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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RZGO
Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245332

2. STATE VENDOR OR MEDICAID NO. (L2) 839427000

3. NAME AND ADDRESS OF FACILITY
(L3) GOLDEN LIVINGCENTER - EXCELSIOR
(L4) 515 DIVISION STREET
(L5) EXCELSIOR, MN (L6) 55331

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

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

6. DATE OF SURVEY 03/17/2015 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) 12/31

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

12.Total Facility Beds 56 (L18)

13.Total Certified Beds 56 (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 56 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE: Gayle Lantto, Supervisor — Date: 03/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL: Anne Kleppe, Enforcement Specialist — Date: 03/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00454 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 03/12/2015 (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5332

March 17, 2015

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

Dear Ms. Lubbesmeyer:

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 March 13, 2015 the above facility is certified for:

56 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

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

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

March 17, 2015

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

RE: Project Number S5332024

Dear Ms. Lubbesmeyer:

On February 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 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 March 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 13, 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 January 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2015, effective March 13, 2015 and therefore remedies outlined in our letter to you dated February 17, 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,

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

Enclosure

cc: Licensing and Certification File

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

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 | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245332 | A. Building<br>B. Wing | 3/17/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET<br>EXCELSIOR, MN 55331 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0156<br>Reg. # 483.10(b)(5) - (10), 483.10(t<br>LSC | 03/13/2015 | ID Prefix F0167<br>Reg. # 483.10(g)(1)<br>LSC | 03/13/2015 | ID Prefix F0221<br>Reg. # 483.13(a)<br>LSC | 03/13/2015 |
| ID Prefix F0241<br>Reg. # 483.15(a)<br>LSC | 03/13/2015 | ID Prefix F0246<br>Reg. # 483.15(e)(1)<br>LSC | 03/13/2015 | ID Prefix F0252<br>Reg. # 483.15(h)(1)<br>LSC | 03/13/2015 |
| ID Prefix F0279<br>Reg. # 483.20(d), 483.20(k)(1)<br>LSC | 03/13/2015 | ID Prefix F0280<br>Reg. # 483.20(d)(3), 483.10(k)(2)<br>LSC | 03/13/2015 | ID Prefix F0282<br>Reg. # 483.20(k)(3)(ii)<br>LSC | 03/13/2015 |
| ID Prefix F0309<br>Reg. # 483.25<br>LSC | 03/13/2015 | ID Prefix F0314<br>Reg. # 483.25(c)<br>LSC | 03/13/2015 | ID Prefix F0315<br>Reg. # 483.25(d)<br>LSC | 03/13/2015 |
| ID Prefix F0323<br>Reg. # 483.25(h)<br>LSC | 03/13/2015 | ID Prefix F0431<br>Reg. # 483.60(b), (d), (e)<br>LSC | 03/13/2015 | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: 03/17/2015 | Signature of Surveyor: 15507 | Date: 03/17/2015 |
|---|---|---|---|---|
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 1/30/2015 | | | |

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

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 | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245332 | A. Building B. Wing 01 - MAIN BUILDING 01 | 3/13/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix Reg. # NFPA 101 LSC K0072 | 03/11/2015 | ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | |
| ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | |
| ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | |
| ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | |
| ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | | ID Prefix Reg. # LSC | |

| Reviewed By State Agency | Reviewed By PS/AK | Date: 03/17/2015 | Signature of Surveyor: 28120 | Date: 03/13/2015 |
|---|---|---|---|---|
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

**Followup to Survey Completed on:** 1/28/2015

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

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

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

ID: RZGO
Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245332**
2. STATE VENDOR OR MEDICAID NO. (L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - EXCELSIOR**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **04/01/2006**
6. DATE OF SURVEY **01/30/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 56 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 03/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 5414

February 17, 2015

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

RE: Project Number S5332024

Dear Ms..Lubbesmeyer:

On January 30, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

**DEPARTMENT CONTACT**

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

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

**Phone: (651) 201-3794**
**Fax: (651) 201-3790**

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 11, 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 March 11, 2015 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

**Original deficiencies not corrected**

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

**Original deficiencies not corrected and new deficiencies found during the revisit**

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

**Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by April 30, 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 July 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5332s15

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A. BUILDING ______ B. WING ______ | 01/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 000 | INITIAL COMMENTS<br><br>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.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and 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.<br><br>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.<br><br>(Date certain 3/13/15 for all tags per admin 3/5/15.) [initials] | 3/13/15 |
| F 156 SS=B | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and | F 156<br><br>POC accepted [initials] 3/5/15 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 3.4.15

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

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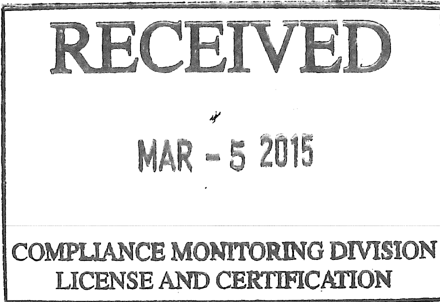
| F 156 | Continued From page 1<br>inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the | F 156 | F 156<br>-Facility has reviewed all Medicare denials. The facility has also reviewed the policy and procedure for issuing of Medicare non-coverage form 48 hours before non-coverage date and assure appropriate notice of the right to request a demand bill.<br>-MDS nurse or designee to issue notice of Medicare non-coverage form 48 hours before non-coverage date and assure appropriate notice of the right to request a demand bill.<br>-Facility designee will complete audits of random Medicare denials twice monthly. Interdisciplinary team will meet and discuss findings monthly at QAPI.<br><br><br> | |

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| F 156 | Continued From page 2<br>facility, and non-compliance with the advance directives requirements.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure appropriate notice of the right to request a demand bill when Medicare was discontinued was provided as required for 2 of 3 residents (R56, R61) reviewed for liability notice.<br><br>Findings include:<br><br>R56 was admitted to the facility on 8/17/14, after a hospital stay related to a left hip fracture. R56 was discharged from Medicare non-coverage on 8/28/14, signed the notice of Medicare non-coverage form on 8/27/14, and was discharged from the facility on 8/28/14.<br><br>R61 was admitted to the facility on 10/2/14. R61 was discharged from Medicare non-coverage on 10/22/14, signed the notice of Medicare non-coverage form on 10/21/14, and was discharged from the facility on 10/22/14. | F 156 | | |

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| F 156 | Continued From page 3<br><br>On 1/27/15, at 12:05 p.m. the Centers for Medicare and Medicaid Services (CMS) form 10123 was reviewed for R56 and R61. The form lacked documentation showing R56 and R61 had been provided a 48-hour notice as required before Medicare non-coverage date.<br><br>On 1/27/15, at 12:17 p.m. the Minimum Data Set/Medicare coordinator stated she should have given R56 and R61 the CMS form 10123 two days prior to when their services ended.<br><br>A policy regarding notice notification to resident regarding Medicare non-coverage was requested but not provided. | F 156 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the most recent state survey results were easily accessible to residents, families and visitors of the facility which had the potential to affect all 47 residents residing in the | F 167 | F 167<br>-Facility has replaced the current "roll-a-dex" type file with a 3-ring binder containing most recent survey results.<br>-R42 was shown the location of the survey results. Resident's attending resident council will be informed of the change from "roll-a-dex" to a 3-ring binder and will be offered to review upon request.<br>-Facility will make the results available for examination, post in a place that is readily and easily accessible to residents, family and/or visitors and with a sign posted of their availability.<br>-Administrator to audit availability monthly and review in QAPI. | 3/13/15 |

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F 167 Continued From page 4
facility, families and/or visitors.

F 167

Findings include:

R42 was interviewed on 1/28/15, at 2:00 p.m. and was not aware where the Minnesota Department of Health survey results were posted.

On 1/28/15, at 2:30 p.m. the current survey results were observed at the front entrance of the facility in a stationary Roll-a-Dex type file. The survey report was filed individually and each page was contained in a hard plastic sheet. The pages would have been difficult to remove without staff assistance and the file cumbersome should someone wish to read the results in private (i.e. not at the public entrance).

The resident council meeting minutes for 11/14, 12/14 and 1/15 indicated "Survey results are located on the table by the front door and will be brought to the Resident Council meetings to review upon request."

On 1/29/15, at 3:15 p.m. the administrator and director of nursing (DON) were interviewed and stated the survey results were "right in the front entrance and people do look at them." The DON said the pages could be removed from the book if needed.

A policy on posting of survey results was requested but not provided.

F 221 SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

F 221

The resident has the right to be free from any physical restraints imposed for purposes of

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| F 221 | Continued From page 5<br>discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to assess the use of a device as potentially restraining for 1 of 1 resident (R38) who utilized a perimeter defining mattress and a pillow or wedge cushion under the mattress of bed.<br><br>Findings include:<br><br>R38 was observed on 1/27/15, at 11:00 a.m. while in bed. A perimeter defining mattress was on the bed and the bed was up against the wall. A pillow was placed beneath the mattress and bed frame in the middle section of the bed.<br><br>On 1/27/15, at 11:55 a.m. nursing assistants (NA)-D and NA-F assisted R38 out of bed and into her wheelchair. NA-D and NA-F were interviewed and explained that the pillow was used underneath the mattress, as the resident "slides out of bed."<br><br>The following day on 1/28/15, at 6:55 a.m. R38 was again observed in bed. The perimeter defining mattress was on the bed and the bed was against the wall. A wedge cushion was placed between the mattress and bed frame in the middle section of the bed. The wedge cushion slightly raised the exit side of the bed.<br><br>On 1/28/15, at 9:55 a.m. NA- D and NA-E assisted R38 out of bed. The NAs reported the reason the resident was partially dressed was | F 221 | F 221<br>-The Facility will assess the use of a device as a potential restraint who utilize a perimeter defining mattress, pillow or wedge cushion under the mattress of bed for all residents.<br>-R38 wedge cushion and pillow under mattress discontinued. Perimeter defining mattress assessment completed for a restraint.<br>-DNS or designee to perform potential restraint assessment on all residents with perimeter defining mattress, pillow or wedge cushion under mattress of bed.<br><br>-3 DNS or designee will complete random chart audits to assure potential restraint assessments have been completed weekly. Results of these audits will be reviewed at QAPI monthly. | 3/13/15 |

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| F 221 | Continued From page 6<br>because she had been awake and was trying to get out of bed, so the night shift staff got her up before 7:00 a.m. NA-D and NA-E further explained they had assisted R38 back into bed because she was "falling out her wheelchair" and was "leaning." The NAs explained the wedge cushion was used because R38 tried to get up and "will roll out of bed." Although she was unable to rise independently, she had rolled out of bed in the past according to NA-D and NA-E.<br><br>The logged fall incidents for the previous six months were reviewed for R38. No incidents were noted of R38 falling or rolling out of bed were noted.<br><br>R38's annual Minimum Data Set (MDS) dated 11/7/14, revealed diagnoses including dementia, and arthritis. Extensive assistance was required of one staff for transfers and bed mobility and the resident was unable to ambulate. R38 had severely impaired cognitive skills, unclear speech, and could sometimes understand others or be understood. Restraint use was not identified on the MDS.<br><br>R38's Care Conference Summary Sheets dated 5/22/14, 8/21/14, and 11/26/14, did not reflect potential restraint use. The care plan (effective 11/6/12 to present) noted R38 was at risk for falls due to a history of falls and psychotropic medication use. The interventions directed staff to utilize a contour mattress on the bed, and on 12/20/14, an addition was made to the care plan to include the use of a bolster cushion underneath the mattress.<br><br>Further record review revealed no assessment had been completed to determine whether the | F 221 | | |

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| F 221 | Continued From page 7<br>perimeter defining mattress (contour mattress) and use of a wedge cushion or pillow was potentially restraining for R38.<br><br>The director of nursing (DON) was interviewed on 1/30/15, at 9:35 a.m. He verified R38 had not had any falls from the bed in the past six months. R38 utilized the perimeter defining mattress and wedge cushion under the mattress of the bed due to history frequent attempts of self-transfers out of bed. The DON also explained R38 was able to independently get out of bed, but not safely, and the wedge cushion was being used to "keep the resident safe" and not allow her to roll out of bed. The DON further confirmed the wedge cushion under the mattress prevented R38 from self-transfers, and acknowledged a restraint assessment had not been completed. | F 221 | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to deliver care in a manner that enhanced self-worth for 1 of 1 resident (R19) reviewed for behavioral status and to promote a dignified dining experience in 1 of 2 dining rooms, potentially affecting the 18 residents on the dementia unit.<br><br>Findings include: | F 241 | F 241<br>-Facility will educate all staff on resident dignity and rights in such a manner that provides an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality throughout the day especially during cares and dining experience.<br>-R19 moved to a new room where transfer process is more conducive to resident's transfer needs and provided a new TV.<br>-R19 pain regimen reviewed with physician and nurse practitioner.<br>-Staff educated on use of PRN medication and offering with signs and symptoms of distress.<br>-Staff educated on signs and symptoms of pain and stopping cares when appropriate.<br>-R19 cares will be audited randomly weekly to assure proper respect and dignity are being provided.<br>-DNS or designee to audit for signs and symptoms for R19 and 2 random residents a week. Results to be reviewed monthly at QAPI.<br>-Dietary manager or designee to perform weekly audits of 2 meals in ACU dining room to assure resident dignity and respect is being provided or enhanced throughout the dining process. Results will be reviewed at QAPI monthly.<br>-Facility to provide center pieces for the tables along with basic table condiments. | 3/13/15 |

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| F 241 | Continued From page 8<br><br>R19 was interviewed on 1/27/15, at 8:53 a.m. When asked if staff treated her with respect and dignity the resident answered, "No. Staff don't talk to you. After staff get me up in the morning they put me in the living room to watch television and then I sit there until they take me to the dining room for a meal. I never get to go to the bathroom because they just lay me in bed and change me. I wet my pad while I am waiting to be changed, and then I sit in the wet pad, and then I go number two in my pad. It makes me feel inferior to the other residents here" (regarding waiting for her brief to be changed and that she could not use the bathroom like her roommate. R19 also stated, "I wish staff would not be so rough with me when they wash me up in the morning...."<br><br>The following day at 7:44 a.m. R19 was observed sitting in her wheelchair (w/c) in the dayroom watching television. At 7:46 a.m. a nursing assistant (NA)-B approached R19 and stated, "Okay it's time to eat," and before waiting for a reply from the resident, proceeded to push R19 in her w/c toward the dining room. At 8:16 a.m. R19 was in the day room drinking a cup of coffee. At 8:28 a.m. NA-B approached R19 from behind and without saying anything to the resident, pulled her backward from the table and pushed her down the hallway. As NA-B turned R19's w/c around in the hallway outside her room, the resident's foot bumped the wall and the resident responded, "Ow." NA-B stated, "If you just look at her she will say that. It's hard to know because she is in real pain,. She just always says 'ow' no matter what, even if you just look at her." NA-B and NA-A transferred R19 from the w/c to the bed with the aid of a mechanical lift. Throughout the process | F 241 | | |

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R19 grimaced and her face was tensed. She repeated, "ow--ow--ow" repeatedly and she was lowered onto the bed and held her arm as she stated, "My arm hurts. You've broken my arm again." NA-B told R19, "We are not even touching your arm." As NA-B and NA-A rolled R19 back and forth from side to side to lower her pants and check the brief, and then to pull the pants up again, R19 grimaced and cried out loudly, "Ouch! Ouch! Ow! Ow!" NA-B delivered care in a hurried fashion without instruction or telling R19 how she was planning to assist the resident next.

On 1/29/15, at 9:26 a.m. R19 was again in the dayroom at a table with two peers and one staff person. A jigsaw puzzle was on the table and R19 stated, "The orange piece goes there," and then again stated, "It goes there." The staff person did not address the resident, who then repeated a little louder, "It goes there." The staff member continued to ignore R19 while talking to one of the other residents at the table. At 9:29 a.m. without looking at R19 the staff answered by stating, "We are watching. We will get there," as she continued to work with the other resident.

On 1/29/15, at 10:01 a.m. NA-G and NA-E assisted R19 onto the bed with the mechanical lift when the resident cried out, "Ouch! My knee." R19's roommate then stated, "There is nothing [expletive] wrong with your legs." As R19 was turned from side to side she grimaced and cried out, "Ow! Ow!" The resident's roommate then stated, "Oh my god!" While lying on her back R19 grimaced and cried out, "Help!" NA-E responded, "One more time." As NA-G washed and dried the resident she grimaced and continued to call out. Her roommate stated loudly enough for the resident to hear, "I can't believe this. I can't have

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any peace. I can't even sleep." As R19's clothing was adjusted she cried out loudly asking, "Will you stop? Will you stop?" NA-E and NA-G replied, "We are almost done." When cares were completed, R19 asked to have her television turned on. R19's roommate then stated, "Of course you want you television on, and someone else will then have to get up and turn it off." R19 was wearing two very different socks. As NA-E lifted up R19's to don a boot the resident again cried out. NA-E asked, "Is that better?" NA-E also asked R19 if she was comfortable. R19 responded, "My neck hurts with that pillow jammed under my head. I don't even want to be in here." NA-G did not respond to R19's statement as she gave the resident her call light and remote control. R19 requested the staff turn off the overhead light. When R19's television was turned on, loud scratchy noises were heard, and there were gray jagged lines across the TV screen. R19's roommate stated, "I have to listen to that" and got up and left the room. The NAs left the room without turning off the light as R19 had requested.

Following the care observations at 10:15 a.m. R19 rated her pain at "7 1/2" of of 10 (10 being the worst) and stated, "I don't even have a PRN (as needed) pain medication." R19 said her TV was always that way on channel 11, but said, "I did not tell anyone about my TV as they don't listen to me--just like at the puzzle table this morning." R19 further stated, "Or the nurse will say to me when I tell her I have pain, 'I just gave you something for that.'" R19 also stated, "Now with all that rolling around, I just urinated in my pants and I will just have to stay here wet until they get me up--if they do." R19 said she would like to get up at 8:00 a.m. every morning, but

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"today I got up at 7:25 a.m." R19 had a white substance on her lower bottom teeth and reported the NA did not assist her to brush her teeth that morning. R19 said she had her roommate's comments about her, which were typical. She added, "I asked them to turn my light off and they didn't." She described an issue with her eyes where she found the light bothersome. R19 added, "I want to be with my son and family."

At 11:16 a.m. R19 remained in bed with the TV on with gray jagged lines across the screen and the TV emitted irritating, scratchy sounds. At 2:41 p.m. R19 had been moved to a different room.

R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 had moderately impaired cognition, presented no behavioral problems or psychosis, and did not reject cares. R19 required extensive staff assistance for activities of daily living. Diagnoses indicated on the MDS included hemiplegia (paralysis on one side of the body), depressive disorders, spasm muscle and generalized pain.

On 1/28/15, at 10:38 a.m. NA-G reported R19 never used the toilet, and instead used the mechanical lift and the bed pan. NA-G also stated R19 was completely incontinent, although sometimes reported the need for a bowel movement. NA-G further stated, "She is known to scream out. She always says 'ow,' even if you look at her she will say ow."

On 1/29/15, at 10:26 a.m. the DON stated he had heard R19's roommate left the room when R19 received care. R19 mostly had pain with cares, and was being treated with tramadol (pain

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medication) and MS Contin (narcotic pain medication). The MS Contin had improved the resident's pain. The DON acknowledged the resident's room was small, but had never heard any concerns expressed by R19 regarding this or her roommate.

On 1/29/15, at 10:35 a.m. the licensed social worker (LSW) stated she had not heard of any concerns about R19 and her roommate. The LSW stated, "As far as I know [R19] and her roommate are getting along. I am not aware of anything."

On 1/29/15, at 11:17 a.m. the administrator stated she and R19 had discussed a room change in the past when openings occurred, but the size of those rooms had all been the same as what she had. R19's roommate was planning on discharging soon, so possibly R19 could move to the window. The administrator said they could get a compatible roommate for her, as well. She explained that R19 "guilts" her family so they had not been visiting much. She was unaware the TV was not working. In addition, she was unaware of the derogatory comments made by the R19's roommate and stated, "This is concerning about [R19's] roommate's comments towards [R19] and the staff should not be allowing it to happen. We will offer her another room."

On 1/30/15, at 12:58 p.m. the MDS coordinator stated, "She is a very reliable reporter and knows her pain. She will tell you everything and therefore, she does not need a staff assessment for pain."

R19's current care plan directed staff to "Help me maintain my dignity. Provide emotional support as

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| F 241 | Continued From page 13<br>needed. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Help me with reminders and cues as needed. Please allow me to do what I am capable of doing at my own pace in my own way even if it doesn't make sense to you. Please remember that I am an adult and treat me accordingly. Please tell me what you are going to do before you begin. Explain all procedures and reason before performing. Approach patient in a calm, positive, reassuring manner. Staff to identify self with each contact if needed and explain all procedures before starting. Allow calm, unhurried environment to encourage communication. Answer questions as needed and repeat as necessary. Anticipate patient needs. Encourage patient to verbalize needs. Listen carefully, validate verbal and non verbal expressions. Maintain eye contact if possible. Monitor for ability to make needs known and report significant findings. Use simple and direct communication to promote understanding."<br><br>On 1/30/15, at 8:52 a.m. the DON stated he expected staff to follow the residents' care plans.<br><br>The facility did not provide a dignified dining experience for residents who received meals on the dementia unit.<br><br>On 1/26/15, at 5:10 p.m. staff was observed to begin meal service in the dementia unit. The tables was observed without centerpieces or condiments. At 5:20 p.m. all residents in the dining room were served their meal. At 5:50 p.m. nursing assistants (NA)-J and NA-K begin clearing the dishes off the table using the busing cart as 12 of 18 residents remained in the dining | F 241 | | |

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room. At 5:58 p.m. A registered nurse (RN)-C also assisted in clearing the tables. The table clearing was loud, as staff tapped the plastic bowls on the edge of the cart to remove the food.

