DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RZGO

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

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGE	NCY		Facility I	D: 00988
MEDICARE/MEDICAID PROVIDE (L1) 245332 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) GOLDEN L (L4) 515 DIVISIO	IVINGCENTI		ELSIOR		4. TYPE OF A 1. Initial 3. Termination	2. R	(L8) decertification
(L2) 839427000		(L5) EXCELSIO	R, MN		(L6) 5533	1	5. Validation	6. C	Complaint
5. EFFECTIVE DATE CHANGE OF C (L9) 04/01/2006		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22	CLIA	7. On-Site Vi 8. Full Surve	sit 9. O y After Complai	
6. DATE OF SURVEY 03/1' 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR 12/31		E: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	56 (L18) 56 (L17)	Complianc1. A B. Not in Con		gram	And/Or Approved V 2. Technical 3. 24 Hour R 4. 7-Day RN 5. Life Safet * Code: A*	Personnel N (Rural SN	6. Scope 7. Medic	of Services Lincal Director	mit
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	5			
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or 1861	(j) (1):	(L15))	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY	AGENCY	APPROVAL	Dat	te:
Gayle Lantto, Supervisor			03/17/2015	(L19)	Anne Kleppe, I	Enforcer	nent Specialis	st (03/17/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SIN	NGLE ST	FATE AGENC	CY	
19. DETERMINATION OF ELIGIBILE _X			IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				.513)
2. Pacinty is not Engine	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION VOLUNTARY 01-Merger, Closure	_00	05-F	(L30) OLUNTARY Fail to Meet Hea	alth/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ 03-Risk of Involuntary			Fail to Meet Agr	reement
25. LTC EXTENSION DATE: (L27)		n of Admissions:	(L44)		04-Other Reason for W		<u>OTI</u> 07-I	HER Provider Status Active	Change
	B. Rescind St	aspension Date:	(L45)						
28. TERMINATION DATE:	29	D. INTERMEDIARY			30. REMARKS				
		00454							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE					
	(L32)	03/12/2015		(L33)	DETERMINATIO	ON APPR	ROVAL		



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,

Dre Kleese

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

Licensing and Certification File cc:



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,

Dre Kleepe

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

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 245332	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/17/2015
Name	e of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - EXCELSION		OR	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	(Y4) Item		(Y5)	Date	(Y4)	Item	((Y5)	Date
ID Prefix Reg. # LSC	F0156 483.10(b)(5)	- (10), 483.	Correction Completed 03/13/2015	ID Prefix Reg. # LSC	F0167 483.10(g)(1)		Correction Completed 03/13/2015			F0221 483.13(a)		Correction Completed 03/13/2015
ID Prefix Reg. # LSC	F0241 483.15(a)		Correction Completed 03/13/2015	ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 03/13/2015		ID Prefix Reg. #			Correction Completed 03/13/2015
ID Prefix Reg. # LSC	F0279 483.20(d), 48	83.20(k)(1)	Correction Completed 03/13/2015	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483	3.10(k)(Correction Completed 03/13/2015 2)			F0282 483.20(k)(3)(ii		Correction Completed 03/13/2015
	F0309 483.25		Correction Completed 03/13/2015	Reg. #	F0314 483.25(c)		Correction Completed 03/13/2015		Reg. #	F0315 483.25(d)		Correction Completed 03/13/2015
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 03/13/2015	ID Prefix Reg. # LSC	483.60(b), (d), (e		Correction Completed 03/13/2015					
		I									T	
Reviewed E	· ——	Reviewed	I Ву	Date: 03/17/20	Signature	of Sur	veyor:		1550	7	Date: 03/1	7/2015
State Agen Reviewed E CMS RO	су Зу	Reviewed	I Ву	Date:	Signature	of Sur	veyor:		1330	/	Date:	7/2013
Followup t	o Survey Co 1/30	mpleted oi /2015	n:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245332	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 3/13/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - EXCELSI		R	515 DIVISION STREET	
			EYCELSIOD 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	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 03/11/2015	D #		Correction Completed					
_	NFPA 101 K0072		Reg. # LSC				Reg. # LSC			
Reg. #			Reg. #		Correction Completed		ID Prefix			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					
Reviewed E	By Re	viewed By	Date:	Signature of Sur	veyor:				Date:	
State Agen	cy PS	S/AK	03/17/2015			2	8120		03/13	3/2015
Reviewed B	Зу Re	viewed By	Date:	Signature of Sur	veyor:				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					NO	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RZGO

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

	PART I - TO BE COMPLETED BY						D BY THE STATE SURVEY AGENCY Facility ID: 009			
MEDICARE/MEDICAID PROVIDER (L1) 245332 2.STATE VENDOR OR MEDICAID NO.	NO.	3. NAME AND AD (L3) GOLDEN L 1 (L4) 515 DIVISIO	IVINGCENTI		ELSIOR		4. TYPE Ol 1. Initial 3. Termina		2 (L8) 2. Recertifica 4. CHOW	tion
(L2) 839427000		(L5) EXCELSIO	R, MN		(L6) 55331	1	5. Validati	on	6. Complaint	
5. EFFECTIVE DATE CHANGE OF OW (L9) 04/01/2006		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 C	CLIA	7. On-Site 8. Full Sur	Visit vey After Cor	9. Other	
6. DATE OF SURVEY 01/30/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEA		DATE: (I	.35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	From (a): To (b): A. In Compliance With Program Requirements Compliance Based On: 12.Total Facility Beds 56 (L18) B. Not in Compliance with Program X Requirements and/or Applied Wa					Vaivers Of T Personnel N (Rural SNF Code	7. Me	pe of Service dical Directo ient Room Siz	es Limit r	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS					
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or 1861	(j) (1):	(Li	15)		
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMAR	STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):									
17. SURVEYOR SIGNATURE	7. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:									
Elizabeth Nelson, HFE NE I	I	0	03/06/2015	(L19)	Anne Kleppe, En	nforcem	ent Special	ist	03/11/2	2015 (L20)
PART	II - TO BE	COMPLETED E	BY HCFA RE	EGIONAI	L OFFICE OR SIN	GLE ST	ATE AGEN	ICY		
19. DETERMINATION OF ELIGIBILIT			IPLIANCE WITH HTS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 					
2. Facility is not Eligible	(L21)									
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION	ACTION:		(L30)	
OF PARTICIPATION 07/01/1986	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure	00		NOLUNTAL 5-Fail to Meet	<u>RY</u> : Health/Safety	y
(L24)	(L41)		(L25)		02-Dissatisfaction W/ I		-	5-Fail to Meet	Agreement	
25. LTC EXTENSION DATE: 2		VE SANCTIONS n of Admissions:	J. 440		03-Risk of Involuntary 7 04-Other Reason for Wi		01	<u>THER</u> 7-Provider St)-Active	atus Change	
(L27)	B. Rescind Su	uspension Date:	(L44) (L45)					-Active		
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS					
		00454								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE									
	(L32)			(L33)	DETERMINATIO	N APPR	OVAL			



