maintenance director stated or completing plaster and a facility because residents room when some tasks are the residents refuse to allow a or there is no other place in a sident to go while the work is a sident to go wh	21665			
21870	MN St. Statute 144. Residents of HC Fa	651 Subd. 18 Patients & - ac.Bill of Rights	21870			

(X3) DATE SURVEY

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00945	B. WING		06/0	4/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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
21870	Continued From pa	ge 44	21870			
	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:					
	that a resident count on each of the two or president presiding 2015 meeting was homeous identified the lights was brought on thing specific regular problem and/or resolunder the section for voiced concerns about answered in a time. The resident council was held only on first business issues we March 2015, meeting	Council minutes identified acil meeting was generally held units monthly with one over the group. The January held only on first floor. The nat the old business of call up, however, there was arding the call lights and the olution was not identified. For new business, 4 residents out call lights not being y manner. If meetings for February 2015 at floor and no old or new re identified. Review of the, ags on first and second floor new business issues.				
	identified that the ol not a concern. New	2015, meeting at 1:00 p.m. d business of call lights was business indicated 2 of 4 erns with laundry not being				

(X2) MULTIPLE CONSTRUCTION

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21870 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00945	B. WING		06/0	4/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - LY	NNHIIRST	HURST AVE UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	N SHOULD BE COMPLETE DATE		
21870	Continued From pa	ge 46	21870				
	explained that AA-A resident council pro	A had been trained on the ocess.					
	Although a policy and procedure for resident council was requested, it was not available for review.						
	SUGGESTED MET	HOD OF CORRECTION:					
	that residents concupon timely. The discould review policy monitor systems, is evaluate the process	sing or designee could assure erns are listened to and acted rector of nursing or designee and procedures, train staff, interview residents and as to assure the facility acts cil grievances, specifically perns.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
21880	MN St. Statute 144. Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880				
	shall be encouraged their stay in a facility to understand and expatients, residents, residents may voice changes in policies and others of their content of the content of	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the e of the facility or program, as and telephone numbers for the icility Complaints and the area addsman pursuant to the Older					

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21880 Continued From page 47 21880 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.

Minnesota Department of Health

Findings include:

This MN Requirement is not met as evidenced

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.

During an observation on 6/1/15, at 6:30 p.m. of

PRINTED: 07/09/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00945 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21880 Continued From page 48 21880 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

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).

about it. I sink to the middle of that mattress and

it really hurts my body to lay on it."

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

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Minnesota Department of Health