On 1/28/15, at 9:09 a.m. the meal service was again observed in the dementia unit. The tables again had not centerpieces or condiments. A licensed practical nurse (LPN)-J cleared dishes off the tables using the busing cart as 10 residents remained in the dining room, and R11, R9 and R23 continued to eating.

The breakfast meal on the dementia unit started at 8:00 a.m. and outside of the unit the breakfast meal was served from 7:30 a.m. to 9:00 a.m.

An interview with the registered dietitian (RD) on 1/29/15, at 9:24 a.m. revealed there was no open breakfast on the dementia unit, as there was enough space for all of the residents to eat together at the same time. The RD indicated lack of open breakfast had not been brought up as a concern and residents were provided late trays if requested or needed. The RD indicated staff did not provide condiments on the tables, because the residents "touch everything" and open and eat salt and sugar packets. The RD further stated centerpieces were not placed on the tables because the residents would remove them. At 10:16 am. the RD stated staff should have been discrete and quite when clearing dishes from the tables. If residents were still eating, the busing cart should not have been used at the table. Instead, staff could have removed the dishes when residents were finished eating, and then carried them to the busing cart.

LPN-B who consistently worked on the dementia

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| F 241 | Continued From page 15<br>unit was interviewed on 1/29/15, at 9:53 a.m. LPN-B explained the reason they did not offer an open breakfast on the unit was because there were residents who wandered a lot. Having a set time allowed all of the residents to eat together, and prevented them from eating each others' food. Centerpieces were not used, as the residents may have attempted to eat them, and LPN-B had seen residents attempting to eat paper napkins. Some residents were on special diets, therefore, condiments were not offered.<br><br>The Guidelines for Caregiver Interaction with Dementia (last reviewed 11/12/14), indicated the following: "Staff interaction with patients who have cognitive deficits...Staff will interact with residents in a manner that supports dignity and enhances the resident's ability to successfully participate in life. Staff must try to change their thinking from trying to control behavior to understanding and changing the reason behind the behavior. Always assume the resident can understand what your are saying. Focus on abilities, not limitations, The inability to express oneself does not always effect the ability to understand others." For activities of daily living the policy read, "Strive to let the resident be in control." | F 241 | | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. | F 246 | F 246<br>-Facility will educate staff on call light placement to be within resident reach while in room.<br>-R50 calllight placed within reach.<br>-Random audits of 5 rooms per week will be completed by DNS or designee. Results will reviewed at QAPI monthly. | 3/13/15 |

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| F 246 | Continued From page 16<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the call light was within reach for 1 of 30 residents (R50) who were observed for call light placement.<br><br>Findings include:<br><br>R50 was in a wheelchair in his room during an observation on 1/26/15, at 4:18 p.m. Although the surveyor was deliberately looking for the call light, it was difficult to readily locate. The light was found out of R50's reach and was on the floor at the foot of the bed.<br><br>Immediately following the observations, the call light location was pointed out to a nursing assistant (NA)-H. NA-H placed the call light "where it should have been," within the resident's reach from the wheelchair.<br><br>On 1/26/15, at 4:40 p.m. a registered nurse (RN)-C confirmed the call light should have been in reach, and confirmed R50 was capable of using the call light to summon help from staff.<br><br>A pollicy was requested, however, was not received by the facility. | F 246 | | |
| F 252 SS=D | 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. | F 252 | F 252<br>-R23, R28 and R43 rooms were decorated by facility to provide a more comfortable and home-like environment.<br>-Other resident rooms were reviewed and are decorated and home-like.<br>-Staff re-educated on personalizing rooms and having res. belongings available and visible<br>-2 random room audits completed by ACU director or Social Worker weekly. Results will be reviewed at QAPI monthly. | 3/13/15 |

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure resident room were maintained in a personalized homelike manner for 3 of 18 residents (R23, R28, R43) who resided on the dementia unit.

Findings include:

R23's room was observed on 1/26/15, at 4:28 p.m. The room was bare. The bed was made with one blanket laying at the foot of the bed, and a disposable incontinent pad placed on the center of the bed.

R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia, cerebral vascular accident, (stroke) and anxiety. She required extensive assistance from staff to perform activities of daily living (ADLs). The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood.

R23's care plan (effective 10/22/13 to present), indicated the resident had impaired cognition, hearing and vision, as well as communication and not always was understood. The care plan directed staff to anticipate the resident's needs. A Care Conference Summary dated 11/5/14, indicated "res [resident] has all needs anticipated and met."

On 1/28/15, at 9:27 a.m. a nursing assistant (NA)-D and NA-E were asked about the lack of any pictures or other personal items in R23's

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| F 252 | Continued From page 18<br>room. The NAs then looked around R23's room and located a framed photograph, religious picture, small stuffed animal and dead plant behind the window curtain.<br><br>R28's room was observed to be bare on 1/27/15, at 12:27 p.m. The bed was made, but there was no personalization of the resident's room.<br><br>R28's quarterly MDS dated 11/14/14, revealed diagnoses including dementia and Parkinson disease, and she required extensive assistance with ADLs. Severely impaired cognitive skills was noted, but the resident could usually understand others.<br><br>R28's care plan (effective 5/23/14 to present) indicated impaired communication, cognition, and hearing. The care plan directed staff to anticipate patient needs. A quarterly Psychosocial Progress note dated 11/14/14, indicated "staff anticipate and meet needs."<br><br>On 1/28/15, at 7:42 a.m. NA-D was interviewed and asked about lack of any pictures or other personal items in R28's room. NA-D looked around and acknowledged there were no personal items in the resident's room.<br><br>R43's room was observed to be bare on 1/26/15 at 4:24 p.m. The bed was made and two folded blankets were at the foot of the bed.<br><br>R43's significant change MDS dated 11/28/14, revealed diagnoses including dementia and schizophrenia. She required extensive assistance for ADLs. R43 also had severely impaired cognitive skills, unclear speech, but could usually understand others or be understood. | F 252 | | |

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| F 252 | Continued From page 19<br><br>R43's care plan (effective date 3/4/13 to present) indicated the resident had impaired cognition and communication with episodes of disorganized speech and was not always understood. Staff were directed to anticipate her needs. A quarterly Psychosocial Progress note dated 12/5/14, indicated "Res [resident] is severely impaired, staff anticipate and meet all needs."<br><br>On 1/28/15, at 9:35 a.m. NA-D and NA-E were interviewed regarding the lack of any pictures or other personal items in the resident's room. The NAs looked around the room and found a make-up case labeled with the resident's name. NA-D explained that R43 "moves things around."<br><br>On 1/28/15, at approximately 2:00 p.m. an environmental tour was conducted with the administrator, director of nursing (DON), director of maintenance, and the director of housekeeping. R23, R28, and R43's rooms were observed, and were all bare of any personal items. The administrator and DON verified all three rooms were not homelike, and would have expected the rooms to have a homelike feel. The administrator added they could ask family members to bring in personal items for the residents.<br><br>A policy was requested, however, was not provided by the facility. | F 252 | | |
| F 279<br>SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | | |

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| F 279 | Continued From page 20<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to identify on the care plan the use of perimeter defining mattress for 3 of 4 residents (R5, R16, R28) reviewed for restraints.<br><br>Findings include:<br><br>The care plan did not identify the use of perimeter mattress for R5, R16, and R28.<br><br>R5's morning cares were observed on 1/28/15, at 8:00 a.m. with nursing assistants (NA)-D and NA-E. R5 sat up in bed independently, scooted herself twice to get over the edge of the perimeter mattress of the bed, stand up and walk to her closet with her walker independently. NA-D stated R5 was capable of getting in and out of bed | F 279 | F 279<br>-R5, R16, and R28 care plans updated to reflect the use of perimeter defining mattress and a potential restraint assessment has been completed.<br>-Reviewed all residents that have perimeter mattress and careplans are current.<br>-Re-education with staff regarding assessment and careplanning<br>-3 Random chart audits weekly by DNS or designee to assure potential restraint assessments completed and care plans have been updated with interventions. Results will be reviewed at QAPI monthly. | 3/13/15 |

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| F 279 | Continued From page 21<br>independently.<br><br>R5's quarterly Minimum Data Set (MDS) dated 11/28/14, revealed diagnoses including depression and psychotic disorder. She required limited assistance of one staff for bed mobility, transfers and supervision for walking. The resident had severely impaired cognitive skills, could usually understand others and be understood.<br><br>R5's care plan with effective date 3/3/14, to present, indicated at risk for falls due to history of falls. The care plan interventions did not include use of a perimeter mattress.<br><br>R16's cares were observed on 1/28/15, at 10:26 a.m. NA-D walked with R16 to her bed, providing hand held assistance. NA-D stated R16 is capable of getting in and out of bed independently. A perimeter mattress was observed on the bed.<br><br>R16's quarterly MDS dated 11/14/14, revealed diagnoses including Alzheimer's disease, depression, anxiety and psychotic disorder. She required extensive assistance of one staff for bed mobility, limited assistance for transfers and walking. The resident had severely impaired cognitive skills, unclear speech, could usually understand others and sometimes be understood.<br><br>R16's care plan with effective date 3/3/14, to present, indicated at risk for falls due to wandering and use of medication. The care plan interventions did not include use of perimeter mattress. | F 279 | | |

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| F 279 | Continued From page 22<br>R28's cares were observed on 1/28/15, at 7:42 a.m. while assisted by NA-D and NA-E. R28 was sitting up in bed, stood, and walked to her closet independently. NA-D verified R5 was capable of getting in and out of bed independently.<br><br>R28's quarterly MDS dated 11/14/14, revealed diagnoses including dementia and Parkinson disease. She required extensive assistance of one staff for bed mobility, limited assistance for transfers and walking. The resident had severely impaired cognitive skills, could usually understand others.<br><br>R28's care plan effective 5/23/14 to present, indicated at risk for falls due to history of wandering, use of medication and diagnoses of Parkinson disease. The care plan did not include the use of a perimeter mattress.<br><br>The director of nursing (DON) was interviewed on 1/30/15, at 9:46 a.m. The DON indicated perimeter mattresses were implemented for residents who had experienced a fall from the bed. The DON further stated that R5, R16, and R28 were all able to transfer independently from their beds. The DON added that the use of perimeter mattresses should have been identified as fall interventions on R5, R16, and R28's care plans.<br><br>The Falls Management Guidelines policy dated 1/22/15, indicated "Following a resident fall appropriate interventions are implemented, care plan is updated." | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP | F 280 | | |

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| F 280 | Continued From page 23<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to revise care plans when changes were required for 1 of 1 resident (R34) reviewed for dialysis and for 1 of 3 residents (R15) reviewed for accidents.<br><br>Findings include:<br><br>R34 was observed while in bed on 1/27/15, at 3:51 p.m. He reported he had dialysis the next day, and would be returning to the facility after 11:00 a.m. The following morning R34's room was observed at 1/28/15, at 8:09 a.m. while R34 was at dialysis. No water pitcher or other fluids were observed at that time in his room. | F 280 | F 280<br><br>-R34's care plan has been reviewed and revised to meet patient needs, including dialysis requirements and nutrition.<br>-R15's care plan for falls has been reviewed and revised with most recent fall interventions.<br>-The system for reviewing falls and careplans and interventions has been initiated, reviewed and completed.<br>-Re-educated staff on system of reviewing falls and careplans and interventions.<br>-3 Random chart audits weekly by DNS or designee to assure compliance with reviewing and revising care plans. Results will be reviewed at QAPI monthly. | 3/13/15 |

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In an interview with R34 on 1/29/15, at 11:27 a.m. he reported, "They took me off the special [unknown] diet. I've been on a regular diet for about a month." He also indicated he was drinking whatever fluids he wanted at present. He explained his dialysis shunt had recently been replaced by an upper chest access line. He added that dressing changes were performed by staff at dialysis and said, "The nurses here don't change or look at it."

R34 received kidney dialysis three times weekly for end stage renal disease (kidney failure). In addition, the resident had other diagnoses including type II diabetes.

R34's care plan dated 11/3/14, included a plan for nutritional risk related to the need for extra protein and refusal of meals with poor intake, weight loss since his last admission, and several opened skin area. A handwritten addendum read "1500 cc [cubic centimeters] fluid Restriction [sic] 12/2014." Goals for R34 included weight above 190 pounds and improved laboratory values. Interventions included diet as orders with extra protein and supplementation at meals. Staff were also to monitor daily meal consumption and monthly weights. For the residents' alteration in kidney function the plan (also dated 11/3/14) with a risk for sodium and potassium excess. Goals including laboratory values within therapeutic ranges, and staff were directed to "check access site daily fistula/graft/catheter" for signs of infection. "Diet and fluid restrictions as ordered by Physician. Encourage patient to follow nutritional and hydration program interventions...." Additionally, staff were to complete laboratory work as orderd by the physician and when a

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change in clinical signs or symptoms was noted. "Monitor thrill and bruit daily" (shunt function) and to document and report abnormal findings to the physician. Dialysis time was noted as "2 PM," with a written communication form reviewing weights and any changes in condition to be sent between the dialysis provider and the facility.

A nursing assistant (NA)-H was interviewed on 1/29/15, at 2:41 p.m. and reported an awareness R34 was prescribed a renal diet, and went to dialysis on Monday, Wednesday, and Friday. NA-H stated R34 had been on a fluid restriction, "but not now." He explained that information regarding R34's care was noted on the NA assignment sheet.

During an interview on 1/29/15, at 3:41 p.m. the assistant director of nursing (ADON) reported communication between the facility and the dialysis center was typically in the form of telephone calls versus written information. "They called us today to say they would work on his fistula tomorrow, and said they had called his transportation company to tell them too" (due to a changed departure time from the dialysis facility). Additionally, the ADON reported R34 was no longer on fluid restrictions, but was still prescribed a renal diet, "..but he orders sandwiches out or Domino's [pizza]."

During a telephone call to the dialysis facility on 1/30/15, at 11:55 a.m. a dialysis RN-A reported she was "[R34]'s nurse." She verified communication between the dialysis and the residential facility was most often not written. "Usually I call with concerns...and talk to his nurse...some nursing homes send a sheet--this one does not, so we call them or they call us with

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concerns." The dialysis RN-A

She also indicated R34, "has fluid gains between runs, and we educate him that it's hard on his heart and he may have to go back to the hospital."

On 1/30/15, 2:01 p.m. a licensed practical nurse (LPN)-F indicated R34's weight was to be measured by the day shift staff either before the resident left for dialysis or upon his return. The nurse was responsible for recording the weights in the computer. However, she added that she did not think the NAs were taking the weight daily, and stated, "You're right, they're not all there. We should maybe get a system to get them only when he gets up. Because it's often hard to get them when he gets back." LPN-F said when R34 returned he was likely to be "...really hungry and really tired."

During an interview on 1/30/15, at 2:10 p.m. NA-A stated R34 had a fluid restriction, and he was not supposed to give the resident extra fluid. He added, "There is pop in the room sometimes. I'm not sure where that fits within the fluid restriction. Maybe the nurse could answer that better than me."

The current physician orders included daily weights, and a dialysis diet, but did not include a fluid restriction. Nursing staff were to check the access site daily for symptoms of infection or bleeding. No notes were found to show the access site was observed by the nurses, however, in an interview on 1/30/15, at 2:01 p.m. LPN-F said it was being completed.

R34's care plan contained conflicting fluid intake

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indications, but the most recent change dated 12/20/14, indicated the resident's fluids should have been restricted to 1500 ccs. The care plan also noted the resident had dialysis in the afternoons, but the resident and staff both had indicated he had morning dialysis. Weights and laboratory results, as well as intake and output records were requested but were not supplied by the facility.

Progress notes were reviewed from 11/2/14 through 1/30/15. Notes reflected communication (all calls from the dialysis center to the facility) were recorded on two days during the three months on 1/24/15, and two notes dated 12/23/14. An eMAR--Medication Administration Note was dated 11/10/14, at 10:23 and noted staff was to record the residents daily weight every shift related to edema (excess fluid in the tissues), however, R34 had left for dialysis before the NAs were able to weigh him. The notes did not reflect infomation related to checking the fistula for thrill or bruit, nor was the change in location of the dialysis access site as reported by R34 from the arm fistula to a chest catheter indicated in any of the notes. In addition, attempts and/or care of the access site was not noted.

R15's fall interventions from 11/24/14, and 1/24/15, were not updated on R15's careplan.

A Minnesota Incident Report dated 11/24/14, for R15 indicated the resident experienced a fall on 11/24/14, at 9:15 a.m. A description of the fall indicated R15 "slid from bed to floor--covers were bunched at edge, only socks on." It was noted the resident was confused and stated she "'wanted to get up for lunch.'" Contributing factors were

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identified as "Stocking feet, bunched bedding." Specific Recommendation/Intervention were for "Gripper socks at all times." R15's family response on the report was noted as, "'Good idea--gripper socks.'" A corresponding progress not indicated the resident reported she was getting up to eat, and the bedding was bunched up and she was "stocking footed...gripper socks applied."

A Minnesota Incident Report dated 1/24/15, for R15 indicated the resident fell on 1/24/15, at 10:50 a.m. R15 was found sitting on the floor between the bed and curtain. According to the NA, the w/c brakes were not on, and it was thought R15 "may have tried to self-transfer and slipped and fell on her buttocks." A contributing factor was identified as "Brakes on w/c were not on." Specific Recommendation/Intervention were, "Put brakes on, encourage resident to use call light with transfer." The summary indicated "Resident stated that she was trying to get out of bed." A corresponding progress note on 1/14/15, read "[R15] likes to transfer self from w/c to bed. Assist of 1 with transfers and ADLs [activities of daily living].

R15's falls careplan dated 1/24/15, indicated R15 needed staffs' assistance with transfers. The interventions, however, did not include gripper socks at all times as recommended after the 11/24/14 fall. In addition, staff were not directed in the care plan to ensure R15's w/c brakes were applied or to encourage the resident to call for help as recommended after the 1/24/15 fall.

On 1/28/15, at 10:09 a.m. the assistant director of nursing (ADON) explained that all managers met the day after a resident fell, to brainstorm, decide

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| F 280 | Continued From page 29<br>on fall interventions and update the careplan. The ADON also said interventions were also listed on the back of each resident's care plan. RN-A then verified the most recent fall intervention on the back of R15's care plan (page 2, print date 12/23/14) had been on 6/24/14.<br><br>On 1/29/15, at 9:33 a.m. NA-G who had worked at the facility for several years was interviewed. NA-G explained that sometimes R15 wore both socks and shoes and at other times she preferred to only wear socks without shoes. NA-G confirmed the socks were normal socks and not gripper socks.<br><br>NA-E who had worked at the facility for several years also stated on 1/29/15, at 9:52 a.m. sometimes R15 wore shoes and socks, and other times just wore her own socks. NA-E also stated he had never assisted R15 to wear gripper socks, as the resident wore her own socks.<br><br>On 1/29/15, at 2:24 p.m. LPN-C stated she worked the night shift and R15 sometimes self-transferred. LPN-C also stated R15 removed her shoes and socks and was also able to put her shoes back on again. The resident was experiencing intermittent confusion and was getting the days and nights mixed up. When asked whether R15 wore gripper socks LPN-C answered, "All the residents should have gripper socks at night so they don't fall."<br><br>At 2:29 p.m. LPN-D explained R15 was at risk for falls, and needed one staff to assist her with transfers. R15, however, sometimes "forgot" and transferred herself. LPN-D verified R15 usually just wore her own personal socks when she was lying in bed. | F 280 | | |

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| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure toileting was provided as directed by the care plan for 1 of 2 residents (R23) reviewed for urinary incontinence and to ensure repositioning was provided as directed by the care plan for 1 of 4 residents (R23) reviewed for pressure ulcers. In addition, the care plan was not followed for 1 of 3 residents (R19) reviewed for dignity.<br><br>Findings include:<br><br>R23's care plan with effective date 10/21/13, to present, directed staff to provide scheduled toileting plan of check and change every 2 hours and as needed, use of briefs/pads for incontinence protection and monitor for signs and symptoms for UTI. The Comprehensive Skin Assessment reviewed on 1/8/15, indicated R23 was identified as being at moderate risk for pressures ulcer development and the plan included to reposition resident every two hours. The undated, care sheet for R23 directed staff to provided total assistance with ADL's (activities of daily living) and the resident was non-ambulatory. It was also noted the resident was at "risk for pressure sore," was non-ambulatory, required the assistance for wheelchair mobility and total assistance with all activities of daily living. | F 282 | F 282<br>-R19 is receiving care provided by professional standards.<br>-R23 careplans were reviewed and revised and is care by staff by professional standards.<br>-Facility will educate staff on following care plan for incontinence care, toileting, repositioning, pressure ulcers (prevention or care) and dignity.<br>-DNS or designee will observe 2 direct care observations 2 patients weekly in regards to following the care plans of incontinence care, toileting, repositioning, pressure ulcers (prevention or care) and dignity. Results will be reviewed at QAPI monthly. | 3/13/15 |

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R23 was not provided assistance with toileting needs and repositioning every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours, 32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. nursing assistant (NA)-D sat down and assisted resident with eating. R23 remained in the dining room with no assistance with toileting until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed with NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief. NA-D and NA-E confirmed the incontinent brief showed wetness.

During an interview on 1/28/15, at 10:18 a.m. NA-D, who consistently worked on the dementia unit, reported he and NA-E were running late with morning cares and usually done by 9:00 a.m. and indicated R23 was assisted out of bed at 6:45 a.m. NA-D acknowledged R23 was not provided assistance with toileting and repositioning needs for greater than two hours.

During an interview on 1/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistance had care guides for each resident and the care guides identified the resident's toileting and repositioning needs. The ADON further stated the NAs were expected to follow the care guides, and "We also rely on the shift nurse to try to keep on eye on cares."

The Incontinence Management/Bladder Function Guideline policy, dated 1/13/15, reviewed on 1/19/15, indicated the procedure purpose was

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"Prevent skin problems such as pressure areas and excoriation, Avoid possibility of urinary infection, Manage urinary incontinence, restore of maintain as much normal bladder function as possible."