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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING M 19 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR EXCELSIOR, MN 55331** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 The facility's plan of correction (POC) will serve Submission of this Response and as your allegation of compliance upon the Plan of Correction is not a legal Department's acceptance. Your signature at the admission that a deficiency exists or bottom of the first page of the CMS-2567 form will that this Statement of Deficiency be used as verification of compliance. was correctly cited, and is also not to be construed as an admission of Upon receipt of an acceptable POC an on-site fault by the facility, the Executive revisit of your facility may be conducted to Director or any employees, agents validate that substantial compliance with the or other individuals who draft or may regulations has been attained in accordance with be discussed in this Response and vour verification. Plan of Correction. In addition, F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF F 156 preparation and submission of this SS=B RIGHTS, RULES, SERVICES, CHARGES Plan of Correction does not constitute an admission The facility must inform the resident both orally agreement of any kind by the facility and in writing in a language that the resident of the truth of any facts alleged or understands of his or her rights and all rules and the correctness of any conclusions regulations governing resident conduct and set forth in the allegations. responsibilities during the stay in the facility. The facility must also provide the resident with the Accordingly, the Facility notice (if any) of the State developed under prepared and submitted this Plan of §1919(e)(6) of the Act. Such notification must be Correction prior to the resolution of made prior to or upon admission and during the any appeal which may be filed resident's stay. Receipt of such information, and

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

any amendments to it, must be acknowledged in

solely because of the requirements

under state and federal law that

mandate submission of a Plan of Correction within ten (10) days of

the survey as a condition to

participate in Title 18 and Title 19

programs. This plan of Correction is

submitted as the facility's credible

allegation of compliance.

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

and for which the resident may be charged, and the amount of charges for those services; and

(X6) DATE

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.

writing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR EXCELSIOR, MN 55331** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 156 Continued From page 1 F 156 inform each resident when changes are made to the items and services specified in paragraphs (5) F 156 (i)(A) and (B) of this section. -Facility has reviewed all Medicare The facility has also denials. The facility must inform each resident before, or reviewed the policy and procedure at the time of admission, and periodically during for issuing of Medicare nonthe resident's stay, of services available in the coverage form 48 hours before nonfacility and of charges for those services, and assure coverage date including any charges for services not covered appropriate notice of the right to under Medicare or by the facility's per diem rate. request a demand bill. -MDS nurse or designee to issue The facility must furnish a written description of notice of Medicare non-coverage legal rights which includes: A description of the manner of protecting personal form 48 hours before non-coverage funds, under paragraph (c) of this section; date and assure appropriate notice of the right to request a demand bill. A description of the requirements and procedures -Facility designee will complete for establishing eligibility for Medicaid, including audits of random Medicare denials the right to request an assessment under section twice monthly. Interdisciplinary 1924(c) which determines the extent of a couple's team will meet and discuss findings non-exempt resources at the time of monthly at QAPI. 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. RECEIVED 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 COMPLIANCE MONITORING DIVISION unit; and a statement that the resident may file a LICENSE AND CERTIFICATION complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 02/17/2019 MAPPROVED
STATEMEN'	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		IPLE CONSTRUCTION	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
		245332	B. WING	à			1/20/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR			STREET ADDRESS, CITY, STATE, ZIP CO 515 DIVISION STREET EXCELSIOR, MN 55331	DE	1/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE	SHOULD BE	(X5) COMPLETION DATE
	facility, and non-condirectives requirements. The facility must information, applysician responsib. The facility must prowritten information, applicants for admisinformation about he Medicare and Medicare and Medicare are funds for psuch benefits. This REQUIREMEN by: Based on interview facility failed to ensuright to request a deright to request a deright to request a deright to request a deright (R56, R61). Findings include: R56 was admitted to a hospital stay relate was discharged from 8/28/14, signed the mon-coverage form odischarged from the R61 was admitted to	Inpliance with the advance ents. Dorm each resident of the di way of contacting the le for his or her care. Dominently display in the facility and provide to residents and sion oral and written ow to apply for and use raid benefits, and how to previous payments covered by T is not met as evidenced and document review, the re appropriate notice of the mand bill when Medicare was ovided as required for 2 of 3 or reviewed for liability notice. The facility on 8/17/14, after d to a left hip fracture. R56 of Medicare non-coverage on notice of Medicare in 8/27/14, and was facility on 8/28/14. The facility on 10/2/14. R61 of Medicare non-coverage on notice notice notice notice notice notice notice notice noti	F	156	6		

DEP	ARTMENT OF HEALTH	HAND HUMAN SERVICES			Р		D: 02/17/201 MAPPROVEI
CEN	TERS FOR MEDICARE	E & MEDICAID SERVICES	1		0		0. 0938-039
AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DA	TE SURVEY
W.9		245332	B. WING	э <u> </u>		01	/30/2015
	OF PROVIDER OR SUPPLIER DEN LIVINGCENTER - EX				STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 -	/JU/2010
(X4) II PREFI TAG	IX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	=IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) RE	(X5) COMPLETION DATE
F 15	Continued From page	ıge 3	F	156	6		
	Medicare and Medicare and Medicare and Medicare and Indiana In	7 p.m. the Minimum Data linator stated she should have the CMS form 10123 two					
F 16	regarding Medicare but not provided. 483.10(g)(1) RIGHT	notice notification to resident non-coverage was requested	F 10	67			
	The facility must mal examination and must accessible to reside their availability.	ight to examine the results of vey of the facility conducted by veyors and any plan of with respect to the facility. Ake the results available for ust post in a place readily ents and must post a notice of			F 167 -Facility has replaced the curn "roll-a-dex" type file with a 3-r binder containing most reconsurvey resultsR42 was shown the location of the survey results. Resident's attending resident council will be informed the change from "roll-a-dex" to a ring binder and will be offered review upon requestFacility will make the resultance that is readility, but the resultance that is readility.	ing ent the ing of 3- to	3113/15
	Based on observation failed to ensure the name results were easily action families and visitors of	on and interview, the facility most recent state survey ccessible to residents, of the facility which had the 47 residents residing in the			place that is readily and eas accessible to residents, fam and/or visitors and with a sign posted of their availability. -Administrator to audit availability and review in QAPI.	ily ily gn	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245332	B. WING _			01/30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	01/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 167	Continued From pa facility, families and	-	F 16	67		2
*	Findings include:		,			
	R42 was interviewe was not aware when of Health survey res	d on 1/28/15, at 2:00 p.m. and re the Minnesota Department sults were posted.				
	results were observ facility in a stationa survey report was fi was contained in a I would have been dif assistance and the	p.m. the current survey ed at the front entrance of the ry Roll-a-Dex type file. The led individually and each page hard plastic sheet. The pages ficult to remove without staff file cumbersome should ad the results in private (i.e. rance).				
	12/14 and 1/15 indic located on the table	I meeting minutes for 11/14, cated "Survey results are by the front door and will be lent Council meetings to t."				
	director of nursing (I stated the survey re- entrance and people	p.m. the administrator and DON) were interviewed and sults were "right in the front do look at them." The DON do be removed from the book if				
	A policy on posting	of survey results was				
F 221 SS=D	requested but not pr 483.13(a) RIGHT TO PHYSICAL RESTRA	D BE FREE FROM NINTS	F 22	21		
	The resident has the physical restraints in	e right to be free from any imposed for purposes of				