The Prevention of Pressure Ulcer policy (dated 1/8/15 last reviewed 1/26/15), indicated the procedure purpose was, "To prevent skin breakdown and development of pressure ulcers." The procedure details directed staff to "Establish a turning and positioning schedule in bed and chair to meet the resident needs."

R19's current care plan directed staff to "Help me maintain my dignity. Provide emotional support as needed. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Help me with reminders and cues as needed. Please allow me to do what I am capable of doing at my own pace in my own way even if it doesn't make sense to you. Please remember that I am an adult and treat me accordingly. Please tell me what you are going to do before you begin. Explain all procedures and reason before performing. Approach patient in a calm, positive, reassuring manner. Staff to identify self with each contact if needed and explain all procedures before starting. Allow calm, unhurried environment to encourage communication. Answer questions as needed and repeat as necessary. Anticipate patient needs. Encourage patient to verbalize needs. Listen carefully, validate verbal and non verbal expressions. Maintain eye contact if possible. Monitor for ability to make needs known and report significant findings. Use simple and direct communication to promote understanding."

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| F 282 | Continued From page 33<br><br>R19 was interviewed on 1/27/15, at 8:53 a.m. When asked if staff treated her with respect and dignity the resident answered, "No. Staff don't talk to you. After staff get me up in the morning they put me in the living room to watch television and then I sit there until they take me to the dining room for a meal. I never get to go to the bathroom because they just lay me in bed and change me. I wet my pad while I am waiting to be changed, and then I sit in the wet pad, and then I go number two in my pad. It makes me feel inferior to the other residents here" (regarding waiting for her brief to be changed and that she could not use the bathroom like her roommate. R19 also stated, "I wish staff would not be so rough with me when they wash me up in the morning...."<br><br>The following day at 7:44 a.m. R19 was observed sitting in her wheelchair (w/c) in the dayroom watching television. At 7:46 a.m. a nursing assistant (NA)-B approached R19 and stated, "Okay it's time to eat," and before waiting for a reply from the resident, proceeded to push R19 in her w/c toward the dining room. At 8:16 a.m. R19 was in the day room drinking a cup of coffee. At 8:28 a.m. NA-B approached R19 from behind and without saying anything to the resident, pulled her backward from the table and pushed her down the hallway. As NA-B turned R19's w/c around in the hallway outside her room, the resident's foot bumped the wall and the resident responded, "Ow." NA-B stated, "If you just look at her she will say that. It's hard to know because she is in real pain,. She just always says 'ow' no matter what, even if you just look at her." NA-B and NA-A transferred R19 from the w/c to the bed with the aid of a mechanical lift. Throughout the process | F 282 | | |

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| F 282 | Continued From page 34<br>R19 grimaced and her face was tensed. She repeated, "ow--ow--ow" repeatedly and she was lowered onto the bed and held her arm as she stated, "My arm hurts. You've broken my arm again." NA-B told R19, "We are not even touching your arm." As NA-B and NA-A rolled R19 back and forth from side to side to lower her pants and check the brief, and then to pull the pants up again, R19 grimaced and cried out loudly, "Ouch! Ouch! Ow! Ow!" NA-B delivered care in a hurried fashion without instruction or telling R19 how she was planning to assist the resident next.<br><br>On 1/29/15, at 9:26 a.m. R19 was again in the dayroom at a table with two peers and one staff person. A jigsaw puzzle was on the table and R19 stated, "The orange piece goes there," and then again stated, "It goes there." The staff person did not address the resident, who then repeated a little louder, "It goes there." The staff member continued to ignore R19 while talking to one of the other residents at the table. At 9:29 a.m. without looking at R19 the staff answered by stating, "We are watching. We will get there," as she continued to work with the other resident.<br><br>On 1/29/15, at 10:01 a.m. NA-G and NA-E assisted R19 onto the bed with the mechanical lift when the resident cried out, "Ouch! My knee." R19's roommate then stated, "There is nothing [expletive] wrong with your legs." As R19 was turned from side to side she grimaced and cried out, "Ow! Ow!" The resident's roommate then stated, "Oh my god!" While lying on her back R19 grimaced and cried out, "Help!" NA-E responded, "One more time." As NA-G washed and dried the resident she grimaced and continued to call out. Her roommate stated loudly enough for the resident to hear, "I can't believe this. I can't have | F 282 | | |

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| F 282 | Continued From page 35 any peace. I can't even sleep." As R19's clothing was adjusted she cried out loudly asking, "Will you stop? Will you stop?" NA-E and NA-G replied, "We are almost done." When cares were completed, R19 asked to have her television turned on. R19's roommate then stated, "Of course you want you television on, and someone else will then have to get up and turn it off." R19 was wearing two very different socks. As NA-E lifted up R19's to don a boot the resident again cried out. NA-E asked, "Is that better?" NA-E also asked R19 if she was comfortable. R19 responded, "My neck hurts with that pillow jammed under my head. I don't even want to be in here." NA-G did not respond to R19's statement as she gave the resident her call light and remote control. R19 requested the staff turn off the overhead light. When R19's television was turned on, loud scratchy noises were heard, and there were gray jagged lines across the TV screen. R19's roommate stated, "I have to listen to that" and got up and left the room. The NAs left the room without turning off the light as R19 had requested.<br><br>Following the care observations at 10:15 a.m. R19 "...they don't listen to me--just like at the puzzle table this morning." R19 further stated, "Or the nurse will say to me when I tell her I have pain, 'I just gave you something for that.'" R19 also stated, "Now with all that rolling around, I just urinated in my pants and I will just have to stay here wet until they get me up--if they do." R19 said she would like to get up at 8:00 a.m. every morning, but "today I got up at 7:25 a.m." R19 had a white substance on her lower bottom teeth and reported the NA did not assist her to brush her teeth that morning. R19 said she had her roommate's comments about her, which were | F 282 | | |

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typical. She added, "I asked them to turn my light off and they didn't." She described an issue with her eyes where she found the light bothersome. R19 added, "I want to be with my son and family."

At 11:16 a.m. R19 remained in bed with the TV on with gray jagged lines across the screen and the TV emitted irritating, scratchy sounds. At 2:41 p.m. R19 had been moved to a different room.

R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 had moderately impaired cognition, presented no behavioral problems or psychosis, and did not reject cares. R19 required extensive staff assistance for activities of daily living. Diagnoses indicated on the MDS included hemiplegia (paralysis on one side of the body), depressive disorders, spasm muscle and generalized pain.

On 1/28/15, at 10:38 a.m. NA-G reported R19 never used the toilet, and instead used the mechanical lift and the bed pan. NA-G also stated R19 was completely incontinent, although sometimes reported the need for a bowel movement. NA-G further stated, "She is known to scream out. She always says 'ow,' even if you look at her she will say ow."

On 1/29/15, at 10:26 a.m. the DON stated he had heard R19's roommate left the room when R19 received care. R19 mostly had pain with cares, and was being treated with tramadol (pain medication) and MS Contin (narcotic pain medication).

On 1/28/15, at 10:38 a.m. NA-G stated, "She is known to scream out. She always says 'ow,'

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even if you look at her she will say ow."

On 1/29/15, at 11:17 a.m. the explained that R19 "guilts" her family so they had not been visiting much. She was unaware the TV was not working. In addition, she was unaware of the derogatory comments made by the R19's roommate and stated, "This is concerning about [R19's] roommate's comments towards [R19] and the staff should not be allowing it to happen. We will offer her another room."

R19's 1/15 care plan directed staff to "Evaluate and establish level of pain on numeric scale/resident's acceptable level of pain is verbalized as a '5' according to the resident. Make sure I am not in pain or uncomfortable, Assess for pain every shift, Administer pain medication as ordered, Evaluate characteristics and frequency/pattern of pain, Evaluate need to provide medications prior to treatment or therapy, Evaluate what makes the pain worse, Observe for sensory changes to extremities such as pain, warmth, redness, Provide medications as ordered by physician and evaluate for effectiveness, Provide non-pharmaceutical interventions of redirecting, calm behavior and environment, Monitor for pain or stiffness, Observe for complaints of pain, specific locations of pain, response to nursing interventions taken to relieve pain, Anticipate patient needs, Provide emotional support as needed."

No supporting documentation was found on the e-mar (electronic medication administration record) for R19's physician order "Offer PRN oxycodone (narcotic pain medication) at least every 4 hours". In addition, R19 was not given a prn (as needed) pain medication three separate

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| F 282 | Continued From page 38 incidences; once on 12/22/14, and twice on 1/28/15, when R19 reported pain above R19's acceptable level of pain '5' indicated on R19's care plan.<br><br>On 1/27/15, at 9:15 a.m. R19 was asked if she had any pain with no relief R19 stated, "My left side, my left ankle hurts right now, a '7 or 8' [out of 10]" R19 also stated, "I don't feel my pain is well controlled."<br><br>R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 was cognitively moderately impaired. The quarterly MDS dated 1/3/5, also indicated R19 had no behaviors, no delirium, no psychosis, no rejection of cares, and R19 needed extensive staff assist for activities of daily living (ADLs). The quarterly MDS dated 1/3/15, further indicated 'Yes' R19 received pain regimen, 'No' R19 had not received PRN (as needed) pain medication, and 'Yes' R19 had received non-medication intervention for pain. The quarterly MDS dated 1/3/15, also indicated R19 reported 'frequently hurting' also indicated R19 gave a 'moderate' for verbal descriptor of pain, and also indicated R19's pain did not affect sleep or limit day activities.<br><br>On 1/30/15, at 8:52 a.m. the DON stated he expected staff to follow the residents' care plans. | F 282 | | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment | F 309 | F 309<br>-R48, R68, R26, R55, R46, R16 are receiving person centered care.<br>-All the other residents on the ACU unit are receiving person centered care.<br>-Facility will provide education to staff for proper interaction with patients who have a diagnosis of Dementia, in a person centered language that reflects understanding the cause of the behavior, | 3/13/15 |

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and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure employee's demonstrated specialized dementia care knowledge which included addressing residents in person centered language for 6 of 18 (R48, R68, R26, R55, R46, R16) residents who resided on the dementia unit and were cognitively impaired. In addition, the facility failed to coordinate hospice services and identify services provided for 1 of 1 resident (R23) reviewed for hospice, to provide ---- for 1 of 4 residents (R19) reviewed for behavioral status, and 1 of 1 residents (R34) reviewed for dialysis.

Findings include:

Person Centered Care

The following concerns suggested a lack of demonstrated dementia related training among facility staff:
Random observations were conducted on 1/26/15 from 2:48 p.m. until 7:30 p.m. in the dementia unit. At 2:49 p.m. nursing assistant (NA)-J called out to R48 in a corrective tone, "... [name of resident] What are you trying to do? Remember you can't push him" as R48 was attempting to push another resident in his wheelchair. Staff then said to R68 in a corrective tone "No, No that is [another resident's] sandwich" as R68 was attempting to take a sandwich off the table.
R48's care plan dated 6/24/14, revealed diagnoses including dementia. The plan

F 309 meeting the resident where they are at in their disease process, and effectively meeting the residents needs.
~ED or ACU Director to observe staff interactions with residents to ensure person center care 2x weekly audit and report finding at QAPI monthly.
-Facility has met with hospice services and will provide them a folder where all faxed hospice communication will be put for hospice to file into patient chart. Folder is located behind facilities main nurses station.
-Staff re-educated on hospice communication process.
-DNS or designee to audit hospice folder and chart one time weekly to assure compliance and proper coordination of care. Results of audit to be reviewed at QAPI monthly.
-R34s dialysis care plan has been reviewed and updated to reflect current interventions and coordination of services with dialysis.
-Facility has implemented a dialysis referral sheet to send with patient each time they go to dialysis to enhance coordination of care.
-DNS or designee to audit 2 random care plans weekly to assure proper interventions in place and care is coordinated with outside services.
-Staff educated on sending and receiving communication form to and from dialysis unit.
-DNS or designee to audit 1x weekly and results to be reviewed at QAPI monthly.

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| F 309 | Continued From page 40<br>indicated, "My safety is at risk and there is a potential for abuse due to decreased cognitive ability, wandering, decreased physical ability, hearing deficits." Interventions directed staff to "Please explain my environment to me if I don't understand what is going on around me." The communication plan dated 6/20/14, also indicated "Impaired communication due to confusion and impaired hearing." The interventions directed staff to "Anticipate patient needs, encourage patient to verbalize needs, listen carefully, validate verbal and non-verbal expressions."<br>R68's care plan dated 1/22/15, revealed diagnoses including dementia. The care plan indicated, "I am still adjusting to my new surroundings and would like help getting comfortable in my new home. I am planning on LTC [long term care] here." The interventions directed staff to "Help me maintain my preferences for daily living." The plan dated 1/19/15, also indicated "At risk for elopement related to wandering and move to secure dementia unit." The interventions directed staff to "Involve the patient in decision making regarding daily choices."<br>At 5:12 p.m. NA-F stated to R26 in a corrective tone while pointing to a spoon, "[Name of resident] use your spoon."<br><br>R26's care plan dated 8/13/14, revealed diagnoses including dementia. The care plan indicated, "My safety is at risk and there is a potential for abuse due to decreased cognitive ability, history of wandering, decreased physical ability, difficulty communicating needs." The interventions directed staff to "Anticipate needs if unable to verbalize, Please explain my environment to me if I don't understand what is going on around me." The care plan dated | F 309 | -R19 pain regimen reviewed with physician and nurse practitioner.<br>-Staff educated on use of PRN medication and offering with signs and symptoms of distress.<br>-DNS or designee to audit for signs and symptoms for R19 and 2 random residents a week. Results to be reviewed monthly at QAPI.<br>-DNS or designee to perform direct care audit on R19 weekly.<br>-Staff educated on signs and symptoms of pain and stopping cares when appropriate. | |

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5/22/12, also indicated "Impaired communication due to confusion and dementia." Interventions directed staff to "Encourage patient to verbalize needs, Listen carefully, validate verbal and non verbal expressions."

At 5:39 p.m. NA-F told R55 "[Name of resident] don't worry. Just relax. I will get that" as R55 was attempting to clear the dishes from the table. NA-F then stated "[Name of resident] I will put you to bed at 6:30 p.m. You can go to your room and relax. I will tuck you in."

R55's care plan dated 8/27/14, revealed diagnoses including dementia. The care plan indicated, "Impaired communication due to impaired cognition, confusion." Interventions directed staff to "Anticipate patient needs, Encourage patient to verbalize needs". The plan dated 8/15/14, also indicated "At risk for elopement related to anger at placement in living enter, Attempts to leave." The interventions directed staff to "Involve the patient in decision making regarding daily choices."

At 6:10 p.m. R46 walked up behind a registered nurse (RN)-C putting his face in front of the nurse's face, startling the RN. RN-C stated name of resident aloud. NA-J who was standing next to RN-C responded in a corrective tone to R46 "[Name of resident], not okay."

R46's care plan dated 12/5/13, revealed diagnoses including Wernicke-Korsakoff (brain disorder characterized by mental confusion and short term memory impairment). The care plan indicated, "Impaired communication due to impaired cognition, confusion, episodes of disorganized speech." The interventions directed

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staff to "Anticipate patient needs, Use simple and direct communication to promote understanding". The plan dated 11/26/13, also indicated "At risk for elopement related to attempts to leave living center, wandering." The interventions directed staff to "Involve the patient tin decision making regarding daily choices."

At 6:30 p.m. NA-J turned on the television in the dining room to the "I Love Lucy" show. A group of nine residents were seated in front of the television. R16 remained seated at the dining room table with her back to the television. At 6:40 p.m. R16 was clapping her hands as music from the television. R16 remained seated with her back to the television and was periodically clapping until 7:30 p.m. Although NA-J and RN-C entered and exited the dining room several times, R16 was not provided assistance to face the television.
R16's care plan dated 12/5/13, revealed diagnoses including Alzheimer's disease. The care plan indicated "Due to cognitive loss, diminished decision making and safety and security issuers, placement in the secure Alzheimer's care unit (ACU) with programs designed for this population is needed as evidenced by Alzheimer's disease." The interventions directed staff to "Provide cues through the ACU to minimize effects of cognitive deficits." The plan dated 3/29/11, also indicated "Impaired communication due to impaired cognition." Interventions directed staff to "Anticipate patient needs."

The administrator was interviewed on 1/29/15, at 3:57 p.m. The administrator explained that all department managers, including the director of nursing (DON) and herself monitored interactions

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between staff and residents in the dementia unit. The administrator further stated the facility does "in the moment coaching" for staff if concerns were observed, and the facility held monthly staff meetings for all nursing staff.

The DON was interviewed on 1/30/15, at 9:50 a.m. and reported the facility had been actively working to hire a director for the dementia unit. The DON further acknowledged that dementia training related to addressing residents with dementia in person centered language needed to be reviewed with direct care staff. The DON further acknowledged that R16 should have been assisted with relocating herself so she could have watched television.

The Admission/Discharge Criteria Alzheimer Care Unit dated 2009, indicated the criteria for admission to unit included: "A primary diagnosis of Alzheimer's or other related cognitive disorder was established, The resident may be demonstrating behaviors associated with dementia such as memory dysfunction (immediate, recent and remote); poor judgment, disorientation to time; place, person, decreased attention span; mood fluctuations; wandering and exit-seeking; expression of anxiety centering on specific fantasy; catastrophic reaction."

The Guidelines for Caregiver Interaction with Dementia dated 11/12/14, indicated the following: "Staff interaction with patients who have cognitive deficits--Staff will interact with residents in a manner that supports dignity and enhances the resident's ability to successfully participate in life. Staff must try to change their thinking from trying to control behavior to understanding and changing the reason behind the behavior.

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Recognize the resident cannot control his/her behavior. Do not ridicule, scold or use a threatening tone of voice. Always assume the resident can understand what your are saying. The inability to express oneself does not always effect the ability to understand others."

Hospice:

R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia and cerebral vascular accident, (stroke). The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood and required extensive assistance with activities of daily living (ADLs).

R23's care plan dated 10/22/13, identified hospice care with a goal of being able to reside on the dementia unit as long as resident benefits and meets the criteria. Interventions included, "Work with [hospice agency] to meet needs and provide quality of life. Invite to care conferences and integrate care plans." The plan, however, did not specify services the hospice agency would provide for R23.

Although hospice was imitated for R23 on 1/19/15, there were no progress notes related to hospice visits, nor was there a hospice care plan with identified goals and interventions. In the front of the resident's medical record a flow sheet identified the hospice case manager and phone number, and the next nurse visit date. No other disciplines were identified.

During interview on 1/28/15 at 9:27 a.m. NA-D and NA-E who consistently worked on the dementia unit, verified R23 received hospice care

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| **GOLDEN LIVINGCENTER - EXCELSIOR** | **515 DIVISION STREET EXCELSIOR, MN 55331** |

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| F 309 | Continued From page 45<br>and had a hospice aide that came on Sundays. Staff indicated the hospice aide assisted R23 with bathing and activities of daily living. NA-D and NA-E said the nurse informed them when the hospice aide was coming.<br><br>During interview on 1/29/15, at 9:43 a.m. a licensed practical nurse (LPN)- B who consistently worked on the dementia unit, reviewed R23's hospice chart. LPN-B was unable to find a schedule of services that was to be provided to R23 from the hospice agency, progress notes or plan of care. LPN-B further stated if resident had a hospice aide, the schedule should have been in the chart, which LPN-B was unable to find. LPN-B stated the hospice aides typically had facility nursing staff sign papers to confirm they were at facility and provided care to the resident.<br><br>During interview on 1/29/15, at 3:30 p.m. the DON explained that the hospice agency sent the aide schedule to the facility. It was kept at the front desk and, "the aides know it is here." The DON proceeded to look through a stack of papers in a lateral file at the front desk. He located a form from hospice agency that included R23's name, the name of hospice aide and day of week she would be coming to facility. The form did not include what services the aide would be providing to the resident. The DON then reviewed R23's hospice chart with the surveyor and confirmed the chart did not include a hospice plan of care, noting what disciplines/services were to be provided for the resident and notes describing those visits.<br><br>On 1/20/15, at 8:30 a.m. the DON indicated he had contacted hospice agency and had a plan of | F 309 | | |

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care and nursing notes faxed to the facility.

A policy on hospice care was requested but not provided.

Dialysis:
R34 received dialysis, however, conflicting information was reported by the resident, staff, and in information in the resident's medical record related to dialysis care.

R34 was observed while in bed on 1/27/15, at 3:51 p.m. He reported he had dialysis the next day, and would be returning to the facility after 11:00 a.m. The following morning R34's room was observed at 1/28/15, at 8:09 a.m. while R34 was at dialysis. No water pitcher or other fluids were observed at that time in his room.

In an interview with R34 on 1/29/15, at 11:27 a.m. he reported, "They took me off the special [unknown] diet. I've been on a regular diet for about a month." He also indicated he was drinking whatever fluids he wanted at present. He explained his dialysis shunt had recently been replaced by an upper chest access line. He added that dressing changes were performed by staff at dialysis and said, "The nurses here don't change or look at it."

R34 received kidney dialysis three times weekly for end stage renal disease (kidney failure). In addition, the resident had other diagnoses including type II diabetes.

R34's care plan dated 11/3/14, included a plan for nutritional risk related to the need for extra protein and refusal of meals with poor intake, weight loss

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since his last admission, and several opened skin area. A handwritten addendum read "1500 cc [cubic centimeters] fluid Restriction [sic] 12/2014." Goals for R34 included weight above 190 pounds and improved laboratory values. Interventions included diet as orders with extra protein and supplementation at meals. Staff were also to monitor daily meal consumption and monthly weights. For the residents' alteration in kidney function the plan (also dated 11/3/14) with a risk for sodium and potassium excess. Goals including laboratory values within therapeutic ranges, and staff were directed to "check access site daily fistula/graft/catheter" for signs of infection. "Diet and fluid restrictions as ordered by Physician. Encourage patient to follow nutritional and hydration program interventions...." Additionally, staff were to complete laboratory work as ordered by the physician and when a change in clinical signs or symptoms was noted. "Monitor thrill and bruit daily" (shunt function) and to document and report abnormal findings to the physician. Dialysis time was noted as "2 PM," with a written communication form reviewing weights and any changes in condition to be sent between the dialysis provider and the facility.

NA-H was interviewed on 1/29/15, at 2:41 p.m. and reported an awareness R34 was prescribed a renal diet, and went to dialysis on Monday, Wednesday, and Friday. NA-H stated R34 had been on a fluid restriction, "but not now." He explained that information regarding R34's care was noted on the NA assignment sheet.

During an interview on 1/29/15, at 3:41 p.m. the assistant director of nursing (ADON) reported communication between the facility and the dialysis center was typically in the form of

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telephone calls versus written information. "They called us today to say they would work on his fistula tomorrow, and said they had called his transportation company to tell them too" (due to a changed departure time from the dialysis facility). Additionally, the ADON reported R34 was no longer on fluid restrictions, but was still prescribed a renal diet, "..but he orders sandwiches out or Domino's [pizza]."

During a telephone call to the dialysis facility on 1/30/15, at 11:55 a.m. a dialysis RN-A reported she was "[R34]'s nurse." She verified communication between the dialysis and the residential facility was most often not written. "Usually I call with concerns...and talk to his nurse...some nursing homes send a sheet--this one does not, so we call them or they call us with concerns." The dialysis RN-A

She also indicated R34, "has fluid gains between runs, and we educate him that it's hard on his heart and he may have to go back to the hospital."

On 1/30/15, 2:01 p.m. a licensed practical nurse (LPN)-F indicated R34's weight was to be measured by the day shift staff either before the resident left for dialysis or upon his return. The nurse was responsible for recording the weights in the computer. However, she added that she did not think the NAs were taking the weight daily, and stated, "You're right, they're not all there. We should maybe get a system to get them only when he gets up. Because it's often hard to get them when he gets back." LPN-F said when R34 returned he was likely to be "...really hungry and really tired."

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During an interview on 1/30/15, at 2:10 p.m. NA-A stated R34 had a fluid restriction, and he was not supposed to give the resident extra fluid. He added, "There is pop in the room sometimes. I'm not sure where that fits within the fluid restriction. Maybe the nurse could answer that better than me."

The current physician orders included daily weights, and a dialysis diet, but did not include a fluid restriction. Nursing staff were to check the access site daily for symptoms of infection or bleeding. No notes were found to show the access site was observed by the nurses, however, in an interview on 1/30/15, at 2:01 p.m. LPN-F said it was being completed.

R34's care plan contained conflicting fluid intake indications, but the most recent change dated 12/20/14, indicated the resident's fluids should have been restricted to 1500 ccs. The care plan also noted the resident had dialysis in the afternoons, but the resident and staff both had indicated he had morning dialysis. Weights and laboratory results, as well as intake and output records were requested but were not supplied by the facility.

Progress notes were reviewed from 11/2/14 through 1/30/15. Notes reflected communication (all calls from the dialysis center to the facility) were recorded on two days during the three months on 1/24/15, and two notes dated 12/23/14. An eMAR--Medication Administration Note was dated 11/10/14, at 10:23 and noted staff was to record the residents daily weight every shift related to edema (excess fluid in the tissues), however, R34 had left for dialysis before the NAs were able to weigh him. The notes did

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| F 309 | Continued From page 50<br>not reflect information related to checking the fistula for thrill or bruit, nor was the change in location of the dialysis access site as reported by R34 from the arm fistula to a chest catheter indicated in any of the notes. In addition, attempts and/or care of the access site was not noted.<br><br>R19<br>On 1/27/15, at 9:15 a.m. R19 was asked if she had any pain with no relief R19 stated, "My left side, my left ankle hurts right now, a "7 or 8" [out of 10]" R19 also stated, "I don't feel my pain is well controlled."<br><br>No supporting documentation was found on the electronic medication administration record (EMAR) for R19's physician order "Offer PRN Oxycodone (narcotic pain medication) at least every 4 hours. In addition, R19 was not given as needed (PRN) pain medication three separate incidences; once on 12/22/14, and twice on 1/28/15, when R19 reported pain above R19's acceptable level of pain "5" indicated on R19's care plan.<br><br>R19's quarterly MDS dated 1/3/15, indicated R19 was cognitively moderately impaired. The quarterly MDS dated 1/3/5, also indicated R19 had no behaviors, no delirium, no psychosis, no rejection of cares, and R19 needed extensive staff assist for activities of daily living (ADLs). The quarterly MDS dated 1/3/15, further indicated "yes" R19 received pain regimen, "no" R19 had not received PRN (as needed) pain medication, and "yes" R19 had received non-medication intervention for pain. The quarterly MDS dated 1/3/15, also indicated R19 reported "frequently | F 309 | | |

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hurting" also indicated R19 gave a 'moderate' for verbal descriptor of pain, and also indicated R19's pain did not affect sleep or limit day activities.

On 1/27/15, at 10:44 a.m. licensed practical nurse (LPN)-A stated, "I honestly cannot tell if she is in pain--or psychological. Morphine is scheduled every day." LPN-A also stated, "She can ask for PRN pain medication but she does not ask for them very often." LPN-A further stated, "She will want to lie down, then want to get up. There is always something with her."

On 1/29/15, at 10:26 a.m. the DON stated R19 was treated with Tramadol (pain medication) and MS Contin (narcotic pain medication) and R19 had pain mostly during cares. The MS Contin had "helped improve" R19's pain.

On 1/29/15, at 10:54 a.m. a registered nurse (RN)-B stated R19 did not ask for PRNs, but "if you ask her if she does have pain she will take a PRN." RN-B also stated R19 yelled out with cares. RN-B further stated, "I heard her yelling out today." RN-B stated, "I don't know if she has pain during cares. I think she gets so anxious." RN-B then added that probably R19 did have pain in her left leg and ankle. RN-B stated she had given her morning medications, repositioned her and later R19 was asleep. RN-B also stated, "I think her pain is more because of movement and I did ask the nurse practitioner for a new script which pharmacy now has so we can have some PRN pain medication for her, and she can have a PRN Oxycodone [narcotic pain medication].

At 11:00 a.m. LPN-D stated she worked with R19 often, and if she heard R19 complaining she asked R19 if she wanted a PRN pain medication,

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which she sometimes accepted.

On 1/29/15, at 11:09 a.m. RN-A stated R19 had a history of osteomyelitis (bone infection) in her metatarsals (bones in the foot). RN-A stated before R19 came into the facility she refused a treatment that would have removed the bone, and the treated ulcer healed. RN-A thought R19's pain was from the osteomyelitis and R19 received scheduled morphine twice a day for it.

On 1/29/15, at 2:38 p.m. RN-B stated R19 had asked for a pain pill at approximately 1:15 to 1:30 p.m. and because she reported her leg was really hurting. RN-B also stated, "I was really surprised she asked for one."

On 1/30/15, at 12:58 p.m. the MDS Coordinator stated, "She is a very reliable reporter, and knows her pain. She will tell you everything, and therefore she does not need a staff assessment for pain."

R19's Progress Notes dated 8/20/14, indicated "[R19] cries and complains of pain especially during cares and transfers. Had PRN Oxycodone at 11:30 a.m."

Physician Progress Note dated 6/30/14, indicated "She is complaining about pain in her left knee, a problem that has defied several attempts at treatment in the past. In Broda Chair. Grimacing and tense, looks as if left lower extremity pain is severe. Imp [impression]: Inadequate pain control. She has been on Oxycontin for several years. Probably not getting or asking for PRN's as much as she should. Plans: Increased the MS Contin to 15 mg q8h [every 8 hours] and encourage her to ask for breakthrough meds. I

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suspect we may need to go up to 30 or more bid [twice daily] fairly soon. We did have her on Neurontin [anticonvulsant medication commonly used for pain] before, but I am not sure how much it helped."

Physician Progress Note dated 11/12/14, indicated "Still major chronic pain despite many meds, but at least she does get out of the room and sometimes converses." The physician note also indicated "Lots of pain all of the left side, and she did not even want me to take off her sock. At least, the neurotropic ulcer below the left 5th metatarsal head is now closed. A. [Assessment] Severe spastic left hemiplegia with chronic pain. P. [Plan] Meds left same with substantial chronic opiods."

Complete History and Physical dated 12/4/14, indicated "[R19] reporting left foot pain. Is on quite a bit of pain medications and appears comfortable. [R19] says she doesn't ask for PRN medications because she 'never sees the nurses.' Left pain medications unchanged." Diagnoses included "Hemiplegia Nondominant Side from Stroke, Chronic pain syndrome, Dementia with behavioral disturbance, and Hypertension [high blood pressure]."

Physician Orders dated 1/29/15, included: Offer PRN Oxycodone at least every 4 hours, ordered 4/3/14, MS Contin Tablet Extended Release 15 mg (Morphine Sulfate ER); Give 15 mg by mouth three times a day, ordered 6/30/14, and Oxycodone HCL tablet 10 mg; Give 10 mg by mouth every 2 hours as needed for dyspnea and break thru pain, ordered 1/31/14

R19's pain was rated a '6' on R19's 12/14, EMAR

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(electronic medication administration record) on 12/22/14, with no PRN pain medication given. During the month of 12/14, R19 received no PRN pain medications.

R19's 1/15, EMAR indicated R19 had received Oxycodone HCL 10 mg as needed for break through pain twice during the month. The LPN documented R19's pain on 1/29/15 was a '7' left knee pain, PRN effective, and on 1/27/15, an '8' left extremities, with PRN effective. R19's pain was rated a '6' on the 1/15 EMAR on 1/28/15, on both day and evening shift on 1/28/15, with no PRN pain medication given.

R19's 1/15 care plan indicated: Evaluate and establish level of pain on numeric scale/resident's acceptable level of pain is verbalized as a '5' according to the resident. Make sure I am not in pain or uncomfortable. Assess for pain every shift. Administer pain medication as ordered. Evaluate characteristics and frequency/pattern of pain, Evaluate need to provide medications prior to treatment or therapy. Evaluate what makes the pain worse. Observe for sensory changes to extremities such as pain, warmth, redness. Provide medications as ordered by physician and evaluate for effectiveness. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Monitor for pain or stiffness. Observe for complaints of pain, specific locations of pain, response to nursing interventions taken to relieve pain. Anticipate patient needs. Provide emotional support as needed."

On 1/30/15, at 8:52 a.m. the DON stated he expected staff to deliver care according to residents' care plans.

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| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement interventions including timely repositioning for 1 of 4 residents (R23) reviewed who were at risk for pressure ulcer development.<br><br>Findings include:<br><br>R23 was assessed at risk for skin breakdown and was not repositioned every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours, 32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. a nursing assistant (NA)-D sat down and assisted resident with eating. R23 remained in the dining room with no assistance with repositioning until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed by NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief, no skin redness was observed and the skin was intact. NA-D and | F 314 | F 314<br>-R23 assessment completed for tissue tolerance. Care plan updated to reflect tissue tolerance assessment.<br>-All staff trained on following care plan and the importance of turning, repositioning and offloading.<br>-Other residents receiving assistance with repositioning and offloading per their careplan.<br>-DNS or designee to audit turning, repositioning and offloading of 2 residents weekly. Results of audits will be reviewed at QAPI monthly. | 3/13/15 |

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| F 314 | Continued From page 56<br>NA-E confirmed the incontinent brief showed wetness.<br><br>R23's undated, Braden assessment (tool used to identify pressure ulcer risk) identified R23 as being at moderate risk for developing a pressure ulcer. R23's care plan (effective 10/22/13 to present), directed staff to provide turning and repositioning schedule per assessment.<br><br>R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia and cerebral vascular accident (stroke). She required extensive assistance of two staff for transfers, bed mobility and unable to ambulate. The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood. The Care Area Assessment (CAA) summary/analysis for pressure ulcers dated 4/8/14, indicated "Resident is an extensive assist with transfers, bed mobility, locomotion, personal hygiene, eating. Resident did not ambulate, skin checks with cares, weekly by licensed staff. Pressure relieving device in bed and wheelchair, barrier cream applied PRN [as needed]."<br><br>The Comprehensive Skin Assessment reviewed on 1/8/15, indicated R23 was identified as being at moderate risk for pressures ulcer development and the plan included to reposition resident every two hours.<br><br>The undated care sheet for R23 identified the resident at "risk for pressure sore," was non-ambulatory, required the assistance for wheelchair mobility and total assistance with all activities of daily living. | F 314 | | |

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

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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 314 | Continued From page 57<br>During an interview on 1/28/15, at 10:18 a.m. NA-D, who consistently worked on the dementia unit, reported he and NA-E were running late with morning cares. They were usually finished by 9:00 a.m. NA-D reported R23 had been assisted out of bed at 6:45 a.m. and acknowledged she was not provided assistance with repositioning needs for greater than two hours.<br><br>During interview on 1/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistants utilized care guides for each resident, which identified each resident's repositioning needs. The ADON further stated the NAs were expected to follow the care guides. The ADON further indicated, "We also rely on the shift nurse to try to keep on eye on cares."<br><br>The Prevention of Pressure Ulcer policy (dated 1/8/15 last reviewed 1/26/15), indicated the procedure purpose was, "To prevent skin breakdown and development of pressure ulcers." The procedure details directed staff to "Establish a turning and positioning schedule in bed and chair to meet the resident needs." | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | F 315 | F 315<br>-R23 and R54 bowel and bladder diary completed and care plan updated to reflect assessment<br>-All staff trained on following care plan and the importance of toileting patients per their plan of care.<br>-Other residents receiving toileting per their careplan.<br>-DNS or designee to audit toileting for 2 random residents weekly. Results of audits will be reviewed at QAPI monthly. | 3/13/15 |

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| F 315 | Continued From page 58 | F 315 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed implement interventions to improve continence for 1 of 1 resident (R54) who experienced a decline in toileting ability, and to provide timely toileting assistance for 1 of 2 residents (R23) observed who required staff assistance with meeting their toileting needs.

Findings include:

R54 was observed while a nursing assistant (NA)-A assisted the resident with toileting on 1/28/15, at 11:26 a.m. NA-A reported the resident's incontinent brief was wet with a small amount of urine she voided on the toilet, as well. NA-A reported that R54 was frequently wet at the time the NAs would assist her to use the toilet.

When interviewed on 1/28/15, at 10:21 a.m. NA-C stated R54 could verbally tell staff when she needed to use the toilet, but when toileted, her brief would already be wet.

NA-B reported on 1/28/15, at 11:22 a.m. that R54 was toileted every two hours. Although R54 reported when she needed to urinate, she was already wet when staff assisted her to the toilet. NA-B was unaware of any attempts to assist R54 to the toilet more frequently than every two hours.

The care plan dated 8/15/14 identified a goal for the resident to be free of urinary tract infections (UTI's). Interventions included: "Evaluate timing of medications which may cause increased urination...evaluate frequency/timing of

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| F 315 | Continued From page 59<br>incontinence episodes...scheduled toileting plan of check and change every two hours and PRN" (as needed). A review of R54's medical record did not reflect UTI's while at the facility or a history prior to admission. Evidence was lacking to show the residents medication timing had been reviewed related to potentially contributing to incontinence as well as her frequency and timing of incontinence episodes. The care plan reflected checking and changing the resident (an intervention when a resident is totally incontinent), although the resident had the ability to successfully use the toilet.<br><br>R54's admission Minimum Data Set (MDS) dated 11/13/14, indicated the resident had frequent incontinence of urine. A subsequent quarterly MDS dated 11/13/14, showed a decline in R54's continence to always incontinent of bladder. R54 also had severe cognitive impairment, required extensive assistance with toileting and transfers. Despite the resident's decline, the MDS did not reflect a trial bladder retraining program for R54.<br><br>A Bladder Assessment form dated 11/13/14, indicated R54 was to be offered toileting assistance every two hours and upon request. The assessment, however, did not include documentation to support the every two hour toileting plan outlined in the summary conclusion.<br><br>When interviewed on 1/28/15, at 10:46 a.m. the assistant director of nursing (ADON) stated she was unaware R54 had experienced a decline in urinary incontinence. She explained staff was to be completing three-day bladder assessments to determine residents' voiding patterns. It had been determined staff had not been completing the monitoring as they should have been, and a | F 315 | | |

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| F 315 | Continued From page 60 | F 315 | | |

couple weeks prior they had been " reminded. " The ADON was unable to provide documentation showing R54's bladder patterns had been established and an appropriate plan developed based on her individual needs. The ADON was also unaware whether a re-assessment had been completed after the MDS showed a decline, or whether a trial for more frequent toileting had been considered.

When interviewed on 1/29/15, at 2:20 p.m. the director of nursing (DON) stated R54 declined in urinary incontinence when she developed pneumonia and did not wish to get out of bed. The DON was unable to provide documentation showing R54's bladder patterns had been established. The DON verified R54 had not experienced any UTI's while at the facility.

R23 was not provided assistance with toileting needs every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours, 32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. nursing assistant (NA)-D sat down and assisted resident with eating. R23 remained in the dining room with no assistance with toileting until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed with NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief. NA-D and NA-E confirmed the incontinent brief showed wetness.

R23's bladder assessment dated 1/8/15, noted the resident had Alzheimer's disease, and was incontinent of bladder and had no sensation of

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| F 315 | Continued From page 61 | F 315 | | |

urine loss. Staff was directed to check and change resident every two hours and as needed.

R23's quarterly MDS dated 1/8/15, revealed diagnoses including dementia, cerebral vascular accident and (stroke). She required extensive assistance of two staff for transfers, was unable to walk and total dependence for toileting needs, and was identified as always incontinent of bladder. The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood. The Care Area Assessment (CAA) summary/analysis for urinary incontinence dated 4/8/14, indicated "Resident at risk for UTI [urinary tract infection], monitor for signs of odor, clarity, frequency. Resident is always incontinent of bowel and bladder, skin checks with cares, barrier cream applied as needed.

R23's care plan with effective date 10/21/13, to present, directed staff to provide scheduled toileting plan of check and change every 2 hours and as needed, use of briefs/pads for incontinence protection and monitor for signs and symptoms for UTI.

The undated, care sheet for R23 directed staff to provided total assistance with ADL's (activities of daily living) and the resident was non-ambulatory.

During interview on 1/28/15, at 10:18 a.m. NA-D, who consistently worked on the dementia unit, reported he and NA-E were running late with morning cares and usually done by 9:00 a.m. and indicated R23 was assisted out of bed at 6:45 a.m. NA-D acknowledged R23 was not provided assistance with toileting needs for greater than two hours.

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| F 315 | Continued From page 62<br><br>During an interview on 1/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistance had care guides for each resident and the care guides identified the resident's repositioning needs. The ADON further stated the NAs were expected to follow the care guides, and "We also rely on the shift nurse to try to keep on eye on cares."<br><br>The Incontinence Management/Bladder Function Guideline policy, dated 1/13/15, reviewed on 1/19/15, indicated the procedure purpose was "Prevent skin problems such as pressure areas and excoriation, Avoid possibility of urinary infection, Manage urinary incontinence, restore of maintain as much normal bladder function as possible." The guidelines indicated "If a resident is cognitively impaired and is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinent care program." The interdisciplinary care plan team will evaluate the effectiveness of the program and make recommendations to continue, change or discontinue the program with the quarterly MDS review." | F 315 | | |
| F 323<br>SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | | |

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| F 323 | Continued From page 63<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to assess a potential accident hazard for 1 of 4 residents (R38) reviewed for restraints and failed to implement recommended fall interventions for 2 of 4 residents (R15, R6) reviewed for accidents and to miminize the risk of injury or elopement for the 18 residents who resided on the unit.<br><br>Findings include:<br><br>R38 was observed on 1/27/15, at 11:00 a.m. while in bed. A perimeter defining mattress was on bed, and the bed was up against the wall, and a pillow was placed under the middle section of the mattress, between the mattress and the bed frame.<br><br>On 1/27/15, at 11:55 a.m. NA-D and NA-F assisted resident out of bed and into her wheelchair. NA-D and NA-F was interviewed and stated the pillow was placed under the mattress as resident "slides out of bed."<br><br>On the following day, 1/28/15, at 6:55 a.m. R38 was observed in bed, with continued use of defining mattress on bed, bed up against the wall and a wedge cushion was placed under the middle section of the bed. The wedge cushion slightly raised the exit side of the bed.<br><br>On 1/28/15, at 9:55 a.m. NA- D and NA-E assisted R38 out of bed after dressing and providing incontinent cares. Staff reported resident was partially dressed as she was awake and trying to get out of bed so the night shift assisted her out of bed, before 7:00 a.m. NA-D | F 323 | F 323<br>-The Facility will assess the use of a device as a potential restraint who utilize a perimeter defining mattress,<br><br>pillow or wedge cushion under the mattress of bed<br>-Staff re-educated on looking through the ACU doors prior to opening the door, open slowly<br>-ED or designee will audit ACU doors<br>-R38 wedge cushion and pillow under mattress discontinued. Perimeter defining mattress assessment completed for a restraint. for all residents.<br>-DNS or designee to perform potential restraint assessment on all residents with perimeter defining mattress, pillow or wedge cushion under mattress of bed.<br>-R6 and R15 fall care plans reviewed and updated with interventions to prevent falls.<br>-Other residents with<br>-DNS or designee to complete 3 random chart audits weekly to assure potential restraint assessments have been completed and fall interventions are placed in care plan. Results from audits will be reviewed at QAPI monthly. | 3/13/15 |

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| F 323 | Continued From page 64<br>and NA-E further stated she was laid back down by NA-D and NA-E because she was "falling out wheelchair...leaning." Staff further stated the wedge cushion is placed under her bed because she tried to get up, "will roll out of bed." NA-D and NA-E stated the resident was unable to get out of bed independently but had rolled out of bed in the past. Fall log incidents for the past six months was reviewed, and no incident of R38 falling out of bed was noted.<br><br>R38's annual Minimum Data Set (MDS) dated 11/7/14, revealed diagnoses including dementia, and arthritis. She required extensive assistance of one staff for transfers, bed mobility and unable to ambulate. The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood.<br><br>R38's care plan with effective date 11/6/12, to present indicated R38 was at risk for falls due to history of falls and psychotropic medication use. The interventions indicated contour mattress on bed and bolster under mattress (revised 12/20/14).<br><br>Further review of the record revealed no assessment of the perimeter defining mattress (contour mattress) or use of wedge cushion or pillow as a potential accident hazard for R38.<br><br>The DON was interviewed on 1/30/15, at 9:35 a.m. He verified that R38 has not had any falls from bed in the past six months. The DON indicated R38 utilized the perimeter defining mattress and wedge cushion under the mattress of the bed due to history frequent attempts of self-transfers out of bed. The DON indicated R38 is able to get out of bed independently but is not | F 323 | | |

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safe and the wedge cushion was used keep resident safe and not allow her to roll of bed. The DON further confirmed the wedge cushion under the mattress prevented R38 from self-transfers. The DON acknowledged the use of the perimeter defining mattress, and pillow or wedge cushion had not been assessed as a potential accident hazard for R38.