DEPAI	RTMENT OF HEALTH	AND HUMAN SERVICES			PI	RINTE): 02/17/2015
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES	,		OI	FORN MB NC	APPROVED 0. 0938-0391
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
# 19		245332	B. WING			01	/30/2015
NAME O	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01	/30/2015
GOLDE	N LIVINGCENTER - EX	CELSIOR		1	515 DIVISION STREET EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ïX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF	(X5) COMPLETION DATE
F 221	discipline or conventreat the resident's rather resident rather resident rather rathe	ience, and not required to medical symptoms. IT is not met as evidenced on, interview and document iled to assess the use of a restraining for 1 of 1 resident perimeter defining mattress ie cushion under the mattress ie cushion under the mattress ed was up against the wall. Deneath the mattress and dle section of the bed. a.m. nursing assistants sisted R38 out of bed and NA-D and NA-F were ained that the pillow was mattress, as the resident 1/28/15, at 6:55 a.m. R38 in bed. The perimeter is on the bed and the bed. A wedge cushion was nattress and bed frame in the bed. The wedge cushion is side of the bed. Im. NA-D and NA-E ed. The NAs reported the contractions in the contraction is side.	F2		F 221 The Facility will assess the use of device as a potential restraint whutilize a perimeter defining mattress pillow or wedge cushion under the mattress of bed for all residents. R38 wedge cushion and pillow under mattress discontinued. Perimeter defining mattress assessment completed for a restraint. DNS or designee to perform potential restraint assessment on all residents with perimeter defining mattress, pillow or wedge cushion under mattress of bed. 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.	oo s, e r r	3/13/15
	reason the resident w	as partially dressed was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		CONSTRUCTION		TE SURVEY MPLETED
		245332	B. WING	i		01	/20/2015
GOLDEN	PROVIDER OR SUPPLIER N LIVINGCENTER - EX		•	515	EET ADDRESS, CITY, STATE, ZIP CODE DIVISION STREET CELSIOR, MN 55331	<u> Ui,</u>	/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	(X5) COMPLETION DATE
	get out of bed, so the before 7:00 a.m. NA explained they had because she was "f was "leaning." The cushion was used be and "will roll out of be unable to rise indeped in the past accord. The logged fall incide months were review were noted of R38 fawere noted. R38's annual Minimal 11/7/14, revealed dia and arthritis. Extens of one staff for trans resident was unable severely impaired conspeech, and could sor be understood. Ray on the MDS. R38's Care Conference 5/22/14, 8/21/14, and potential restraint us 11/6/12 to present) in due to a history of famedication use. The to utilize a contour module to include the use of underneath the matting the severes of the series of the series of the underneath the matting the series of the seri	heen awake and was trying to the night shift staff got her up A-D and NA-E further assisted R38 back into bed falling out her wheelchair" and NAs explained the wedge because R38 tried to get up bed." Although she was bendently, she had rolled out of ording to NA-D and NA-E. Idents for the previous six wed for R38. No incidents falling or rolling out of bed agnoses including dementia, sive assistance was required after and bed mobility and the eto ambulate. R38 had organitive skills, unclear cometimes understand others destraint use was not identified and 11/26/14, did not reflect see. The care plan (effective noted R38 was at risk for falls alls and psychotropic et interventions directed staff nattress on the bed, and on a was made to the care plan fa bolster cushion cress.	F 2	?21			
	Further record review	w revealed no assessment					

had been completed to determine whether the

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			Р	RINTEI FORI	D: 02/17/201 MAPPROVEI
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
1719		245332	B. WING			01	1/30/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX	CELSIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 01	1/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) RE	(X5) COMPLETION DATE
** F 241 SS=E	and use of a wedge potentially restraining. The director of nursing 1/30/15, at 9:35 a.m. had any falls from the R38 utilized the perioder wedge cushion under the bed. The DON also independently get out the wedge cushion were under the mattress processes where the mattress processes were the mattress processes where the facility must processes and in an entitle encognition of his the second of the mattresses of the facility fail manner that enhances resident (R19) review review.	nattress (contour mattress) cushion or pillow was g for R38. ing (DON) was interviewed on a. He verified R38 had not be bed in the past six months. In the mattress of the bed due attempts of self-transfers out to explained R38 was able to be out of bed, but not safely, and was being used to "keep the bot allow her to roll out of bed. Infirmed the wedge cushion between the wedge a restraint been completed. AND RESPECT OF mote care for residents in a vironment that maintains or ent's dignity and respect in or her individuality. It is not met as evidenced and, interview and document led to deliver care in a led self-worth for 1 of 1 wed for behavioral status and didining experience in 1 of 2 ally affecting the 18	F 24	41	F 241 -Facility will educate all staff resident dignity and rights in such manner that provides an environment that maintains or enhances earesident's dignity and respect in frecognition of his or her individual throughout the day especially duricares and dining experience. -R19 moved to a new room whe transfer process is more conducive resident's transfer needs and provided new TV. -R19 pain regimen reviewed wiphysician and nurse practitioner. -Staff educated on use of PR medication and offering with signs as symptoms of distress. -Staff educated on signs and symptom of pain and stopping cares who appropriate. -R19 cares will be audited random weekly to assure proper respect and dignity are being provided. -DNS or designee to audit for signs as symptoms for R19 and 2 randoresidents a week. Results to reviewed monthly at QAPI. -Dietary manager or designee perform weekly audits of 2 meals ACU dining room to assure resided dignity and respect is being provided enhanced throughout the dining process Results will be reviewed at QAI monthly. -Facility to provide center pieces for the tables along with basic tab condiments.	a ent ch ull ity ng ere to l a ith en lly nd en lin en lly nd en lly	3/13/15