R15 was reportedly found sitting on the floor by her bed on 1/24/15, at 10:50 a.m. according to the assistant director of nursing (ADON) on 1/26/15, at 6:05 p.m. The ADON explained R15 had been attempting to self-transfer, and was not injured from the fall.

On 1/28/15, at 7:26 a.m. R15 was observed sitting at a table in the dining room. The resident was wearing stockings with no shoes. At 8:40 a.m. R15 was lying in bed. At the time of the observation, a nursing assistant (NA)-B explained she had just assisted the resident to use the toilet and to lie down. NA-B also reported R15 sometimes got out of bed on her own, and other times she asked for help.

The following morning at 9:28 a.m. the resident was propelling herself in her wheelchair by using her feet and pulling on the hand rail as she moved toward the dining room. She was wearing socks and shoes.

On 1/28/15, at 9:37 a.m. a licensed practical nurse (LPN)-A stated, "We monitor [R15's] self-transferring if we see it. I have seen her transfer herself...[R15] can transfer from the chair to the bed pretty good, but can't transfer from the bed to the chair...I think it is her coordination. She has been getting more confused lately. Monday

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night when I worked she was sitting in the dining room thinking it was breakfast." LPN-A stated R15 usually tried to get herself out of bed when she was looking for ice cream or had to use the bathroom. LPN-A said ice cream snacks were served at 10:00 a.m. and 3:00 p.m.

On 1/29/15, at 9:33 a.m. NA-G who had worked at the facility for several years was interviewed. NA-G explained that sometimes R15 wore both socks and shoes. At other times she preferred to only wear socks and not shoes. NA-G confirmed the socks were normal socks and the resident did not utilize gripper socks.

At 9:52 a.m. NA-E who worked at the facility for several years also stated sometimes R15 wore shoes and socks, and other times just wore her own socks. NA-E also stated he had never put gripper socks on R15 as the resident had her own socks.

On 1/29/15, at 2:24 p.m. LPN-C stated she worked the night shift and R15 sometimes self-transferred. LPN-C also stated R15 removed her shoes and socks and would also put her shoes back on. The resident was experiencing intermittent confusion, and was getting days and nights mixed up. When asked whether R15 wore gripper socks LPN-C answered, "All the residents should have gripper socks at night so they don't fall."

At 2:29 p.m. LPN-D explained R15 was at risk for falls, and needed one staff to assist her with transfers. R15, however, sometimes "forgot" and transferred herself. LPN-D verified R15 usually just wore her own personal socks when she was lying in bed.

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A Minnesota Incident Report dated 11/24/14, for R15 indicated the resident experienced a fall on 11/24/14, at 9:15 a.m. A description of the fall indicated R15 "slid from bed to floor--covers were bunched at edge, only socks on." It was noted the resident was confused and stated she "'wanted to get up for lunch.'" Contributing factors were identified as "Stocking feet, bunched bedding." Specific Recommendation/Intervention were for "Gripper socks at all times." R15's family response on the report was noted as, "'Good idea--gripper socks.'" A corresponding progress not indicated the resident reported she was getting up to eat, and the bedding was bunched up and she was "stocking footed...gripper socks applied."

A Minnesota Incident Report dated 1/24/15, for R15 indicated the resident fell on 1/24/15, at 10:50 a.m. R15 was found sitting on the floor between the bed and curtain. According to the NA, the w/c brakes were not on, and it was thought R15 "may have tried to self-transfer and slipped and fell on her buttocks." A contributing factor was identified as "Brakes on w/c were not on." Specific Recommendation/Intervention were, "Put brakes on, encourage resident to use call light with transfer." The summary indicated "Resident stated that she was trying to get out of bed." A corresponding progress note on 1/14/15, read "[R15] likes to transfer self from w/c to bed. Assist of 1 with transfers and ADLs [activities of daily living].

A subsequent progress note dated 1/29/15, indicated the resident required assistance with all ADLs and transferring. She was able to make some needs known, but also had some

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| F 323 | Continued From page 68<br>confusion.<br><br>R15's falls care plan dated 1/24/15, indicated R15 needed staff assistance with transfers. The interventions, however, did not include gripper socks at all times as recommended after the 11/24/14 fall. In addition, staff were not directed in the care plan to ensure R15's w/c brakes were applied and to encourage the resident to call for help as recommended after the 1/24/15 fall.<br><br>On 1/28/15, at 10:09 a.m. the assistant director of nursing (ADON) explained that all managers met the day after a resident fell to brainstorm, decide on fall interventions, and update the care plan. The ADON also said interventions were also listed on the back of each resident's care plan. RN-A then verified the latest fall intervention on the back of R15's care plan (page 2, print date 12/23/14) was dated 6/24/14.<br><br>Contributing Factors for R6's fall on 1/14/15, were not identified and the fall intervention was not followed through. R6's care plan was not updated for 2 staff assist with cares after the fall as noted in R6's progress notes. Additionally, R6's care plan was observed to be not followed for footwear to prevent slipping.<br><br>On 1/26/15, at 5:47 p.m. during staff interview when asked if R6 had fallen in the last 30 days, the ADON answered R6 had fallen on 1/14/15, that R6 was trying to walk to the bathroom with her walker, and lost her balance.<br><br>R6's annual MDS dated 11/21/14, indicated R6 was cognitively moderately impaired with no behaviors. The annual MDS also indicated R6 needed extensive staff assist with all ADLs. The | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A. BUILDING ______ B. WING ______ | 01/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 323 | Continued From page 69<br>annual MDS further indicated R6 was not steady, only able to stabilize with staff assist for balance during transitions and walking, moving on and off toilet and surface to surface transfer between bed and chair or w/c.<br><br>On 1/28/15, at 7:56 a.m. R6 was sitting in her w/c in her room next to her bed. NA-B was observed to apply transfer belt around R6's waist. NA-B then held onto R6's left arm and pulled up on back of R6's pants with her right hand and lifted R6 to stand up and turn and sit on side of bed. R6's stocking feet were observed to slip out from under her during the transfer . NA-B lifted R6's legs and swung them into bed. NA-B hurried throughout the transfer. R6's white personal stockings were observed to be blackened on the bottom of her socks.<br><br>On 1/28/15, at 8:25 a.m. NA-B stated R6 walked with one staff assist. At 10:16 a.m. NA-A stated R6 could stand, but could not really walk. At 10:36 a.m. NA-G stated R6 walked in her room with staff. NA-G also stated R6 did not like to wear slippers or shoes, she usually wore socks. NA-G further stated, "I usually put gripper socks on R6, we get them here with rubber on the back."<br><br>On 1/28/15, at 10:53 a.m. R6 was lying in bed. NA-B lifted up R6's legs from the bed and swung around R6 to sit up on the side of the bed. NA-B applied transfer belt to R6 and NA-B and NA-A helped R6 to stand. R6 at the time was not wearing gripper socks, was wearing her own white personal socks. R6 leaned on the walker, very shaky, and NA-B stated, "Get your balance." NA-B held under R6's arm and NA-A held onto R6's transfer belt as R6 walked with walker, very | F 323 | | |

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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 323 | Continued From page 70 | F 323 | | |

unsteady and limped towards the bathroom and the two NAs assisted R6 to the toilet. NA-A stated he looked for R6's balance. NA-A also stated, "She is shaky, assist of two staff is good for her safety. NA-A further stated R6 normally limped and was shaky when she walks. At 11:00 a.m. R6 walked with walker and limped and slightly shaky from toilet to w/c with the two NAs to her w/c to sit down. R6 sitting in her w/c slid her stocking feet back and forth on the floor. R6 did not have gripper socks on. NA-A went to R6 and applied R6's personal slippers to her feet. NA-B stated R6 sometimes wore slippers and sometimes R6 wore gripper socks.

On 1/29/15, at 9:31 a.m. NA-G stated she always every morning put a new pair of gripper socks on R6. Later, at 2:26 p.m. LPN-C stated she usually worked the night shift, and R6 used to need one staff assist but right now required two staffs' assist because of "her behaviors." At 2:28 p.m. LPN-D stated R6 was a fall risk, needed someone with her, and usually just wears gripper socks. At 2:35 p.m. RN-B stated she did not think R6 was a "fall risk" and and stated she did not know what footwear R6 was supposed to wear on her feet.

A Progress Note dated 1/14/15, for R6 indicated "Family members had called facility regarding resident's fall and DON was also notified. Resident's cares with presence of 2 persons until further instruction from DON."

R6's care plan "At risk for falls related to: Fell in the past 30 days, Use of medication, New environment, History of falls" indicated R6 was to wear "Footwear to prevent slipping." The care plan also indicated R6 was to have "PT/OT eval

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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 323 | Continued From page 71 | F 323 | | |

[physical therapy/occupational therapy evaluation] dated 1/15/15. R6's care plan indicated 'I have a physical functioning deficit related to: Self care impairment, Mobility impairment, ROM limitations'...Transfer, Toileting, Locomotion assistance of 1."

The Minnesota Incident Report for R6's fall on 1/14/15, at 6:15 p.m. did not identify any contributing factors for R6's fall. The Specify Recommendations/Interventions Taken to Prevent Reoccurrence indicated 'Further evaluation by therapy to investigate if resident can really use a walker'.

The rehabilitation director stated on 1/29/15, at 2:44 p.m. R6 had refused a PT evaluation on 1/16/15. Rehab director stated the resident had told the therapist to "'come back next week.'" The rehab director further stated therapy was planning to attempt a second time for a therapy evaluation with R6 but had not yet done it. The director said the refusal had not been documented no documentation was provided. The rehab director also stated both the DON and RN-A were aware of R6's refusal for a therapy evaluation.

Observations revealed multiple staff did not implement safety measures to minimize the risk for injury and potential elopement for residents residing on the secured/locked unit. The door to the facility's memory care unit had a sign indicating directing persons who entered the unit to check to use caution to ensure a resident was not on the other side of the door. A visible crack between the two doors allowed some degree of visibility into the hallway, and then if persons slowly opened the door, could then check for a resident potentially standing behind the doorway.

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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 323 | Continued From page 72<br>Residents were known to stand by the doorway, sometimes seeking exit. In addition, a resident could have been hit or pushed over by the opening door. Eleven residents on the unit were ambulatory, and seven were mobile in wheelchairs.<br><br>On 1/28/15, at 7:20 a.m. as one surveyor was informing another surveyor of the code for the dementia unit, and stressing the importance of being carefully entering the unit (because residents stood on the other side of the door and could get hit by the door), the assistant director of nursing (ADON) rather abruptly and without looking pushed the door to the unit open. Observations of staff entering the unit were then conducted and were as follows:<br>7:22 The administrator entered the unit without first looking<br>7:25 A laundry staff person entered the unit without looking and by pushing the door open with her back side as she pulled the laundry cart in after herself.<br>7:30 A dietary staff person (dietary)-A very purposefully looked through the crack and stated, "Good" as she slowly entered.<br>7:31 The Minimum Data Set (MDS) nurse entered as she looked straight ahead toward the crack between the doors<br>7:33 The director of nursing distinctly checked for residents, but then instead of entering the unit entered the adjacent room where surveyors were working.<br>7:35 MDS nurse again entered, but without looking and just pushing the door open<br>7:40 An unknown nursing assistant entered, but it could not be determined whether he checked for residents before entering<br>7:50 The same laundry staff again entered | F 323 | | |

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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 323 | Continued From page 73<br>backward without looking and was pulling a cart<br>7:50 MDS nurse entered without first checking for residents<br>7:53 A second unknown NA entered, but was unclear if he checked for residents<br>7:59 A housekeeper (hskp)-A entered backward without looking while pulling a housekeeping cart<br>8:02 An unknown staff person entered while looking at green button versus through doorway<br>8:03 Dietary-A again looked carefully through door before entering. When the surveyor commented on how very cautious she was prior to opening the door she replied, "Yeah! You have to be. You could take someone out."<br>8:08 The same NA who entered at 7:40 again entered and carefully looked<br><br>On 1/30/15 at 9:43 a.m. the director of nursing (DON) was interviewed regarding safety concerns related to the entrance to the dementia unit. The DON said they had never had any injuries related to residents on the other side of the door. They had a sign on the door instructing people to look before entering, but was not sure whether the sign was still on the door. The DON said the expectation was for staff to look through the crack of the door, open slowly then go through or pull a cart through. He acknowledged it would not have been safe to just enter without first checking for a resident on the other side of the door. The sign was then viewed on the door. The director of maintenance then stated they could consider replacing it with a door with a window. | F 323 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

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| F 431 | Continued From page 74<br>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure multi-dose vials were dated when opened to ensure efficacy of the vaccine contents. This had the potential to affect newly admitted residents who may have | F 431 | F 431<br>-Facility has removed any non-dated or outdated medications in all storage areas, including multi-dose vials.<br>-Other storage areas were reviewed and medications are dated and stored appropriately.<br>-DNS or designee to audit medication storage areas 2 times weekly to check for expired or improper labeling of medications. Audit results will be reviewed at QAPI montly.<br>-Education provided to Nurses on proper labeling of opened medications and disposal of expired or unlabeled medications. | 3/13/15 |

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| F 431 | Continued From page 75<br>been vaccinated.<br><br>Findings include:<br><br>On 1/29/15, at 9:17 a.m. observations of the facility's medication storage was conducted with a licensed practical nurse (LPN)-B.<br><br>The south unit medication room housed both the north and south refrigerated medications. One multi-dose vial whose label indicated it contained FLULAVAL 2014, 2015 Formula flu vaccine, 5 milliliters (ml)/ 10 doses was found open (i.e. with the cap off), but it lacked the expected handwritten open date. The printed label did include an expiration date, "2015 June," which was not a concern. No box was found for the vaccine. On 1/29/15, at 9:41 a.m. LPN-B verified during an interview no open date was present, and he could not find the box for the vaccine. LPN-B indicated he did not know if the vial's lack of an open date was a problem.<br><br>The director of nursing (DON) was interviewed on 1/29/15, at 9:48 a.m. He stated he did not know the facility policy for open dates on vaccine vials off the top of his head. At 9:54 a.m. he indicated he had called the facility's pharmacy representative and was told the vaccine vial should have been discarded 28 days after being pierced. At 10:50 a.m. the DON presented the facility's policy for FLULAVAL, which indicated an open multi-dose vial should be discarded after 28 days. The DON verified in an interview at 10:52 a.m. "If a cap is off I count that as opened and used." The DON returned at 10:58 a.m. to say the vial had been discarded.<br><br>A document containing the manufacturer's | F 431 | | |

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| F 431 | Continued From page 76<br>Prescribing Information for FLULAVAL was reviewed and read, "How Supplied/Storage and Handling...Once entered, a multi-dose vial should be discarded after 28 days." | F 431 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5332025
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 01/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET<br>EXCELSIOR, MN 55331 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Excelsior 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to: | K 000 | POC ok<br>PB 3-6-15<br><br>RECEIVED<br>MAR - 6 2015<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

EXIT: 1-30-15 DC: 3-11-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 3-4-15

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

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|---|---|---|---|
| | 245332 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 01/28/2015 |

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| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>This 1-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 48 beds at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 072<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.<br>7.1.10 | K 072 | K 072<br><br>Facility is going to remove all wheeled storage from the corridors by March 11th, 2015. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A BUILDING 01 - MAIN BUILDING 01<br>B WING ______ | 01/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 072 | Continued From page 2<br><br>This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 11:00 AM on 01/28/2015, observation revealed that there is wheeled storage in several of the resident corridors. The facility does not have a categorical waiver for wheeled storage.<br><br>This deficient practice was verified by the administrator at the time of the inspection. | K 072 | | |

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 5414

February 17, 2015

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5332024

Dear Ms. Lubbesmeyer:

The above facility was surveyed on January 26, 2015 through January 30, 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 St Paul Minnesota 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 Gayle Lantto at (651) 201-3794.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5332s15lic

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00988 | A. BUILDING: ______ B. WING ______ | 01/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOLDEN LIVINGCENTER - EXCELSIOR** | **515 DIVISION STREET EXCELSIOR, MN 55331** |

| (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 |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>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.<br><br>The assigned tag number appears in the far left | 2 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

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| 2 000 | Continued From page 1<br><br>column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 505 | MN Rule 4658.0300 Subp. 1 A-E Use of Restraints<br><br>Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given.<br><br>A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of | 2 505 | | |

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| 2 505 | Continued From page 2<br><br>movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.<br>B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.<br>C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident.<br>D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.<br>E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document | 2 505 | | |

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| 2 505 | Continued From page 3 | 2 505 | | |

Continued From page 3

review, the facility failed to assess the use of a device as potentially restraining for 1 of 1 resident (R38) who utilized a perimeter defining mattress and a pillow or wedge cushion under the mattress of bed.

Findings include:

R38 was observed on 1/27/15, at 11:00 a.m. while in bed. A perimeter defining mattress was on the bed and the bed was up against the wall. A pillow was placed beneath the mattress and bed frame in the middle section of the bed.

On 1/27/15, at 11:55 a.m. nursing assistants (NA)-D and NA-F assisted R38 out of bed and into her wheelchair. NA-D and NA-F were interviewed and explained that the pillow was used underneath the mattress, as the resident "slides out of bed."

The following day on 1/28/15, at 6:55 a.m. R38 was again observed in bed. The perimeter defining mattress was on the bed and the bed was against the wall. A wedge cushion was placed between the mattress and bed frame in the middle section of the bed. The wedge cushion slightly raised the exit side of the bed.

On 1/28/15, at 9:55 a.m. NA- D and NA-E assisted R38 out of bed. The NAs reported the reason the resident was partially dressed was because she had been awake and was trying to get out of bed, so the night shift staff got her up before 7:00 a.m. NA-D and NA-E further explained they had assisted R38 back into bed because she was "falling out her wheelchair" and was "leaning." The NAs explained the wedge cushion was used because R38 tried to get up and "will roll out of bed." Although she was

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| 2 505 | Continued From page 4<br>unable to rise independently, she had rolled out of bed in the past according to NA-D and NA-E.<br><br>The logged fall incidents for the previous six months were reviewed for R38. No incidents were noted of R38 falling or rolling out of bed were noted.<br><br>R38's annual Minimum Data Set (MDS) dated 11/7/14, revealed diagnoses including dementia, and arthritis. Extensive assistance was required of one staff for transfers and bed mobility and the resident was unable to ambulate. R38 had severely impaired cognitive skills, unclear speech, and could sometimes understand others or be understood. Restraint use was not identified on the MDS.<br><br>R38's Care Conference Summary Sheets dated 5/22/14, 8/21/14, and 11/26/14, did not reflect potential restraint use. The care plan (effective 11/6/12 to present) noted R38 was at risk for falls due to a history of falls and psychotropic medication use. The interventions directed staff to utilize a contour mattress on the bed, and on 12/20/14, an addition was made to the care plan to include the use of a bolster cushion underneath the mattress.<br><br>Further record review revealed no assessment had been completed to determine whether the perimeter defining mattress (contour mattress) and use of a wedge cushion or pillow was potentially restraining for R38.<br><br>The director of nursing (DON) was interviewed on 1/30/15, at 9:35 a.m. He verified R38 had not had any falls from the bed in the past six months. R38 utilized the perimeter defining mattress and wedge cushion under the mattress of the bed due | 2 505 | | |

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| 2 505 | Continued From page 5<br>to history frequent attempts of self-transfers out of bed. The DON also explained R38 was able to independently get out of bed, but not safely, and the wedge cushion was being used to "keep the resident safe" and not allow her to roll out of bed. The DON further confirmed the wedge cushion under the mattress prevented R38 from self-transfers, and acknowledged a restraint assessment had not been completed.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about what constitutes a restraint. The DON or designee, could randomly audit resident records to ensure devices that potentially restrain a resident have been assessed to ensure safe and least restrictive restraint use.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 505 | | |
| 2 555 | MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development<br><br>Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen | 2 555 | | |

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| 2 555 | Continued From page 6 | 2 555 | | |

representative.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to identify on the care plan the use of perimeter defining mattress for 3 of 4 residents (R5, R16, R28) reviewed for restraints.

Findings include:

The care plan did not identify the use of perimeter mattress for R5, R16, and R28.

R5's morning cares were observed on 1/28/15, at 8:00 a.m. with nursing assistants (NA)-D and NA-E. R5 sat up in bed independently, scooted herself twice to get over the edge of the perimeter mattress of the bed, stand up and walk to her closet with her walker independently. NA-D stated R5 was capable of getting in and out of bed independently.

R5's quarterly Minimum Data Set (MDS) dated 11/28/14, revealed diagnoses including depression and psychotic disorder. She required limited assistance of one staff for bed mobility, transfers and supervision for walking. The resident had severely impaired cognitive skills, could usually understand others and be understood.

R5's care plan with effective date 3/3/14, to present, indicated at risk for falls due to history of falls. The care plan interventions did not include use of a perimeter mattress.