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/30/2015		
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX			5	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	<u> </u>	30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 241	R19 was interviewe When asked if staff dignity the resident talk to you. After stathey put me in the li and then I sit there room for a meal. I no bathroom because the change me. I wet me changed, and then I go number two in me inferior to the other waiting for her brief could not use the bar R19 also stated, "I we will was asked in the state of the stat	d on 1/27/15, at 8:53 a.m. treated her with respect and answered, "No. Staff don't aff get me up in the morning ving room to watch television until they take me to the dining ever get to go to the they just lay me in bed and y pad while I am waiting to be sit in the wet pad, and then I y pad. It makes me feel residents here" (regarding to be changed and that she athroom like her roommate. vish staff would not be so in they wash me up in the	F 2	41				
	The following day at sitting in her wheelc watching television. assistant (NA)-B app "Okay it's time to ea reply from the reside her w/c toward the dwas in the day room 8:28 a.m. NA-B app without saying anyth backward from the the hallway. As NA-E the hallway outside humped the wall and "Ow." NA-B stated, say that. It's hard to pain,. She just alway even if you just look transferred R19 from	A 7:44 a.m. R19 was observed hair (w/c) in the dayroom At 7:46 a.m. a nursing proached R19 and stated, t," and before waiting for a ent, proceeded to push R19 in lining room. At 8:16 a.m. R19 drinking a cup of coffee. At roached R19 from behind and ing to the resident, pulled her able and pushed her down B turned R19's w/c around in her room, the resident's foot at the resident responded, "If you just look at her she will know because she is in real as says 'ow' no matter what, at her." NA-B and NA-A in the w/c to the bed with the lift. Throughout the process						

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015	
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	(CELSIOR	,	STREET ADDRESS, CITY, STATE, ZI 515 DIVISION STREET EXCELSIOR, MN 55331	IP CODE	01/	30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(======================================	TON SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 241	repeated, "owow-lowered onto the bestated, "My arm hur again." NA-B told R your arm." As NA-B and forth from side check the brief, and again, R19 grimace Ouch! Ow! Ow!" NA fashion without instread as planning to assume of the other respected a little loud member continued to one of the other respected a little loud member continued to one of the other respected as little loud member continued to one of the other respected as little loud member continued to one of the other respected as little loud member continued to one of the other respected as m. without looking stating, "We are was she continued to wo one of the other respected as little loud member continued to wo one of the other respected as members as m. without looking stating, "We are was she continued to wo one of the other respected as a sisted R19 onto the lexpletive] wrong with turned from side to so out, "Ow! Ow!" The stated, "Oh my god! grimaced and cried "One more time." As resident she grimace Her roommate state	ge 9 her face was tensed. She ow" repeatedly and she was ed and held her arm as she its. You've broken my arm 19, "We are not even touching and NA-A rolled R19 back to side to lower her pants and I then to pull the pants up d and cried out loudly, "Ouch! A-B delivered care in a hurried ruction or telling R19 how she sist the resident next. a.m. R19 was again in the with two peers and one staff uzzle was on the table and ange piece goes there," and it goes there." The staff tess the resident, who then der, "It goes there." The staff to ignore R19 while talking to idents at the table. At 9:29 at R19 the staff answered by tching. We will get there," as wrk with the other resident. If a.m. NA-G and NA-E ne bed with the mechanical lift ried out, "Ouch! My knee." en stated, "There is nothing th your legs." As R19 was side she grimaced and cried resident's roommate then "While lying on her back R19 out, "Help!" NA-E responded, s NA-G washed and dried the ed and continued to call out. d loudly enough for the an't believe this. I can't have	F 2	.41				

STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245332	B. WING			01	/20/2045	
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX	(CELSIOR		STREET ADDRESS, 0 515 DIVISION STRI EXCELSIOR, MN		1 01/	/30/2015	-
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)) RE	(X5) COMPLETION DATE	
	was adjusted she of you stop? Will you stop? Will you seplied, "We are aln completed, R19 ask turned on. R19's rocourse you want you else will then have to was wearing two velifted up R19's to do cried out. NA-E asked R19 if she was responded, "My necession jammed under my him here." NA-G did not statement as she gas and remote control. Off the overhead light turned on, loud scraft there were gray jagg screen. R19's room to that" and got up at the room without turnequested. Following the care of R19 rated her pain as	ven sleep." As R19's clothing ried out loudly asking, "Will stop?" NA-E and NA-G nost done." When cares were ked to have her television sommate then stated, "Of u television on, and someone o get up and turn it off." R19 ry different socks. As NA-E in a boot the resident again ed, "Is that better?" NA-E also as comfortable. R19 k hurts with that pillow lead. I don't even want to be not respond to R19's lave the resident her call light R19 requested the staff turn lit. When R19's television was to the stated, "I have to listen and left the room. The NAs left light as R19 had bservations at 10:15 a.m. lit. "7 1/2" of of 10 (10 being	F2	41				
	the worst) and stated (as needed) pain me was always that way did not tell anyone al	d, "I don't even have a PRN edication." R19 said her TV on channel 11, but said, "I bout my TV as they don't at the puzzle table this						
;	morning." R19 furthe say to me when I tell you something for the with all that rolling an pants and I will just he they get me upif the	er stated, "Or the nurse will her I have pain, 'I just gave at." R19 also stated, "Now ound, I just urinated in my lave to stay here wet until by do." R19 said she would a.m. every morning, but						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245332	B. WING			04	/20/0045
	PROVIDER OR SUPPLIER V LIVINGCENTER - EX			5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331	1 01	/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	"today I got up at 7: substance on her lo reported the NA did teeth that morning. roommate's commetypical. She added, off and they didn't." her eyes where she R19 added, "I want At 11:16 a.m. R19 roon with gray jagged the TV emitted irrita 2:41 p.m. R19 had be room. R19's quarterly Mini 1/3/15, indicated R1 cognition, presented psychosis, and did rextensive staff assis living. Diagnoses inchemiplegia (paralysi depressive disorder generalized pain. On 1/28/15, at 10:38 never used the toiled mechanical lift and the R19 was completely sometimes reported movement. NA-G fuscream out. She alwok at her she will sometived care. R19 received care. R19 received care. R19 received care. R19 received recei	25 a.m." R19 had a white ower bottom teeth and not assist her to brush her R19 said she had her ents about her, which were "I asked them to turn my light She described an issue with found the light bothersome. To be with my son and family." emained in bed with the TV lines across the screen and ting, scratchy sounds. At been moved to a different mum Data Set (MDS) dated 9 had moderately impaired in behavioral problems or not reject cares. R19 required stance for activities of daily dicated on the MDS included son one side of the body), is, spasm muscle and a.m. NA-G reported R19 a.m. NA-G also stated incontinent, although the need for a bowel of the stated, "She is known to ways says 'ow,' even if you	F 2	241			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, C 515 DIVISION STRE EXCELSIOR, MN		1 01/	00/2013
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 241	medication). The Maresident's pain. The resident's room was any concerns expreher roommate. On 1/29/15, at 10:3 worker (LSW) state concerns about R19 LSW stated, "As fair roommate are getting anything." On 1/29/15, at 11:11 she and R19 had dipast when openings those rooms had all had. R19's roommate discharging soon, so the window. The action of the derogatory common to been visiting must be and state [R19's] roommate's the staff should not will offer her another on 1/30/15, at 12:56 stated, "She is a verifier pain. She will te	S Contin (narcotic pain IS Contin had improved the EDON acknowledged the EDON ACKNOWLEDGE TO	F 2	41			
	R19's current care p maintain my dignity.	plan directed staff to "Help me Provide emotional support as					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l .	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015	
GOLDEN	PROVIDER OR SUPPLIER N LIVINGCENTER - EX			STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	,	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	ON SHOULD IE APPROPE	BE	(X5) COMPLETION DATE	
F 241	environment. Help ras needed. Please capable of doing at even if it doesn't ma remember that I am accordingly. Please do before you begin reason before perfocalm, positive, reassidentify self with eace explain all procedur unhurried environmecommunication. Ansand repeat as necessineeds. Encourage puisten carefully, valid expressions. Maintal Monitor for ability to report significant fine communication to positive of the dementia unit.	n-pharmaceutical recting, calm behavior and me with reminders and cues allow me to do what I am my own pace in my own way ake sense to you. Please an adult and treat me tell me what you are going to a Explain all procedures and rming. Approach patient in a suring manner. Staff to ch contact if needed and es before starting. Allow calm, ent to encourage swer questions as needed sary. Anticipate patient patient to verbalize needs. date verbal and non verbal ain eye contact if possible. make needs known and dings. Use simple and direct romote understanding." a.m. the DON stated he low the residents' care plans.	F 24	241				
	begin meal service i tables was observed condiments. At 5:20 dining room were se nursing assistants (N clearing the dishes of	p.m. staff was observed to n the dementia unit. The I without centerpieces or p.m. all residents in the rved their meal. At 5:50 p.m. NA)-J and NA-K begin off the table using the busing dents remained in the dining						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245332	B. WING _		01	01/30/2015	
	PROVIDER OR SUPPLIER N LIVINGCENTER - E)		STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	also assisted in clecelearing was loud, a bowls on the edge of the solution of the tables using residents remained R9 and R23 continuates and R23	A registered nurse (RN)-C aring the tables. The table as staff tapped the plastic of the cart to remove the food. a.m. the meal service was he dementia unit. The tables expieces or condiments. A urse (LPN)-J cleared dishes the busing cart as 10 in the dining room, and R11, and to eating. on the dementia unit started taide of the unit the breakfast om 7:30 a.m. to 9:00 a.m. e registered dietitian (RD) on a revealed there was no open mentia unit, as there was all of the residents to eat the time. The RD indicated lack and not been brought up as a not swere provided late trays if d. The RD indicated staff didents on the tables, because a everything" and open and eat ets. The RD further stated not placed on the tables of the placed on the tables of the clearing dishes from the were still eating, the busing the been used at the table. The removed the dishes the finished eating, and then	F 24	.1			