R16's cares were observed on 1/28/15, at 10:26 a.m. NA-D walked with R16 to her bed, providing

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| 2 555 | Continued From page 7 | 2 555 | | |

hand held assistance. NA-D stated R16 is capable of getting in and out of bed independently. A perimeter mattress was observed on the bed.

R16's quarterly MDS dated 11/14/14, revealed diagnoses including Alzheimer's disease, depression, anxiety and psychotic disorder. She required extensive assistance of one staff for bed mobility, limited assistance for transfers and walking. The resident had severely impaired cognitive skills, unclear speech, could usually understand others and sometimes be understood.

R16's care plan with effective date 3/3/14, to present, indicated at risk for falls due to wandering and use of medication. The care plan interventions did not include use of perimeter mattress.

R28's cares were observed on 1/28/15, at 7:42 a.m. while assisted by NA-D and NA-E. R28 was sitting up in bed, stood, and walked to her closet independently. NA-D verified R5 was capable of getting in and out of bed independently.

R28's quarterly MDS dated 11/14/14, revealed diagnoses including dementia and Parkinson disease. She required extensive assistance of one staff for bed mobility, limited assistance for transfers and walking. The resident had severely impaired cognitive skills, could usually understand others.

R28's care plan effective 5/23/14 to present, indicated at risk for falls due to history of wandering, use of medication and diagnoses of Parkinson disease. The care plan did not include the use of a perimeter mattress.

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The director of nursing (DON) was interviewed on 1/30/15, at 9:46 a.m. The DON indicated perimeter mattresses were implemented for residents who had experienced a fall from the bed. The DON further stated that R5, R16, and R28 were all able to transfer independently from their beds. The DON added that the use of perimeter mattresses should have been identified as fall interventions on R5, R16, and R28's care plans.

The Falls Management Guidelines policy dated 1/22/15, indicated "Following a resident fall appropriate interventions are implemented, care plan is updated."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Care Plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use | 2 565

Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.

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| 2 565 | Continued From page 9 | 2 565 | | |

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure toileting was provided as directed by the care plan for 1 of 2 residents (R23) reviewed for urinary incontinence and to ensure repositioning was provided as directed by the care plan for 1 of 4 residents (R23) reviewed for pressure ulcers. In addition, the care plan was not followed for 1 of 3 residents (R19) reviewed for dignity.

Findings include:

R23's care plan with effective date 10/21/13, to present, directed staff to provide scheduled toileting plan of check and change every 2 hours and as needed, use of briefs/pads for incontinence protection and monitor for signs and symptoms for UTI. The Comprehensive Skin Assessment reviewed on 1/8/15, indicated R23 was identified as being at moderate risk for pressures ulcer development and the plan included to reposition resident every two hours. The undated, care sheet for R23 directed staff to provided total assistance with ADL's (activities of daily living) and the resident was non-ambulatory. It was also noted the resident was at "risk for pressure sore," was non-ambulatory, required the assistance for wheelchair mobility and total assistance with all activities of daily living.

R23 was not provided assistance with toileting needs and repositioning every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours, 32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. nursing assistant (NA)-D sat down and

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assisted resident with eating. R23 remained in the dining room with no assistance with toileting until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed with NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief. NA-D and NA-E confirmed the incontinent brief showed wetness.

During an interview on 1/28/15, at 10:18 a.m. NA-D, who consistently worked on the dementia unit, reported he and NA-E were running late with morning cares and usually done by 9:00 a.m. and indicated R23 was assisted out of bed at 6:45 a.m. NA-D acknowledged R23 was not provided assistance with toileting and repositioning needs for greater than two hours.

During an interview on 1/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistance had care guides for each resident and the care guides identified the resident's toileting and repositioning needs. The ADON further stated the NAs were expected to follow the care guides, and "We also rely on the shift nurse to try to keep on eye on cares."

The Incontinence Management/Bladder Function Guideline policy, dated 1/13/15, reviewed on 1/19/15, indicated the procedure purpose was "Prevent skin problems such as pressure areas and excoriation, Avoid possibility of urinary infection, Manage urinary incontinence, restore of maintain as much normal bladder function as possible."

The Prevention of Pressure Ulcer policy (dated 1/8/15 last reviewed 1/26/15), indicated the procedure purpose was, "To prevent skin

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breakdown and development of pressure ulcers." The procedure details directed staff to "Establish a turning and positioning schedule in bed and chair to meet the resident needs."

R19's current care plan directed staff to "Help me maintain my dignity. Provide emotional support as needed. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Help me with reminders and cues as needed. Please allow me to do what I am capable of doing at my own pace in my own way even if it doesn't make sense to you. Please remember that I am an adult and treat me accordingly. Please tell me what you are going to do before you begin. Explain all procedures and reason before performing. Approach patient in a calm, positive, reassuring manner. Staff to identify self with each contact if needed and explain all procedures before starting. Allow calm, unhurried environment to encourage communication. Answer questions as needed and repeat as necessary. Anticipate patient needs. Encourage patient to verbalize needs. Listen carefully, validate verbal and non verbal expressions. Maintain eye contact if possible. Monitor for ability to make needs known and report significant findings. Use simple and direct communication to promote understanding."

R19 was interviewed on 1/27/15, at 8:53 a.m. When asked if staff treated her with respect and dignity the resident answered, "No. Staff don't talk to you. After staff get me up in the morning they put me in the living room to watch television and then I sit there until they take me to the dining room for a meal. I never get to go to the bathroom because they just lay me in bed and change me. I wet my pad while I am waiting to be

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changed, and then I sit in the wet pad, and then I go number two in my pad. It makes me feel inferior to the other residents here" (regarding waiting for her brief to be changed and that she could not use the bathroom like her roommate. R19 also stated, "I wish staff would not be so rough with me when they wash me up in the morning...."

The following day at 7:44 a.m. R19 was observed sitting in her wheelchair (w/c) in the dayroom watching television. At 7:46 a.m. a nursing assistant (NA)-B approached R19 and stated, "Okay it's time to eat," and before waiting for a reply from the resident, proceeded to push R19 in her w/c toward the dining room. At 8:16 a.m. R19 was in the day room drinking a cup of coffee. At 8:28 a.m. NA-B approached R19 from behind and without saying anything to the resident, pulled her backward from the table and pushed her down the hallway. As NA-B turned R19's w/c around in the hallway outside her room, the resident's foot bumped the wall and the resident responded, "Ow." NA-B stated, "If you just look at her she will say that. It's hard to know because she is in real pain,. She just always says 'ow' no matter what, even if you just look at her." NA-B and NA-A transferred R19 from the w/c to the bed with the aid of a mechanical lift. Throughout the process R19 grimaced and her face was tensed. She repeated, "ow--ow--ow" repeatedly and she was lowered onto the bed and held her arm as she stated, "My arm hurts. You've broken my arm again." NA-B told R19, "We are not even touching your arm." As NA-B and NA-A rolled R19 back and forth from side to side to lower her pants and check the brief, and then to pull the pants up again, R19 grimaced and cried out loudly, "Ouch! Ouch! Ow! Ow!" NA-B delivered care in a hurried fashion without instruction or telling R19 how she

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was planning to assist the resident next.

On 1/29/15, at 9:26 a.m. R19 was again in the dayroom at a table with two peers and one staff person. A jigsaw puzzle was on the table and R19 stated, "The orange piece goes there," and then again stated, "It goes there." The staff person did not address the resident, who then repeated a little louder, "It goes there." The staff member continued to ignore R19 while talking to one of the other residents at the table. At 9:29 a.m. without looking at R19 the staff answered by stating, "We are watching. We will get there," as she continued to work with the other resident.

On 1/29/15, at 10:01 a.m. NA-G and NA-E assisted R19 onto the bed with the mechanical lift when the resident cried out, "Ouch! My knee." R19's roommate then stated, "There is nothing [expletive] wrong with your legs." As R19 was turned from side to side she grimaced and cried out, "Ow! Ow!" The resident's roommate then stated, "Oh my god!" While lying on her back R19 grimaced and cried out, "Help!" NA-E responded, "One more time." As NA-G washed and dried the resident she grimaced and continued to call out. Her roommate stated loudly enough for the resident to hear, "I can't believe this. I can't have any peace. I can't even sleep." As R19's clothing was adjusted she cried out loudly asking, "Will you stop? Will you stop?" NA-E and NA-G replied, "We are almost done." When cares were completed, R19 asked to have her television turned on. R19's roommate then stated, "Of course you want you television on, and someone else will then have to get up and turn it off." R19 was wearing two very different socks. As NA-E lifted up R19's to don a boot the resident again cried out. NA-E asked, "Is that better?" NA-E also asked R19 if she was comfortable. R19

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responded, "My neck hurts with that pillow jammed under my head. I don't even want to be in here." NA-G did not respond to R19's statement as she gave the resident her call light and remote control. R19 requested the staff turn off the overhead light. When R19's television was turned on, loud scratchy noises were heard, and there were gray jagged lines across the TV screen. R19's roommate stated, "I have to listen to that" and got up and left the room. The NAs left the room without turning off the light as R19 had requested.

Following the care observations at 10:15 a.m. R19 "...they don't listen to me--just like at the puzzle table this morning." R19 further stated, "Or the nurse will say to me when I tell her I have pain, 'I just gave you something for that.'" R19 also stated, "Now with all that rolling around, I just urinated in my pants and I will just have to stay here wet until they get me up--if they do." R19 said she would like to get up at 8:00 a.m. every morning, but "today I got up at 7:25 a.m." R19 had a white substance on her lower bottom teeth and reported the NA did not assist her to brush her teeth that morning. R19 said she had her roommate's comments about her, which were typical. She added, "I asked them to turn my light off and they didn't." She described an issue with her eyes where she found the light bothersome. R19 added, "I want to be with my son and family."

At 11:16 a.m. R19 remained in bed with the TV on with gray jagged lines across the screen and the TV emitted irritating, scratchy sounds. At 2:41 p.m. R19 had been moved to a different room.

R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 had moderately impaired

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cognition, presented no behavioral problems or psychosis, and did not reject cares. R19 required extensive staff assistance for activities of daily living. Diagnoses indicated on the MDS included hemiplegia (paralysis on one side of the body), depressive disorders, spasm muscle and generalized pain.

On 1/28/15, at 10:38 a.m. NA-G reported R19 never used the toilet, and instead used the mechanical lift and the bed pan. NA-G also stated R19 was completely incontinent, although sometimes reported the need for a bowel movement. NA-G further stated, "She is known to scream out. She always says 'ow,' even if you look at her she will say ow."

On 1/29/15, at 10:26 a.m. the DON stated he had heard R19's roommate left the room when R19 received care. R19 mostly had pain with cares, and was being treated with tramadol (pain medication) and MS Contin (narcotic pain medication).

On 1/28/15, at 10:38 a.m. NA-G stated, "She is known to scream out. She always says 'ow,' even if you look at her she will say ow."

On 1/29/15, at 11:17 a.m. the explained that R19 "guilts" her family so they had not been visiting much. She was unaware the TV was not working. In addition, she was unaware of the derogatory comments made by the R19's roommate and stated, "This is concerning about [R19's] roommate's comments towards [R19] and the staff should not be allowing it to happen. We will offer her another room."

R19's 1/15 care plan directed staff to "Evaluate and establish level of pain on numeric

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scale/resident's acceptable level of pain is verbalized as a '5' according to the resident. Make sure I am not in pain or uncomfortable, Assess for pain every shift, Administer pain medication as ordered, Evaluate characteristics and frequency/pattern of pain, Evaluate need to provide medications prior to treatment or therapy, Evaluate what makes the pain worse, Observe for sensory changes to extremities such as pain, warmth, redness, Provide medications as ordered by physician and evaluate for effectiveness, Provide non-pharmaceutical interventions of redirecting, calm behavior and environment, Monitor for pain or stiffness, Observe for complaints of pain, specific locations of pain, response to nursing interventions taken to relieve pain, Anticipate patient needs, Provide emotional support as needed."

No supporting documentation was found on the e-mar (electronic medication administration record) for R19's physician order "Offer PRN oxycodone (narcotic pain medication) at least every 4 hours". In addition, R19 was not given a prn (as needed) pain medication three separate incidences; once on 12/22/14, and twice on 1/28/15, when R19 reported pain above R19's acceptable level of pain '5' indicated on R19's care plan.

On 1/27/15, at 9:15 a.m. R19 was asked if she had any pain with no relief R19 stated, "My left side, my left ankle hurts right now, a '7 or 8' [out of 10]" R19 also stated, "I don't feel my pain is well controlled."

R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 was cognitively moderately impaired. The quarterly MDS dated 1/3/5, also indicated R19 had no behaviors, no delirium, no

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psychosis, no rejection of cares, and R19 needed extensive staff assist for activities of daily living (ADLs). The quarterly MDS dated 1/3/15, further indicated 'Yes' R19 received pain regimen, 'No' R19 had not received PRN (as needed) pain medication, and 'Yes' R19 had received non-medication intervention for pain. The quarterly MDS dated 1/3/15, also indicated R19 reported 'frequently hurting' also indicated R19 gave a 'moderate' for verbal descriptor of pain, and also indicated R19's pain did not affect sleep or limit day activities.

On 1/30/15, at 8:52 a.m. the DON stated he expected staff to follow the residents' care plans.

TO COMPLY: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The DON or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 570 | MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision | 2 570

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, and, to the extent practicable, with the participation of the resident, the resident's legal

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guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to revise care plans when changes were required for 1 of 1 resident (R34) reviewed for dialysis and for 1 of 3 residents (R15) reviewed for accidents.

Findings include:

R34 was observed while in bed on 1/27/15, at 3:51 p.m. He reported he had dialysis the next day, and would be returning to the facility after 11:00 a.m. The following morning R34's room was observed at 1/28/15, at 8:09 a.m. while R34 was at dialysis. No water pitcher or other fluids were observed at that time in his room.

In an interview with R34 on 1/29/15, at 11:27 a.m. he reported, "They took me off the special [unknown] diet. I've been on a regular diet for about a month." He also indicated he was drinking whatever fluids he wanted at present. He explained his dialysis shunt had recently been replaced by an upper chest access line. He added that dressing changes were performed by staff at dialysis and said, "The nurses here don't change or look at it."

R34 received kidney dialysis three times weekly for end stage renal disease (kidney failure). In addition, the resident had other diagnoses including type II diabetes.

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| 2 570 | Continued From page 19<br>R34's care plan dated 11/3/14, included a plan for nutritional risk related to the need for extra protein and refusal of meals with poor intake, weight loss since his last admission, and several opened skin area. A handwritten addendum read "1500 cc [cubic centimeters] fluid Restriction [sic] 12/2014." Goals for R34 included weight above 190 pounds and improved laboratory values. Interventions included diet as orders with extra protein and supplementation at meals. Staff were also to monitor daily meal consumption and monthly weights. For the residents' alteration in kidney function the plan (also dated 11/3/14) with a risk for sodium and potassium excess. Goals including laboratory values within therapeutic ranges, and staff were directed to "check access site daily fistula/graft/catheter" for signs of infection. "Diet and fluid restrictions as ordered by Physician. Encourage patient to follow nutritional and hydration program interventions...." Additionally, staff were to complete laboratory work as orderd by the physician and when a change in clinical signs or symptoms was noted. "Monitor thrill and bruit daily" (shunt function) and to document and report abnormal findings to the physician. Dialysis time was noted as "2 PM," with a written communication form reviewing weights and any changes in condition to be sent between the dialysis provider and the facility.<br><br>A nursing assistant (NA)-H was interviewed on 1/29/15, at 2:41 p.m. and reported an awareness R34 was prescribed a renal diet, and went to dialysis on Monday, Wednesday, and Friday. NA-H stated R34 had been on a fluid restriction, "but not now." He explained that information regarding R34's care was noted on the NA assignment sheet.<br><br>During an interview on 1/29/15, at 3:41 p.m. the | 2 570 | | |

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assistant director of nursing (ADON) reported communication between the facility and the dialysis center was typically in the form of telephone calls versus written information. "They called us today to say they would work on his fistula tomorrow, and said they had called his transportation company to tell them too" (due to a changed departure time from the dialysis facility). Additionally, the ADON reported R34 was no longer on fluid restrictions, but was still prescribed a renal diet, "..but he orders sandwiches out or Domino's [pizza]."

During a telephone call to the dialysis facility on 1/30/15, at 11:55 a.m. a dialysis RN-A reported she was "[R34]'s nurse." She verified communication between the dialysis and the residential facility was most often not written. "Usually I call with concerns...and talk to his nurse...some nursing homes send a sheet--this one does not, so we call them or they call us with concerns." The dialysis RN-A

She also indicated R34, "has fluid gains between runs, and we educate him that it's hard on his heart and he may have to go back to the hospital."

On 1/30/15, 2:01 p.m. a licensed practical nurse (LPN)-F indicated R34's weight was to be measured by the day shift staff either before the resident left for dialysis or upon his return. The nurse was responsible for recording the weights in the computer. However, she added that she did not think the NAs were taking the weight daily, and stated, "You're right, they're not all there. We should maybe get a system to get them only when he gets up. Because it's often hard to get them when he gets back." LPN-F said when R34 returned he was likely to be "...really hungry and

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really tired."

During an interview on 1/30/15, at 2:10 p.m. NA-A stated R34 had a fluid restriction, and he was not supposed to give the resident extra fluid. He added, "There is pop in the room sometimes. I'm not sure where that fits within the fluid restriction. Maybe the nurse could answer that better than me."

The current physician orders included daily weights, and a dialysis diet, but did not include a fluid restriction. Nursing staff were to check the access site daily for symptoms of infection or bleeding. No notes were found to show the access site was observed by the nurses, however, in an interview on 1/30/15, at 2:01 p.m. LPN-F said it was being completed.

R34's care plan contained conflicting fluid intake indications, but the most recent change dated 12/20/14, indicated the resident's fluids should have been restricted to 1500 ccs. The care plan also noted the resident had dialysis in the afternoons, but the resident and staff both had indicated he had morning dialysis. Weights and laboratory results, as well as intake and output records were requested but were not supplied by the facility.

Progress notes were reviewed from 11/2/14 through 1/30/15. Notes reflected communication (all calls from the dialysis center to the facility) were recorded on two days during the three months on 1/24/15, and two notes dated 12/23/14. An eMAR--Medication Administration Note was dated 11/10/14, at 10:23 and noted staff was to record the residents daily weight every shift related to edema (excess fluid in the tissues), however, R34 had left for dialysis before

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the NAs were able to weigh him. The notes did not reflect infomation related to checking the fistula for thrill or bruit, nor was the change in location of the dialysis access site as reported by R34 from the arm fistula to a chest catheter indicated in any of the notes. In addition, attempts and/or care of the access site was not noted.

R15's fall interventions from 11/24/14, and 1/24/15, were not updated on R15's careplan.

A Minnesota Incident Report dated 11/24/14, for R15 indicated the resident experienced a fall on 11/24/14, at 9:15 a.m. A description of the fall indicated R15 "slid from bed to floor--covers were bunched at edge, only socks on." It was noted the resident was confused and stated she "'wanted to get up for lunch.'" Contributing factors were identified as "Stocking feet, bunched bedding." Specific Recommendation/Intervention were for "Gripper socks at all times." R15's family response on the report was noted as, "'Good idea--gripper socks.'" A corresponding progress not indicated the resident reported she was getting up to eat, and the bedding was bunched up and she was "stocking footed...gripper socks applied."

A Minnesota Incident Report dated 1/24/15, for R15 indicated the resident fell on 1/24/15, at 10:50 a.m. R15 was found sitting on the floor between the bed and curtain. According to the NA, the w/c brakes were not on, and it was thought R15 "may have tried to self-transfer and slipped and fell on her buttocks." A contributing factor was identified as "Brakes on w/c were not on." Specific Recommendation/Intervention were, "Put brakes on, encourage resident to use call light with transfer." The summary indicated

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"Resident stated that she was trying to get out of bed." A corresponding progress note on 1/14/15, read "[R15] likes to transfer self from w/c to bed. Assist of 1 with transfers and ADLs [activities of daily living].

R15's falls careplan dated 1/24/15, indicated R15 needed staffs' assistance with transfers. The interventions, however, did not include gripper socks at all times as recommended after the 11/24/14 fall. In addition, staff were not directed in the care plan to ensure R15's w/c brakes were applied or to encourage the resident to call for help as recommended after the 1/24/15 fall.

On 1/28/15, at 10:09 a.m. the assistant director of nursing (ADON) explained that all managers met the day after a resident fell, to brainstorm, decide on fall interventions and update the careplan. The ADON also said interventions were also listed on the back of each resident's care plan. RN-A then verified the most recent fall intervention on the back of R15's care plan (page 2, print date 12/23/14) had been on 6/24/14.

On 1/29/15, at 9:33 a.m. NA-G who had worked at the facility for several years was interviewed. NA-G explained that sometimes R15 wore both socks and shoes and at other times she preferred to only wear socks without shoes. NA-G confirmed the socks were normal socks and not gripper socks.

NA-E who had worked at the facility for several years also stated on 1/29/15, at 9:52 a.m. sometimes R15 wore shoes and socks, and other times just wore her own socks. NA-E also stated he had never assisted R15 to wear gripper socks, as the resident wore her own socks.

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| 2 570 | Continued From page 24<br>On 1/29/15, at 2:24 p.m. LPN-C stated she worked the night shift and R15 sometimes self-transferred. LPN-C also stated R15 removed her shoes and socks and was also able to put her shoes back on again. The resident was experiencing intermittent confusion and was getting the days and nights mixed up. When asked whether R15 wore gripper socks LPN-C answered, "All the residents should have gripper socks at night so they don't fall."<br><br>At 2:29 p.m. LPN-D explained R15 was at risk for falls, and needed one staff to assist her with transfers. R15, however, sometimes "forgot" and transferred herself. LPN-D verified R15 usually just wore her own personal socks when she was lying in bed.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 570 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and | 2 830 | | |

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plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

This MN Requirement is not met as evidenced by:
R15 was reportedly found sitting on the floor by her bed on 1/24/15, at 10:50 a.m. according to the assistant director of nursing (ADON) on 1/26/15, at 6:05 p.m. The ADON explained R15 had been attempting to self-transfer, and was not injured from the fall.

On 1/28/15, at 7:26 a.m. R15 was observed sitting at a table in the dining room. The resident was wearing stockings with no shoes. At 8:40 a.m. R15 was lying in bed. At the tim eof the observation, a nursing assistant (NA)-B explained she had just assisted the resident to use the toilet and to lie down. NA-B also reported R15 sometimes got out of bed on her own, and other times she asked for help.

The following morning at 9:28 a.m. the resident was propelling herself in her wheelchair by using her feet and pulling on the hand rail as she moved toward the dining room. She was wearing socks and shoes.

On 1/28/15, at 9:37 a.m. a licensed practical nurse (LPN)-A stated, "We monitor [R15's] self-transferring if we see it. I have seen her transfer herself...[R15] can transfer from the chair to the bed pretty good, but can't transfer from the

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bed to the chair...I think it is her coordination. She has been getting more confused lately. Monday night when I worked she was sitting in the dining room thinking it was breakfast." LPN-A stated R15 usually tried to get herself out of bed when she was looking for ice cream or had to use the bathroom. LPN-A said ice cream snacks were served at 10:00 a.m. and 3:00 p.m.

On 1/29/15, at 9:33 a.m. NA-G who had worked at the facility for several years was interviewed. NA-G explained that sometimes R15 wore both socks and shoes. At other times she preferred to only wear socks and not shoes. NA-G confirmed the socks were normal socks and the resident did not utilize gripper socks.

At 9:52 a.m. NA-E who worked at the facility for several years also stated sometimes R15 wore shoes and socks, and other times just wore her own socks. NA-E also stated he had never put gripper socks on R15 as the resident had her own socks.

On 1/29/15, at 2:24 p.m. LPN-C stated she worked the night shift and R15 sometimes self-transferred. LPN-C also stated R15 removed her shoes and socks and would also put her shoes back on. The resident was experiencing intermittent confusion, and was getting days and nights mixed up. When asked whether R15 wore gripper socks LPN-C answered, "All the residents should have gripper socks at night so they don't fall."

At 2:29 p.m. LPN-D explained R15 was at risk for falls, and needed one staff to assist her with transfers. R15, however, sometimes "forgot" and transferred herself. LPN-D verified R15 usually just wore her own personal socks when she was

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| 2 830 | Continued From page 27<br>lying in bed.<br><br>A Minnesota Incident Report dated 11/24/14, for R15 indicated the resident experienced a fall on 11/24/14, at 9:15 a.m. A description of the fall indicated R15 "slid from bed to floor--covers were bunched at edge, only socks on." It was noted the resident was confused and stated she "'wanted to get up for lunch.'" Contributing factors were identified as "Stocking feet, bunched bedding." Specific Recommendation/Intervention were for "Gripper socks at all times." R15's family response on the report was noted as, "'Good idea--gripper socks.'" A corresponding progress not indicated the resident reported she was getting up to eat, and the bedding was bunched up and she was "stocking footed...gripper socks applied."<br><br>A Minnesota Incident Report dated 1/24/15, for R15 indicated the resident fell on 1/24/15, at 10:50 a.m. R15 was found sitting on the floor between the bed and curtain. According to the NA, the w/c brakes were not on, and it was thought R15 "may have tried to self-transfer and slipped and fell on her buttocks." A contributing factor was identified as "Brakes on w/c were not on." Specific Recommendation/Intervention were, "Put brakes on, encourage resident to use call light with transfer." The summary indicated "Resident stated that she was trying to get out of bed." A corresponding progress note on 1/14/15, read "[R15] likes to transfer self from w/c to bed. Assist of 1 with transfers and ADLs [activities of daily living].<br><br>A subsequent progress note dated 1/29/15, indicated the resident required assistance with all ADLs and transferring. She was able to make some needs known, but also had some | 2 830 | | |

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confusion.

R15's falls careplan dated 1/24/15, indicated R15 needed staff assistance with transfers. The interventions, however, did not include gripper socks at all times as recommended after the 11/24/14 fall. In addition, staff were not directed in the care plan to ensure R15's w/c brakes were applied and to encourage the resident to call for help as recommended after the 1/24/15 fall.

On 1/28/15, at 10:09 a.m. the assistant director of nursing (ADON) explained that all managers met the day after a resident fell to brainstorm, decide on fall interventions, and update the careplan. The ADON also said interventions were also listed on the back of each resident's care plan. RN-A then verified the latest fall intervention on the back of R15's care plan (page 2, print date 12/23/14) was dated 6/24/14.

Dialysis:
R34 received dialysis, however, conflicting information was reported by the resident, staff, and in information in the resident's medical record related to dialysis care.

R34 was observed while in bed on 1/27/15, at 3:51 p.m. He reported he had dialysis the next day, and would be returning to the facility after 11:00 a.m. The following morning R34's room was observed at 1/28/15, at 8:09 a.m. while R34 was at dialysis. No water pitcher or other fluids were observed at that time in his room.

In an interview with R34 on 1/29/15, at 11:27 a.m. he reported, "They took me off the special [unknown] diet. I've been on a regular diet for about a month." He also indicated he was drinking whatever fluids he wanted at present.

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He explained his dialysis shunt had recently been replaced by an upper chest access line. He added that dressing changes were performed by staff at dialysis and said, "The nurses here don't change or look at it."

R34 received kidney dialysis three times weekly for end stage renal disease (kidney failure). In addition, the resident had other diagnoses including type II diabetes.

R34's care plan dated 11/3/14, included a plan for nutritional risk related to the need for extra protein and refusal of meals with poor intake, weight loss since his last admission, and several opened skin area. A handwritten addendum read "1500 cc [cubic centimeters] fluid Restriction [sic] 12/2014." Goals for R34 included weight above 190 pounds and improved laboratory values. Interventions included diet as orders with extra protein and supplementation at meals. Staff were also to monitor daily meal consumption and monthly weights. For the residents' alteration in kidney function the plan (also dated 11/3/14) with a risk for sodium and potassium excess. Goals including laboratory values within therapeutic ranges, and staff were directed to "check access site daily fistula/graft/catheter" for signs of infection. "Diet and fluid restrictions as ordered by Physician. Encourage patient to follow nutritional and hydration program interventions...." Additionally, staff were to complete laboratory work as ordered by the physician and when a change in clinical signs or symptoms was noted. "Monitor thrill and bruit daily" (shunt function) and to document and report abnormal findings to the physician. Dialysis time was noted as "2 PM," with a written communication form reviewing weights and any changes in condition to be sent between the dialysis provider and the facility.

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NA-H was interviewed on 1/29/15, at 2:41 p.m. and reported an awareness R34 was prescribed a renal diet, and went to dialysis on Monday, Wednesday, and Friday. NA-H stated R34 had been on a fluid restriction, "but not now." He explained that information regarding R34's care was noted on the NA assignment sheet.

During an interview on 1/29/15, at 3:41 p.m. the assistant director of nursing (ADON) reported communication between the facility and the dialysis center was typically in the form of telephone calls versus written information. "They called us today to say they would work on his fistula tomorrow, and said they had called his transportation company to tell them too" (due to a changed departure time from the dialysis facility). Additionally, the ADON reported R34 was no longer on fluid restrictions, but was still prescribed a renal diet, "..but he orders sandwiches out or Domino's [pizza]."

During a telephone call to the dialysis facility on 1/30/15, at 11:55 a.m. a dialysis RN-A reported she was "[R34]'s nurse." She verified communication between the dialysis and the residential facility was most often not written. "Usually I call with concerns...and talk to his nurse...some nursing homes send a sheet--this one does not, so we call them or they call us with concerns." The dialysis RN-A

She also indicated R34, "has fluid gains between runs, and we educate him that it's hard on his heart and he may have to go back to the hospital."

On 1/30/15, 2:01 p.m. a licensed practical nurse (LPN)-F indicated R34's weight was to be

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measured by the day shift staff either before the resident left for dialysis or upon his return. The nurse was responsible for recording the weights in the computer. However, she added that she did not think the NAs were taking the weight daily, and stated, "You're right, they're not all there. We should maybe get a system to get them only when he gets up. Because it's often hard to get them when he gets back." LPN-F said when R34 returned he was likely to be "...really hungry and really tired."

During an interview on 1/30/15, at 2:10 p.m. NA-A stated R34 had a fluid restriction, and he was not supposed to give the resident extra fluid. He added, "There is pop in the room sometimes. I'm not sure where that fits within the fluid restriction. Maybe the nurse could answer that better than me."

The current physician orders included daily weights, and a dialysis diet, but did not include a fluid restriction. Nursing staff were to check the access site daily for symptoms of infection or bleeding. No notes were found to show the access site was observed by the nurses, however, in an interview on 1/30/15, at 2:01 p.m. LPN-F said it was being completed.

R34's care plan contained conflicting fluid intake indications, but the most recent change dated 12/20/14, indicated the resident's fluids should have been restricted to 1500 ccs. The care plan also noted the resident had dialysis in the afternoons, but the resident and staff both had indicated he had morning dialysis. Weights and laboratory results, as well as intake and output records were requested but were not supplied by the facility.

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Progress notes were reviewed from 11/2/14 through 1/30/15. Notes reflected communication (all calls from the dialysis center to the facility) were recorded on two days during the three months on 1/24/15, and two notes dated 12/23/14. An eMAR--Medication Administration Note was dated 11/10/14, at 10:23 and noted staff was to record the residents daily weight every shift related to edema (excess fluid in the tissues), however, R34 had left for dialysis before the NAs were able to weigh him. The notes did not reflect information related to checking the fistula for thrill or bruit, nor was the change in location of the dialysis access site as reported by R34 from the arm fistula to a chest catheter indicated in any of the notes. In addition, attempts and/or care of the access site was not noted.

R19
On 1/27/15, at 9:15 a.m. R19 was asked if she had any pain with no relief R19 stated, "My left side, my left ankle hurts right now, a "7 or 8" [out of 10]" R19 also stated, "I don't feel my pain is well controlled."

No supporting documentation was found on the electronic medication administration record (EMAR) for R19's physician order "Offer PRN Oxycodone (narcotic pain medication) at least every 4 hours. In addition, R19 was not given as needed (PRN) pain medication three separate incidences; once on 12/22/14, and twice on 1/28/15, when R19 reported pain above R19's acceptable level of pain "5" indicated on R19's care plan.

R19's quarterly MDS dated 1/3/15, indicated R19 was cognitively moderately impaired. The quarterly MDS dated 1/3/5, also indicated R19

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had no behaviors, no delirium, no psychosis, no rejection of cares, and R19 needed extensive staff assist for activities of daily living (ADLs). The quarterly MDS dated 1/3/15, further indicated "yes" R19 received pain regimen, "no" R19 had not received PRN (as needed) pain medication, and "yes" R19 had received non-medication intervention for pain. The quarterly MDS dated 1/3/15, also indicated R19 reported "frequently hurting" also indicated R19 gave a 'moderate' for verbal descriptor of pain, and also indicated R19's pain did not affect sleep or limit day activities.

On 1/27/15, at 10:44 a.m. licensed practical nurse (LPN)-A stated, "I honestly cannot tell if she is in pain--or psychological. Morphine is scheduled every day." LPN-A also stated, "She can ask for PRN pain medication but she does not ask for them very often." LPN-A further stated, "She will want to lie down, then want to get up. There is always something with her."

On 1/29/15, at 10:26 a.m. the DON stated R19 was treated with Tramadol (pain medication) and MS Contin (narcotic pain medication) and R19 had pain mostly during cares. The MS Contin had "helped improve" R19's pain.

On 1/29/15, at 10:54 a.m. a registered nurse (RN)-B stated R19 did not ask for PRNs, but "if you ask her if she does have pain she will take a PRN." RN-B also stated R19 yelled out with cares. RN-B further stated, "I heard her yelling out today." RN-B stated, "I don't know if she has pain during cares. I think she gets so anxious." RN-B then added that probably R19 did have pain in her left leg and ankle. RN-B stated she had given her morning medications, repositioned her and later R19 was asleep. RN-B also stated, "I think her pain is more because of movement and

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I did ask the nurse practitioner for a new script which pharmacy now has so we can have some PRN pain medication for her, and she can have a PRN Oxycodone [narcotic pain medication].

At 11:00 a.m. LPN-D stated she worked with R19 often, and if she heard R19 complaining she asked R19 if she wanted a PRN pain medication, which she sometimes accepted.

On 1/29/15, at 11:09 a.m. RN-A stated R19 had a history of osteomyelitis (bone infection) in her metatarsals (bones in the foot). RN-A stated before R19 came into the facility she refused a treatment that would have removed the bone, and the treated ulcer healed. RN-A thought R19's pain was from the osteomyelitis and R19 received scheduled morphine twice a day for it.

On 1/29/15, at 2:38 p.m. RN-B stated R19 had asked for a pain pill at approximately 1:15 to 1:30 p.m. and because she reported her leg was really hurting. RN-B also stated, "I was really surprised she asked for one."

On 1/30/15, at 12:58 p.m. the MDS Coordinator stated, "She is a very reliable reporter, and knows her pain. She will tell you everything, and therefore she does not need a staff assessment for pain."

R19's Progress Notes dated 8/20/14, indicated "[R19] cries and complains of pain especially during cares and transfers. Had PRN Oxycodone at 11:30 a.m."

Physician Progress Note dated 6/30/14, indicated "She is complaining about pain in her left knee, a problem that has defied several attempts at treatment in the past. In Broda Chair. Grimacing

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and tense, looks as if left lower extremity pain is severe. Imp [impression]: Inadequate pain control. She has been on Oxycontin for several years. Probably not getting or asking for PRN's as much as she should. Plans: Increased the MS Contin to 15 mg q8h [every 8 hours] and encourage her to ask for breakthrough meds. I suspect we may need to go up to 30 or more bid [twice daily] fairly soon. We did have her on Neurontin [anticonvulsant medication commonly used for pain] before, but I am not sure how much it helped."

Physician Progress Note dated 11/12/14, indicated "Still major chronic pain despite many meds, but at least she does get out of the room and sometimes converses." The physician note also indicated "Lots of pain all of the left side, and she did not even want me to take off her sock. At least, the neurotropic ulcer below the left 5th metatarsal head is now closed. A. [Assessment] Severe spastic left hemiplegia with chronic pain. P. [Plan] Meds left same with substantial chronic opiods."

Complete History and Physical dated 12/4/14, indicated "[R19] reporting left foot pain. Is on quite a bit of pain medications and appears comfortable. [R19] says she doesn't ask for PRN medications because she 'never sees the nurses.' Left pain medications unchanged." Diagnoses included "Hemiplegia Nondominant Side from Stroke, Chronic pain syndrome, Dementia with behavioral disturbance, and Hypertension [high blood pressure]."

Physician Orders dated 1/29/15, included: Offer PRN Oxycodone at least every 4 hours, ordered 4/3/14, MS Contin Tablet Extended Release 15 mg (Morphine Sulfate ER); Give 15 mg by mouth

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three times a day, ordered 6/30/14, and Oxycodone HCL tablet 10 mg; Give 10 mg by mouth every 2 hours as needed for dyspnea and break thru pain, ordered 1/31/14

R19's pain was rated a '6' on R19's 12/14, EMAR (electronic medication administration record) on 12/22/14, with no PRN pain medication given. During the month of 12/14, R19 received no PRN pain medications.

R19's 1/15, EMAR indicated R19 had received Oxycodone HCL 10 mg as needed for break through pain twice during the month. The LPN documented R19's pain on 1/29/15 was a '7' left knee pain, PRN effective, and on 1/27/15, an '8' left extremities, with PRN effective. R19's pain was rated a '6' on the 1/15 EMAR on 1/28/15, on both day and evening shift on 1/28/15, with no PRN pain medication given.

R19's 1/15 care plan indicated: Evaluate and establish level of pain on numeric scale/resident's acceptable level of pain is verbalized as a '5' according to the resident. Make sure I am not in pain or uncomfortable. Assess for pain every shift. Administer pain medication as ordered. Evaluate characteristics and frequency/pattern of pain, Evaluate need to provide medications prior to treatment or therapy. Evaluate what makes the pain worse. Observe for sensory changes to extremities such as pain, warmth, redness. Provide medications as ordered by physician and evaluate for effectiveness. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Monitor for pain or stiffness. Observe for complaints of pain, specific locations of pain, response to nursing interventions taken to relieve pain. Anticipate patient needs. Provide emotional support as

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| 2 830 | Continued From page 37<br>needed."<br><br>On 1/30/15, at 8:52 a.m. the DON stated he expected staff to deliver care according to residents' care plans.<br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to fall assessments, monitoring and care, and could provide staff education related to the care of resident related to falls. The director of nursing or designee could ensure hospice and dialysis care is coordinated and appopriate care is provided. An audit tool could be developed and the results of the audit brought to the quality committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. | 2 900 | | |

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 4 residents (R23) who were dependent on staff for repositioning.

Findings include:

R23 was assessed at risk for skin breakdown and was not repositioned every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours, 32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. a nursing assistant (NA)-D sat down and assisted resident with eating. R23 remained in the dining room with no assistance with repositioning until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed by NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief, no skin redness was observed and the skin was intact. NA-D and NA-E confirmed the incontinent brief showed wetness.

R23's undated, Braden assessment (tool used to identify pressure ulcer risk) identified R23 as being at moderate risk for developing a pressure ulcer. R23's care plan (effective 10/22/13 to present), directed staff to provide turning and repositioning schedule per assessment.

R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia and cerebral vascular accident (stroke). She

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required extensive assistance of two staff for transfers, bed mobility and unable to ambulate. The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood. The Care Area Assessment (CAA) summary/analysis for pressure ulcers dated 4/8/14, indicated "Resident is an extensive assist with transfers, bed mobility, locomotion, personal hygiene, eating. Resident did not ambulate, skin checks with cares, weekly by licensed staff. Pressure relieving device in bed and wheelchair, barrier cream applied PRN [as needed]."

The Comprehensive Skin Assessment reviewed on 1/8/15, indicated R23 was identified as being at moderate risk for pressures ulcer development and the plan included to reposition resident every two hours.

The undated care sheet for R23 identified the resident at "risk for pressure sore," was non-ambulatory, required the assistance for wheelchair mobility and total assistance with all activities of daily living.

During an interview on 1/28/15, at 10:18 a.m. NA-D, who consistently worked on the dementia unit, reported he and NA-E were running late with morning cares. They were usually finished by 9:00 a.m. NA-D reported R23 had been assisted out of bed at 6:45 a.m. and acknowledged she was not provided assistance with repositioning needs for greater than two hours.

During interview on 1/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistants utilized care guides for each resident, which identified each resident's repositioning needs. The ADON further stated the

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NAs were expected to follow the care guides. The ADON further indicated, "We also rely on the shift nurse to try to keep on eye on cares."

The Prevention of Pressure Ulcer policy (dated 1/8/15 last reviewed 1/26/15), indicated the procedure purpose was, "To prevent skin breakdown and development of pressure ulcers." The procedure details directed staff to "Establish a turning and positioning schedule in bed and chair to meet the resident needs."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 910 MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence — 2 910

Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates

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that catheterization was necessary; and
B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed implement interventions to improve continence for 1 of 1 resident (R54) who experienced a decline in toileting ability, and to provide timely toileting assistance for 1 of 2 residents (R54) observed for toileting who required staff assistance.

Findings include:

R54 was observed while a nursing assistant (NA)-A assisted the resident with toileting on 1/28/15, at 11:26 a.m. NA-A reported the resident's incontinent brief was wet with a small amount of urine she voided on the toilet, as well. NA-A reported that R54 was frequently wet at the time the NAs would assist her to use the toilet.

When interviewed on 1/28/15, at 10:21 a.m. NA-C stated R54 could verbally tell staff when she needed to use the toilet, but when toileted, her brief would already be wet.

NA-B reported on 1/28/15, at 11:22 a.m. that R54 was toileted every two hours. Although R54 reported when she needed to urinate, she was already wet when staff assisted her to the toilet. NA-B was unaware of any attempts to assist R54 to the toilet more frequently than every two hours.

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The care plan dated 8/15/14 identified a goal for the resident to be free of urinary tract infections (UTI's). Interventions included: "Evaluate timing of medications which may cause increased urination...evaluate frequency/timing of incontinence episodes...scheduled toileting plan of check and change every two hours and PRN" (as needed). A review of R54's medical record did not reflect UTI's while at the facility or a history prior to admission. Evidence was lacking to show the residents medication timing had been reviewed related to potentially contributing to incontinence as well as her frequency and timing of incontinence episodes. The care plan reflected checking and changing the resident (an intervention when a resident is totally incontinent), although the resident had the ability to successfully use the toilet.

R54's admission Minimum Data Set (MDS) dated 11/13/14, indicated the resident had frequent incontinence of urine. A subsequent quarterly MDS dated 11/13/14, showed a decline in R54's continence to always incontinent of bladder. R54 also had severe cognitive impairment, required extensive assistance with toileting and transfers. Despite the resident's decline, the MDS did not reflect a trial bladder retraining program for R54.

A Bladder Assessment form dated 11/13/14, indicated R54 was to be offered toileting assistance every two hours and upon request. The assessment, however, did not include documentation to support the every two hour toileting plan outlined in the summary conclusion.

When interviewed on 1/28/15, at 10:46 a.m. the assistant director of nursing (ADON) stated she was unaware R54 had experienced a decline in

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urinary incontinence. She explained staff was to be completing three-day bladder assessments to determine residents' voiding patterns. It had been determined staff had not been completing the monitoring as they should have been, and a couple weeks prior they had been " reminded. " The ADON was unable to provide documentation showing R54's bladder patterns had been established and an appropriate plan developed based on her individual needs. The ADON was also unaware whether a re-assessment had been completed after the MDS showed a decline, or whether a trial for more frequent toileting had been considered.