DEPAF CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/17/2015 FORM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
1 45.9		245332	B. WING	à	04/00/004=
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/30/2015
GOLDE	N LIVINGCENTER - EX			515 DIVISION STREET EXCELSIOR, MN 55331	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETION
F 246 SS=D	unit was interviewed LPN-B explained the open breakfast on the were residents who time allowed all of the and prevented them food. Centerpieces residents may have LPN-B had seen respaper napkins. Son diets, therefore, con The Guidelines for Commentia (last revier following: "Staff intercognitive deficitsS in a manner that sup the resident's ability life. Staff must try to trying to control behad changing the reason assume the resident are saying. Focus or inability to express of the ability to understadily living the policy resident be in control 483.15(e)(1) REASCOF NEEDS/PREFER	d on 1/29/15, at 9:53 a.m. e reason they did not offer an he unit was because there wandered a lot. Having a set he residents to eat together, a from eating each others' were not used, as the attempted to eat them, and sidents attempting to eat me residents were on special adiments were not offered. Caregiver Interaction with ewed 11/12/14), indicated the raction with patients who have taff will interact with residents oports dignity and enhances to successfully participate in change their thinking from avior to understanding and a behind the behavior. Always to can understand what your in abilities, not limitations, The preself does not always effect and others." For activities of a read, "Strive to let the oli." DNABLE ACCOMMODATION RENCES	F 24	F 246 -Facility will educate staff on call placement to be within resident.	light reach 3/13//5
	services in the facility accommodations of i	y with reasonable individual needs and when the health or safety of		while in room. -R50 calllight placed within reachRandom audits of 5 rooms per will be completed by DNS or desi Results will reviewed at monthly.	WECK

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRI	INTED: FORM	: 02/17/201 APPROVEI
STATEMEN	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T (X3) MII	II TIP	OM	<u>1B NO.</u>	. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1		G		E SURVEY IPLETED
* ## 19	I	245332	B. WING	à		04/	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/	30/2015
GOLDE	N LIVINGCENTER - EX	(CFI SIOR	1	1	515 DIVISION STREET		
				E	EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 246	Continued From page	ge 16	F2	246			
	This REQUIREMEN	NT is not met as evidenced					
	failed to ensure the	cion and interview, the facility call light was within reach for (150) who were observed for .		i			
	Findings include:						
,	observation on 1/26, surveyor was delibe it was difficult to read	chair in his room during an i/15, at 4:18 p.m. Although the erately looking for the call light, dily locate. The light was each and was on the floor at		•	· , ·		
থ্য	light location was po assistant (NA)-H. N.	ng the observations, the call binted out to a nursing IA-H placed the call light re been," within the resident's elchair.			,		
	(RN)-C confirmed th in reach, and confirm	p.m. a registered nurse ne call light should have been ned R50 was capable of summon help from staff.			F 252 -R23, R28 and R43 rooms w decorated by facility to provide a months.	ore	3/13/10
F 252 SS=D	received by the facilite 483.15(h)(1)	ted, however, was not ity.	F 25	52	comfortable and home-lenvironment. -Other resident rooms were review and are decorated and home-like. -Staff re-educated on personalizing	wed	3/13/15
	The facility must prov comfortable and hom	nelike environment, allowing is or her personal belongings			rooms and having res. belonging available and visible -2 random room audits completed ACU director or Social Worker week Results will be reviewed at QA	by	

to the extent possible.

monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	(CELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET KCELSIOR, MN 55331	3-7	99,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From pa	ge 17	F2	52			
	by: Based on observat review, the facility fa were maintained in	NT is not met as evidenced ion, interview and document ailed to ensure resident room a personalized homelike residents (R23, R28, R43) dementia unit.					
	Findings include:						
	p.m. The room was one blanket laying a	served on 1/26/15, at 4:28 bare. The bed was made with at the foot of the bed, and a ent pad placed on the center					
	1/8/15, revealed dia cerebral vascular ac She required extens perform activities of resident had severe	imum Data Set (MDS) dated agnoses including dementia, ecident, (stroke) and anxiety, sive assistance from staff to daily living (ADLs). The sly impaired cognitive skills, and sometimes understand tood.					
	indicated the reside hearing and vision, not always was und directed staff to anti Care Conference Si	ective 10/22/13 to present), nt had impaired cognition, as well as communication and erstood. The care plan cipate the resident's needs.—Aummary dated 11/5/14, ent] has all needs anticipated					
	(NA)-D and NA-E w	a.m. a nursing assistant ere asked about the lack of r personal items in R23's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245332	B. WING		01.	/30/2015	
	PROVIDER OR SUPPLIER	KCELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331		9,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 252	room. The NAs the and located a fram picture, small stuffe behind the window R28's room was of at 12:27 p.m. The no personalization R28's quarterly ME diagnoses includin disease, and she rwith ADLs. Severe noted, but the residuthers. R28's care plan (eindicated impaired hearing. The care patient needs. A quante dated 11/14/1 and meet needs." On 1/28/15, at 7:42 and asked about lapersonal items in Faround and acknown personal items in the R43's room was of at 4:24 p.m. The biblankets were at the R43's significant crevealed diagnose schizophrenia. She for ADLs. R43 als	en looked around R23's room ed photograph, religious ed animal and dead plant curtain. Diserved to be bare on 1/27/15, bed was made, but there was of the resident's room. DS dated 11/14/14, revealed g dementia and Parkinson equired extensive assistance ely impaired cognitive skills was dent could usually understand Effective 5/23/14 to present) communication, cognition, and plan directed staff to anticipate uarterly Psychosocial Progress 4, indicated "staff anticipate ack of any pictures or other R28's room. NA-D looked wledged there were no he resident's room. Diserved to be bare on 1/26/15 ed was made and two folded he foot of the bed. Change MDS dated 11/28/14, is including dementia and erequired extensive assistance of had severely impaired clear speech, but could usually	F2	252			

I OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245332	B. WING	_		01/30/2015	
PROVIDER OR SUPPLIER N LIVINGCENTER - EX	CELSIOR		5	515 DIVISION STREET	<u> </u>	30/2013
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOL		BE	(X5) COMPLETION DATE
R43's care plan (effindicated the reside communication with speech and was nowere directed to ant Psychosocial Progresidicated "Res [resident and On 1/28/15, at 9:35 interviewed regarding other personal items NAs looked around make-up case label NA-D explained that On 1/28/15, at appropriate and On 1/28/15, at appropriate and NA-D explained that On 1/28/15, at appropriate and the environmental tour value and the environmental	rective date 3/4/13 to present) nt had impaired cognition and a episodes of disorganized to always understood. Staff cicipate her needs. A quarterly ess note dated 12/5/14, dent] is severely impaired, meet all needs." a.m. NA-D and NA-E were not the resident's room. The the room and found a led with the resident's name. It R43 "moves things around." Eximately 2:00 p.m. an eximately 2:0	F 2	52			
483.20(d), 483.20(k) COMPREHENSIVE A facility must use the to develop, review as	CARE PLANS The results of the assessment and revise the resident's	F 27	79			
	PROVIDER OR SUPPLIER LIVINGCENTER - EX SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa R43's care plan (effindicated the reside communication with speech and was nowere directed to ant Psychosocial Progresindicated "Res [resistaff anticipate and On 1/28/15, at 9:35 interviewed regarding other personal items NAs looked around make-up case label NA-D explained that On 1/28/15, at appropriate and were items. The administrator, direct of maintenance, and housekeeping. R23 observed, and were items. The administrator added members to bring in residents. A policy was request provided by the facil 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the develop, review at	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 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	PROVIDER OR SUPPLIER **N LIVINGCENTER - EXCELSION** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 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. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	PROVIDER OR SUPPLIER ILIVINGCENTER - EXCELSIOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 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. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	PROVIDER OR SUPPLIER 245332 RIVINGCENTER - EXCELSION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECORD BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) COntinued From page 19 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 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. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	PROVIDER OR SUPPLIER 1 STREET ADDRESS. CITY, STATE, ZIP CODE 515 DIVISION STREET SUMMARY STATEMENT OF DEFICIENCIES (ACAH DEFICIENCY WAS TEREST OF THE STATE OF THE STAT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) P		1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
· W·2			7 20,25						
		245332	B. WING _		01	/30/2015			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EXCELSIOR				STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
F 279	plan for each resided objectives and time medical, nursing, at needs that are identificated assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any sobe required under § due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on observative review the facility far plan the use of pering of 4 residents (R5, I restraints.	velop a comprehensive care ent that includes measurable tables to meet a resident's and mental and psychosocial tified in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment on, interview and document ailed to identify on the care meter defining mattress for 3 R16, R28) reviewed for	F 27	F 279 -R5, R16, and R28 care plans to reflect the use of perimeter of mattress and a potential rassessment has been completedReviewed all residents that perimeter mattress and careple currentRe-education with staff resussessment and careplanning3 Random chart audits weekly for designee to assure potential rassessments completed and care have been updated with intervalent Results will be reviewed at monthly.	defining restraint t have ans are egarding by DNS restraint re plans entions.	3/13/15			
	8:00 a.m. with nursi NA-E. R5 sat up in I herself twice to get of mattress of the bed, closet with her walk	were observed on 1/28/15, at ng assistants (NA)-D and ped independently, scooted over the edge of the perimeter stand up and walk to her per independently. NA-D stated against and out of bod							

PRINTED: 02/17/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR EXCELSIOR, MN 55331** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRFFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 279 Continued From page 21 F 279 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 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

mattress.

understood.

cognitive skills, unclear speech, could usually

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

understand others and sometimes be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245332 B. WING					01/30/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EXCELSIOR				STREET ADDRESS, CITY, STATE, ZIP CODE 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	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
F 279	R28's cares were of a.m. while assisted sitting up in bed, strindependently. NA getting in and out of R28's quarterly MD diagnoses including disease. She required one staff for bed metransfers and walking impaired cognitives understand others. R28's care plan efficient of the company of th	bserved on 1/28/15, at 7:42 by NA-D and NA-E. R28 was bod, and walked to her closet D verified R5 was capable of bed independently. S dated 11/14/14, revealed dementia and Parkinson red extensive assistance of obility, limited assistance for ng. The resident had severely skills, could usually ective 5/23/14 to present, falls due to history of medication and diagnoses of The care plan did not include the mattress. Sing (DON) was interviewed on the DON indicated es were implemented for experienced a fall from the her stated that R5, R16, and obtransfer independently from DN added that the use of es should have been identified on R5, R16, and R28's care	F2	79				
F 280 SS=D	1/22/15, indicated " appropriate intervel plan is updated." 483.20(d)(3), 483.1	Following a resident fall ntions are implemented, care	F 2	80				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR EXCELSIOR, MN 55331** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 280 Continued From page 23 F 280 The resident has the right, unless adjudged F 280 incompetent or otherwise found to be incapacitated under the laws of the State, to -R34's care plan has been reviewed and participate in planning care and treatment or revised to meet patient needs, including changes in care and treatment. dialysis requirements and nutrition. -R15's care plan for falls has been A comprehensive care plan must be developed reviewed and revised with most recent within 7 days after the completion of the fall interventions. comprehensive assessment; prepared by an -The system for reviewing falls and interdisciplinary team, that includes the attending careplans and interventions has been physician, a registered nurse with responsibility initiated, reviewed and completed. 3/13/15 for the resident, and other appropriate staff in -Re-educated staff on system of disciplines as determined by the resident's needs, reviewing falls and careplans and and, to the extent practicable, the participation of interventions. the resident, the resident's family or the resident's -3 Random chart audits weekly by DNS legal representative; and periodically reviewed or designee to assure compliance with and revised by a team of qualified persons after reviewing and revising care plans. each assessment. Results will be reviewed at OAPI monthly. This 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245332	B. WING			01/30/2015
	PROVIDER OR SUPPLIER	CELSIOR		STREET ADDRESS, CITY, STATE, ZI 515 DIVISION STREET EXCELSIOR, MN 55331		01/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	he reported, "They [unknown] diet. I've about a month." He drinking whatever f He explained his di replaced by an upp added that dressing staff at dialysis and change or look at it R34 received kidne for end stage renal addition, the reside including type II dia R34's care plan dainutritional risk relat and refusal of meal since his last admisarea. A handwritter [cubic centimeters] Goals for R34 incluand improved labor included diet as ord supplementation at monitor daily meal weights. For the refunction the plan (a for sodium and potrincluding laboratory ranges, and staff w site daily fistula/grainfection. "Diet and by Physician. Enco	R34 on 1/29/15, at 11:27 a.m. took me off the special been on a regular diet for e also indicated he was luids he wanted at present. alysis shunt had recently been er chest access line. He g changes were performed by said, "The nurses here don't." y dialysis three times weekly disease (kidney failure). In nt had other diagnoses	F2	280		
		ere to complete laboratory he physician and when a				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - E)	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	1 01/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 280	change in clinical s "Monitor thrill and b to document and re physician. Dialysis with a written comm weights and any ch between the dialysi A nursing assistant 1/29/15, at 2:41 p.n R34 was prescribed dialysis on Monday NA-H stated R34 h "but not now." He e regarding R34's cat assignment sheet. During an interview assistant director of communication bet dialysis center was telephone calls vers called us today to s fistula tomorrow, ar transportation comp changed departure Additionally, the AD longer on fluid restr a renal diet, "but I Domino's [pizza]." During a telephone 1/30/15, at 11:55 a.	igns or symptoms was noted. Irruit daily" (shunt function) and aport abnormal findings to the time was noted as "2 PM," nunication form reviewing anges in condition to be sent is provider and the facility. (NA)-H was interviewed on in. and reported an awareness of a renal diet, and went to it, Wednesday, and Friday. It was noted on the NA (NA)-Horizona finding restriction, explained that information re was noted on the NA (NA)-Horizona finding restriction, explained that information re was noted on the NA (NA)-Horizona finding reported ween the facility and the finding fi	F 2	280			
	she was "[R34]'s nu communication bet residential facility w "Usually I call with o nursesome nursir						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		FE SURVEY MPLETED
		245332	B. WING _		01	/30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - E)	(CELSIOR		STREET ADDRESS, CITY, STATE, ZIP C 515 DIVISION STREET EXCELSIOR, MN 55331		,00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	runs, and we educe heart and he may hospital." On 1/30/15, 2:01 p (LPN)-F indicated for measured by the direction left for dial nurse was responsing the computer. He did not think the NA and stated, "You're should maybe get awhen he gets up. Ethem when he gets returned he was like really tired." During an interview stated R34 had a fl supposed to give the added, "There is point sure where that Maybe the nurse come." The current physicis weights, and a dialyfluid restriction. Nuraccess site daily for bleeding. No notes access site was ob however, in an inter LPN-F said it was the stated it was the stated in the said it was the s	R34, "has fluid gains between ate him that it's hard on his have to go back to the .m. a licensed practical nurse R34's weight was to be ay shift staff either before the lysis or upon his return. The ible for recording the weights lowever, she added that she as were taking the weight daily, right, they're not all there. We a system to get them only because it's often hard to get back." LPN-F said when R34 ely to be "really hungry and on 1/30/15, at 2:10 p.m. NA-A uid restriction, and he was not the resident extra fluid. He pin the room sometimes. I'm at fits within the fluid restriction. Sould answer that better than an orders included daily lysis diet, but did not include a rsing staff were to check the r symptoms of infection or were found to show the served by the nurses, rview on 1/30/15, at 2:01 p.m.	F 28	30		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245332	B. WING			01/:	30/2015
	PROVIDER OR SUPPLIER			515	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET CCELSIOR, MN 55331		99/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	indications, but the 12/20/14, indicated have been restrict also noted the res afternoons, but the indicated he had n laboratory results, records were requite facility. Progress notes we through 1/30/15. N (all calls from the were recorded on months on 1/24/18 12/23/14. An eMA Note was dated 17 was to record the shift related to edetissues), however, the NAs were able not reflect informat fistula for thrill or blocation of the dial R34 from the arm indicated in any of attempts and/or canoted. R15's fall intervent.	e most recent change dated di the resident's fluids should ed to 1500 ccs. The care plan ident had dialysis in the e resident and staff both had norning dialysis. Weights and as well as intake and output ested but were not supplied by ere reviewed from 11/2/14 lotes reflected communication dialysis center to the facility) two days during the three 5, and two notes dated ARMedication Administration 1/10/14, at 10:23 and noted staff residents daily weight every ema (excess fluid in the R34 had left for dialysis before to weigh him. The notes did ion related to checking the oruit, nor was the change in lysis access site as reported by fistula to a chest catheter in the notes. In addition, are of the access site was not updated on R15's careplan.	F	280			