When interviewed on 1/29/15, at 2:20 p.m. the director of nursing (DON) stated R54 declined in urinary incontinence when she developed pneumonia and did not wish to get out of bed. The DON was unable to provide documentation showing R54's bladder patterns had been established. The DON verified R54 had not experienced any UTI's while at the facility.

R23 was not provided assistance with toileting needs every two hours during continuous observation on 1/28/15, from 6:55 a.m. until 9:27 a.m. (2 hours,32 minutes). At 6:55 a.m. R23 was in a wheelchair seated in the dining room. At 8:36 a.m. R23 was served breakfast. At 8:37 a.m. nursing assistant (NA)-D sat down and assisted resident with eating. R23 remained in the dining room with no assistance with toileting until she was wheeled to her room. At 9:27 a.m. R23 was provided extensive assistance to transfer to bed with NA-D and NA-E. Staff proceeded to assist resident with rolling from side to side in bed, to provide peri-care and change incontinent brief. NA-D and NA-E confirmed the incontinent brief showed wetness.

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R23's bladder assessment dated 1/8/15, noted the resident had Alzheimer's disease/ dementia, and was incontinent of bladder and had no sensation of urine loss. Staff was directed to check and change resident every 2 hours and as needed.

R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia, cerebral vascular accident, (CVA), seizure disorder and anxiety. She required extensive assistance of two staff for transfers, bed mobility, unable to walk and total dependence for toileting needs, and was identified as always incontinent of bladder. The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood. The Care Area Assessment (CAA) summary/analysis for urinary incontinence dated 4/8/14, indicated "Resident at risk for UTI [urinary tract infection], monitor for signs of odor, clarity, frequency. Resident is always incontinent of bowel and bladder, skin checks with cares, barrier cream applied as needed.

R23's care plan with effective date 10/21/13, to present, directed staff to provide scheduled toileting plan of check and change every 2 hours and as needed, use of briefs/pads for incontinence protection and monitor for signs and symptoms for UTI.

The undated, care sheet for R23 directed staff to provided total assistance with ADL's (activities of daily living) and non-ambulatory.

During interview on 1/28/15, at 10:18 a.m. NA-D, who consistently works on the dementia unit, reported he and NA-E were running late with

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morning cares and usually done by 9 a.m. and indicated R23 was assisted out of bed at 6:45 a.m. NA-D acknowledged R23 was not provided assistance with toileting needs for greater than 2 hours.

During interview on 01/30/15, at 12:58 p.m. the assistant director of nurses (ADON) reported the nursing assistance have care guides for each resident and the care guides identify the resident's repositioning needs. The ADON further stated it is expected the care guides are followed by the nursing assistance. The ADON further indicated "we also rely on the shift nurse to try to keep on eye on cares."

The Incontinence Management/Bladder Function Guideline policy, dated 1/13/15, reviewed on 1/19/15, indicated the procedure purpose was "Prevent skin problems such as pressure areas and excoriation, Avoid possibility of urinary infection, Manage urinary incontinence, restore of maintain as much normal bladder function as possible." The guidelines indicated "If a resident is cognitively impaired and is unsuccessful at toilet training or is unable to participate in retraining than the resident should be placed on incontinent care program." The interdisciplinary care plan team will evaluate the effectiveness of the program and make recommendations to continue, change or discontinue the program with the quarterly MDS review."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could educate employees responsible for assisting residents with toileting needs on the importance of timely care in order to promote need to assess and develop interventions to prevent urinary tract infections. The director of nursing could inservice

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| 2 910 | Continued From page 46<br>all emplyees responsible to follow physcian orders for intermittent catherization and audit for complaince. The drector of nusring could inservice all employees responsible for monitoring, evaluating and assessing urine output and audit for complaince.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 910 | | |
| 21395 | MN Rule 4658.0805 Persons Providing Services<br><br>All persons providing services, including volunteers, with a communicable disease as listed in part 4605.7040 or with infected skin lesions must not be permitted to work in the nursing home unless it is determined that the person's condition will permit the person to work without endangering the health and safety of residents and other staff. The employee health policies required in part 4658.0800, subpart 4, item F, must address grounds for excluding persons from work and for reinstating persons to work due to a communicable disease or infected skin lesions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review, the facility failed to initiate tuberculin skin test (TST) and tuberculosis (TB) symptom screening for 2 of 6 newly hired nursing assistants (NA-D, NA-E) whose personnel records were reviewed for TB prevention practices. This had the potential to affect all 47 of 47 residents who resided in the facility.<br><br>Findings include: | 21395 | | |

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NA-D and NA-E were hired on 11/25/14. NA-D and NA-E's personnel file lacked documentation they had received the two-step TST, or evidence TB symptom screening had been competed prior to having direct contact with residents as required.

On 1/27/15, at 12:54 p.m. the director of nursing (DON) verified both NA-D and NA-E's TST and TB symptom screening forms were not in their personnel files as they should have been. The DON said he expected all employees have had a first step TST and symptom screening completed prior to direct care with residents, and then two weeks later a second step TST would need to be completed.

The facility's undated policy, Tuberculin Skin Testing (TST) for Screening Health Care Workers (HCW's) directed staff to conduct pre-employment screening which included a history and symptom screen and to administer two-step TST; "First step must be administered and results read prior to first day of working with residents/patients." The policy further directed "if no previous TST result recommend two-step baseline or if previous negative TST results and greater than 12 months before new employment, recommend two step baseline TST."

SUGGESTED METHOD OF CORRECTION:
The infection control nurse could ensure current TB practices are followed and all staff are appropriately screened and tested for TB. An audit tool could be developed to ensure the plan is followed.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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| 21665 | MN Rule 4658.1400 Physical Environment | 21665 | | |

A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure resident room were maintained in a personalized homelike manner for 3 of 18 residents (R23, R28, R43) who resided on the dementia unit.

Findings include:

R23's room was observed on 1/26/15, at 4:28 p.m. The room was bare. The bed was made with one blanket laying at the foot of the bed, and a disposable incontinent pad placed on the center of the bed.

R23's quarterly Minimum Data Set (MDS) dated 1/8/15, revealed diagnoses including dementia, cerebral vascular accident, (stroke) and anxiety. She required extensive assistance from staff to perform activities of daily living (ADLs). The resident had severely impaired cognitive skills, unclear speech, could sometimes understand others or be understood.

R23's care plan (effective 10/22/13 to present), indicated the resident had impaired cognition, hearing and vision, as well as communication and not always was understood. The care plan directed staff to anticipate the resident's needs. A Care Conference Summary dated 11/5/14, indicated "res [resident] has all needs anticipated

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and met."

On 1/28/15, at 9:27 a.m. a nursing assistant (NA)-D and NA-E were asked about the lack of any pictures or other personal items in R23's room. The NAs then looked around R23's room and located a framed photograph, religious picture, small stuffed animal and dead plant behind the window curtain.

R28's room was observed to be bare on 1/27/15, at 12:27 p.m. The bed was made, but there was no personalization of the resident's room.

R28's quarterly MDS dated 11/14/14, revealed diagnoses including dementia and Parkinson disease, and she required extensive assistance with ADLs. Severely impaired cognitive skills was noted, but the resident could usually understand others.

R28's care plan (effective 5/23/14 to present) indicated impaired communication, cognition, and hearing. The care plan directed staff to anticipate patient needs. A quarterly Psychosocial Progress note dated 11/14/14, indicated "staff anticipate and meet needs."

On 1/28/15, at 7:42 a.m. NA-D was interviewed and asked about lack of any pictures or other personal items in R28's room. NA-D looked around and acknowledged there were no personal items in the resident's room.

R43's room was observed to be bare on 1/26/15 at 4:24 p.m. The bed was made and two folded blankets were at the foot of the bed.

R43's significant change MDS dated 11/28/14, revealed diagnoses including dementia and

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schizophrenia. She required extensive assistance for ADLs. R43 also had severely impaired cognitive skills, unclear speech, but could usually understand others or be understood.

R43's care plan (effective date 3/4/13 to present) indicated the resident had impaired cognition and communication with episodes of disorganized speech and was not always understood. Staff were directed to anticipate her needs. A quarterly Psychosocial Progress note dated 12/5/14, indicated "Res [resident] is severely impaired, staff anticipate and meet all needs."

On 1/28/15, at 9:35 a.m. NA-D and NA-E were interviewed regarding the lack of any pictures or other personal items in the resident's room. The NAs looked around the room and found a make-up case labeled with the resident's name. NA-D explained that R43 "moves things around."

On 1/28/15, at approximately 2:00 p.m. an environmental tour was conducted with the administrator, director of nursing (DON), director of maintenance, and the director of housekeeping. R23, R28, and R43's rooms were observed, and were all bare of any personal items. The administrator and DON verified all three rooms were not homelike, and would have expected the rooms to have a homelike feel. The administrator added they could ask family members to bring in personal items for the residents.

A policy was requested, however, was not provided by the facility.

SUGGESTED METHOD OF CORRECTION: The licensed social workers could ensure each resident's room is personalized. Family members

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| 21665 | Continued From page 51<br>could be encouraged to bring personal belongings of residents. As new residents are admitted, they could be encouraged to personalize the resident's room. Periodic audits could be conducted to ensure a homelike environment is maintained to the extent possible.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21665 | | |
| 21800 | MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff | 21800 | | |

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| 21800 | Continued From page 52<br>person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure appropriate notice of the right to request a demand bill when Medicare was discontinued was provided as required for 2 of 3 residents (R56, R61) reviewed for liability notice.<br><br>Findings include:<br><br>R56 was admitted to the facility on 8/17/14, after a hospital stay related to a left hip fracture. R56 was discharged from Medicare non-coverage on 8/28/14, signed the notice of Medicare non-coverage form on 8/27/14, and was discharged from the facility on 8/28/14.<br><br>R61 was admitted to the facility on 10/2/14. R61 was discharged from Medicare non-coverage on 10/22/14, signed the notice of Medicare non-coverage form on 10/21/14, and was discharged from the facility on 10/22/14.<br><br>On 1/27/15, at 12:05 p.m. the Centers for Medicare and Medicaid Services (CMS) form 10123 was reviewed for R56 and R61. The form lacked documentation showing R56 and R61 had been provided a 48-hour notice as required before Medicare non-coverage date.<br><br>On 1/27/15, at 12:17 p.m. the Minimum Data Set/Medicare coordinator stated she should have given R56 and R61 the CMS form 10123 two days prior to when their services ended. | 21800 | | |

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| 21800 | Continued From page 53<br><br>A policy regarding notice notification to resident regarding Medicare non-coverage was requested but not provided.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure residents receive the required Medicare denial and appeal rights notices. Staff could be educated. Monitoring systems could be implemented to ensure ongoing compliance, and ensure the findings are reported to the quality committee.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21800 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to deliver care in a manner that enhanced self-worth for 1 of 1 resident (R19) reviewed for behavioral status and to promote a dignified dining experience in 1 of 2 dining rooms, potentially affecting the 18 residents on the dementia unit.<br><br>Findings include: | 21805 | | |

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R19 was interviewed on 1/27/15, at 8:53 a.m. When asked if staff treated her with respect and dignity the resident answered, "No. Staff don't talk to you. After staff get me up in the morning they put me in the living room to watch television and then I sit there until they take me to the dining room for a meal. I never get to go to the bathroom because they just lay me in bed and change me. I wet my pad while I am waiting to be changed, and then I sit in the wet pad, and then I go number two in my pad. It makes me feel inferior to the other residents here" (regarding waiting for her brief to be changed and that she could not use the bathroom like her roommate. R19 also stated, "I wish staff would not be so rough with me when they wash me up in the morning...."

The following day at 7:44 a.m. R19 was observed sitting in her wheelchair (w/c) in the dayroom watching television. At 7:46 a.m. a nursing assistant (NA)-B approached R19 and stated, "Okay it's time to eat," and before waiting for a reply from the resident, proceeded to push R19 in her w/c toward the dining room. At 8:16 a.m. R19 was in the day room drinking a cup of coffee. At 8:28 a.m. NA-B approached R19 from behind and without saying anything to the resident, pulled her backward from the table and pushed her down the hallway. As NA-B turned R19's w/c around in the hallway outside her room, the resident's foot bumped the wall and the resident responded, "Ow." NA-B stated, "If you just look at her she will say that. It's hard to know because she is in real pain,. She just always says 'ow' no matter what, even if you just look at her." NA-B and NA-A transferred R19 from the w/c to the bed with the aid of a mechanical lift. Throughout the process R19 grimaced and her face was tensed. She

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repeated, "ow--ow--ow" repeatedly and she was lowered onto the bed and held her arm as she stated, "My arm hurts. You've broken my arm again." NA-B told R19, "We are not even touching your arm." As NA-B and NA-A rolled R19 back and forth from side to side to lower her pants and check the brief, and then to pull the pants up again, R19 grimaced and cried out loudly, "Ouch! Ouch! Ow! Ow!" NA-B delivered care in a hurried fashion without instruction or telling R19 how she was planning to assist the resident next.

On 1/29/15, at 9:26 a.m. R19 was again in the dayroom at a table with two peers and one staff person. A jigsaw puzzle was on the table and R19 stated, "The orange piece goes there," and then again stated, "It goes there." The staff person did not address the resident, who then repeated a little louder, "It goes there." The staff member continued to ignore R19 while talking to one of the other residents at the table. At 9:29 a.m. without looking at R19 the staff answered by stating, "We are watching. We will get there," as she continued to work with the other resident.

On 1/29/15, at 10:01 a.m. NA-G and NA-E assisted R19 onto the bed with the mechanical lift when the resident cried out, "Ouch! My knee." R19's roommate then stated, "There is nothing [expletive] wrong with your legs." As R19 was turned from side to side she grimaced and cried out, "Ow! Ow!" The resident's roommate then stated, "Oh my god!" While lying on her back R19 grimaced and cried out, "Help!" NA-E responded, "One more time." As NA-G washed and dried the resident she grimaced and continued to call out. Her roommate stated loudly enough for the resident to hear, "I can't believe this. I can't have any peace. I can't even sleep." As R19's clothing was adjusted she cried out loudly asking, "Will

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you stop? Will you stop?" NA-E and NA-G replied, "We are almost done." When cares were completed, R19 asked to have her television turned on. R19's roommate then stated, "Of course you want you television on, and someone else will then have to get up and turn it off." R19 was wearing two very different socks. As NA-E lifted up R19's to don a boot the resident again cried out. NA-E asked, "Is that better?" NA-E also asked R19 if she was comfortable. R19 responded, "My neck hurts with that pillow jammed under my head. I don't even want to be in here." NA-G did not respond to R19's statement as she gave the resident her call light and remote control. R19 requested the staff turn off the overhead light. When R19's television was turned on, loud scratchy noises were heard, and there were gray jagged lines across the TV screen. R19's roommate stated, "I have to listen to that" and got up and left the room. The NAs left the room without turning off the light as R19 had requested.

Following the care observations at 10:15 a.m. R19 rated her pain at "7 1/2" of of 10 (10 being the worst) and stated, "I don't even have a PRN (as needed) pain medication." R19 said her TV was always that way on channel 11, but said, "I did not tell anyone about my TV as they don't listen to me--just like at the puzzle table this morning." R19 further stated, "Or the nurse will say to me when I tell her I have pain, 'I just gave you something for that.'" R19 also stated, "Now with all that rolling around, I just urinated in my pants and I will just have to stay here wet until they get me up--if they do." R19 said she would like to get up at 8:00 a.m. every morning, but "today I got up at 7:25 a.m." R19 had a white substance on her lower bottom teeth and reported the NA did not assist her to brush her

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teeth that morning. R19 said she had her roommate's comments about her, which were typical. She added, "I asked them to turn my light off and they didn't." She described an issue with her eyes where she found the light bothersome. R19 added, "I want to be with my son and family."

At 11:16 a.m. R19 remained in bed with the TV on with gray jagged lines across the screen and the TV emitted irritating, scratchy sounds. At 2:41 p.m. R19 had been moved to a different room.

R19's quarterly Minimum Data Set (MDS) dated 1/3/15, indicated R19 had moderately impaired cognition, presented no behavioral problems or psychosis, and did not reject cares. R19 required extensive staff assistance for activities of daily living. Diagnoses indicated on the MDS included hemiplegia (paralysis on one side of the body), depressive disorders, spasm muscle and generalized pain.

On 1/28/15, at 10:38 a.m. NA-G reported R19 never used the toilet, and instead used the mechanical lift and the bed pan. NA-G also stated R19 was completely incontinent, although sometimes reported the need for a bowel movement. NA-G further stated, "She is known to scream out. She always says 'ow,' even if you look at her she will say ow."

On 1/29/15, at 10:26 a.m. the DON stated he had heard R19's roommate left the room when R19 received care. R19 mostly had pain with cares, and was being treated with tramadol (pain medication) and MS Contin (narcotic pain medication). The MS Contin had improved the resident's pain. The DON acknowledged the resident's room was small, but had never heard

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|---|---|---|---|
| | 00988 | A. BUILDING: ______ B. WING ______ | 01/30/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - EXCELSIOR | 515 DIVISION STREET EXCELSIOR, MN 55331 |

| (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 |
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any concerns expressed by R19 regarding this or her roommate.

On 1/29/15, at 10:35 a.m. the licensed social worker (LSW) stated she had not heard of any concerns about R19 and her roommate. The LSW stated, "As far as I know [R19] and her roommate are getting along. I am not aware of anything."

On 1/29/15, at 11:17 a.m. the administrator stated she and R19 had discussed a room change in the past when openings occurred, but the size of those rooms had all been the same as what she had. R19's roommate was planning on discharging soon, so possibly R19 could move to the window. The administrator said they could get a compatible roommate for her, as well. She explained that R19 "guilts" her family so they had not been visiting much. She was unaware the TV was not working. In addition, she was unaware of the derogatory comments made by the R19's roommate and stated, "This is concerning about [R19's] roommate's comments towards [R19] and the staff should not be allowing it to happen. We will offer her another room."

On 1/30/15, at 12:58 p.m. the MDS coordinator stated, "She is a very reliable reporter and knows her pain. She will tell you everything and therefore, she does not need a staff assessment for pain."

R19's current care plan directed staff to "Help me maintain my dignity. Provide emotional support as needed. Provide non-pharmaceutical interventions of redirecting, calm behavior and environment. Help me with reminders and cues as needed. Please allow me to do what I am capable of doing at my own pace in my own way

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even if it doesn't make sense to you. Please remember that I am an adult and treat me accordingly. Please tell me what you are going to do before you begin. Explain all procedures and reason before performing. Approach patient in a calm, positive, reassuring manner. Staff to identify self with each contact if needed and explain all procedures before starting. Allow calm, unhurried environment to encourage communication. Answer questions as needed and repeat as necessary. Anticipate patient needs. Encourage patient to verbalize needs. Listen carefully, validate verbal and non verbal expressions. Maintain eye contact if possible. Monitor for ability to make needs known and report significant findings. Use simple and direct communication to promote understanding."

On 1/30/15, at 8:52 a.m. the DON stated he expected staff to follow the residents' care plans.

The facility did not provide a dignified dining experience for residents who received meals on the dementia unit.

On 1/26/15, at 5:10 p.m. staff was observed to begin meal service in the dementia unit. The tables was observed without centerpieces or condiments. At 5:20 p.m. all residents in the dining room were served their meal. At 5:50 p.m. nursing assistants (NA)-J and NA-K begin clearing the dishes off the table using the busing cart as 12 of 18 residents remained in the dining room. At 5:58 p.m. A registered nurse (RN)-C also assisted in clearing the tables. The table clearing was loud, as staff tapped the plastic bowls on the edge of the cart to remove the food.

On 1/28/15, at 9:09 a.m. the meal service was again observed in the dementia unit. The tables

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again had not centerpieces or condiments. A licensed practical nurse (LPN)-J cleared dishes off the tables using the busing cart as 10 residents remained in the dining room, and R11, R9 and R23 continued to eating.

The breakfast meal on the dementia unit started at 8:00 a.m. and outside of the unit the breakfast meal was served from 7:30 a.m. to 9:00 a.m.

An interview with the registered dietitian (RD) on 1/29/15, at 9:24 a.m. revealed there was no open breakfast on the dementia unit, as there was enough space for all of the residents to eat together at the same time. The RD indicated lack of open breakfast had not been brought up as a concern and residents were provided late trays if requested or needed. The RD indicated staff did not provide condiments on the tables, because the residents "touch everything" and open and eat salt and sugar packets. The RD further stated centerpieces were not placed on the tables because the residents would remove them. At 10:16 am. the RD stated staff should have been discrete and quite when clearing dishes from the tables. If residents were still eating, the busing cart should not have been used at the table. Instead, staff could have removed the dishes when residents were finished eating, and then carried them to the busing cart.

LPN-B who consistently worked on the dementia unit was interviewed on 1/29/15, at 9:53 a.m. LPN-B explained the reason they did not offer an open breakfast on the unit was because there were residents who wandered a lot. Having a set time allowed all of the residents to eat together, and prevented them from eating each others' food. Centerpieces were not used, as the residents may have attempted to eat them, and

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LPN-B had seen residents attempting to eat paper napkins. Some residents were on special diets, therefore, condiments were not offered.

The Guidelines for Caregiver Interaction with Dementia (last reviewed 11/12/14), indicated the following: "Staff interaction with patients who have cognitive deficits...Staff will interact with residents in a manner that supports dignity and enhances the resident's ability to successfully participate in life. Staff must try to change their thinking from trying to control behavior to understanding and changing the reason behind the behavior. Always assume the resident can understand what your are saying. Focus on abilities, not limitations, The inability to express oneself does not always effect the ability to understand others." For activities of daily living the policy read, "Strive to let the resident be in control."

SUGGESTED METHOD OF CORRECTION: The licensed social workers and director of nursing could review/revise policies and procedures related to the provision of dignified care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.