	R15 indicated the 11/24/14, at 9:15 a indicated R15 "slid bunched at edge, resident was conf	ent Report dated 11/24/14, for resident experienced a fall on a.m. A description of the fall d from bed to floorcovers were only socks on." It was noted the used and stated she "wanted to Contributing factors were					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY PLETED
		245332	B. WING			01/3	30/2015
	PROVIDER OR SUPPLIER	(CELSIOR		5	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 01/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE
F 280	identified as "Stock Specific Recomme "Gripper socks at a response on the re ideagripper socks not indicated the regetting up to eat, at up and she was "st applied." A Minnesota Incide R15 indicated the r 10:50 a.m. R15 wa between the bed at NA, the w/c brakes thought R15 "may I slipped and fell on factor was identified on." Specific Recom "Put brakes on, endight with transfer." "Resident stated the bed." A correspond read "[R15] likes to Assist of 1 with transdaily living]. R15's falls careplar needed staffs' assisinterventions, howe socks at all times a 11/24/14 fall. In add the care plan to ensapplied or to encounhelp as recommend.	ing feet, bunched bedding." Indation/Intervention were for all times." R15's family port was noted as, "'Good as." A corresponding progress esident reported she was and the bedding was bunched ocking footedgripper socks Int Report dated 1/24/15, for esident fell on 1/24/15, at a found sitting on the floor and curtain. According to the were not on, and it was have tried to self-transfer and ther buttocks." A contributing das "Brakes on w/c were not mmendation/Intervention were, courage resident to use call The summary indicated at she was trying to get out of ding progress note on 1/14/15, transfer self from w/c to bed. In dated 1/24/15, indicated R15 estance with transfers. The ever, did not include gripper as recommended after the dition, staff were not directed in sure R15's w/c brakes were arage the resident to call for ded after the 1/24/15 fall.	F 2	280			
		dent fell, to brainstorm, decide					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
		245332	B. WING	i		01/	30/2015
	PROVIDER OR SUPPLIER	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	01/	50/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 280	The ADON also sai listed on the back of RN-A then verified to intervention on the 2, print date 12/23/20 On 1/29/15, at 9:33 at the facility for sev NA-G explained the socks and shoes are to only wear socks confirmed the socks gripper socks. NA-E who had work years also stated or sometimes R15 wo times just wore her he had never assist as the resident work on 1/29/15, at 2:24 worked the night she self-transferred. LF her shoes and sock shoes back on agai experiencing interming the days and asked whether R15	and update the careplan. d interventions were also f each resident's care plan. he most recent fall back of R15's care plan (page 4) had been on 6/24/14. a.m. NA-G who had worked veral years was interviewed. It sometimes R15 wore both had at other times she preferred without shoes. NA-G s were normal socks and not ted at the facility for several h 1/29/15, at 9:52 a.m. re shoes and socks, and other own socks. NA-E also stated ed R15 to wear gripper socks, her own socks. p.m. LPN-C stated she ift and R15 sometimes N-C also stated R15 removed s and was also able to put her h. The resident was ittent confusion and was d nights mixed up. When wore gripper socks LPN-C esidents should have gripper	F 2	280			
	falls, and needed or transfers. R15, how transferred herself.	explained R15 was at risk for ne staff to assist her with ever, sometimes "forgot" and LPN-D verified R15 usually ersonal socks when she was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		E SURVEY IPLETED
r #19		245332	B. WING				1001001-
NAME OF	PROVIDER OR SUPPLIER	2-13002	D. WING		DEET ADDRESS OFFI STATE TO SORE	<u> 01/</u>	/30/2015
	I LIVINGCENTER - EX	CELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET (CELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Т	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	O BE	(X5) COMPLETION DATE
F 282 SS=D	PERSONS/PER CATThe services provided by accordance with eacare. This REQUIREMENT by: Based on observate review, the facility faprovided as directed residents (R23) reviand to ensure repost directed by the care (R23) reviewed for the care plan was not (R19) reviewed for of the care plan was not (R19) reviewed for the care plan with present, directed statioleting plan of che and as needed, use incontinence protect symptoms for UTI. Assessment review was identified as be pressures ulcer deviced.	led or arranged by the facility y qualified persons in ch resident's written plan of which resident's written plan of the resident's written plan of the resident's written plan of the resident was allowed for urinary incontinence with the residents of the residents or the residents or the residents of the resident residents of the resident residents of the resident resident residents of the resident reside	F2	82	F 282 -R19 is receiving care provided professional standardsR23 careplans were reviewed revised and is care by staff professional standardsFacility will educate staff on followare plan for incontinence of toileting, repositioning, pressure ul (prevention or care) and dignityDNS or designee will observe 2 d care observations 2 patients weekl regards to following the care plan incontinence care, toiled	and by wing care, cers irect y in s of ting, cers	3113/15
	The undated, care s provided total assist daily living) and the It was also noted the pressure sore," was assistance for whee	on resident every two hours. Sheet for R23 directed staff to tance with ADL's (activities of resident was non-ambulatory. The resident was at "risk for non-ambulatory, required the elchair mobility and total positivities of daily living.			•		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245332	B. WING			01/:	30/2015
	PROVIDER OR SUPPLIER	CELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET XCELSIOR, MN 55331	1 01/	99/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	R23 was not provide needs and reposition continuous observations. In a room, a.m. until 9:27 a.m. a.m. R23 was in a room. At 8:36 a.m. 8:37 a.m. nursing a assisted resident with the dining room with until she was whee R23 was provided transfer to bed with proceeded to assist to side in bed, to princontinent brief. Notincontinent brief should be a morning an interview NA-D, who consist unit, reported he at morning cares and indicated R23 was a.m. NA-D acknown assistance with toil for greater than two During an interview assistant director conursing assistance resident and the care.	ded assistance with toileting oning every two hours during ation on 1/28/15, from 6:55 (2 hours, 32 minutes). At 6:55 wheelchair seated in the dining R23 was served breakfast. At assistant (NA)-D sat down and with eating. R23 remained in the no assistance with toileting sled to her room. At 9:27 a.m. extensive assistance to a NA-D and NA-E. Staff at resident with rolling from side rovide peri-care and change A-D and NA-E confirmed the according wetness. If on 1/28/15, at 10:18 a.m. ently worked on the dementia and NA-E were running late with usually done by 9:00 a.m. and assisted out of bed at 6:45 yledged R23 was not provided eting and repositioning needs	F2	282	DEFICIENCY)		
	ADON further state follow the care guid shift nurse to try to The Incontinence I Guideline policy, definitions of the care guideline policy, definitions of the care guideline	ded the NAs were expected to des, and "We also rely on the keep on eye on cares." Management/Bladder Function ated 1/13/15, reviewed on the procedure purpose was					

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245332	B. WING _		01	/30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	_ 1 01	750/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	"Prevent skin proble and excoriation, Avinfection, Manage umaintain as much in possible." The Prevention of F 1/8/15 last reviewed procedure purpose breakdown and dev The procedure deta a turning and positic chair to meet the remaintain my dignity. needed. Provide no interventions of redienvironment. Help ras needed. Please a capable of doing at even if it doesn't maremember that I am accordingly. Please do before you begin reason before perfocalm, positive, reassidentify self with eace explain all procedur unhurried environmecommunication. Ansand repeat as neces needs. Encourage pusten carefully, valid expressions. Mainta Monitor for ability to report significant fine	ems such as pressure areas oid possibility of urinary irinary incontinence, restore of formal bladder function as Pressure Ulcer policy (dated 1/26/15), indicated the was, "To prevent skin relopment of pressure ulcers." ills directed staff to "Establish oning schedule in bed and sident needs." Dian directed staff to "Help me Provide emotional support as n-pharmaceutical recting, calm behavior and ne with reminders and cues allow me to do what I am my own pace in my own way like sense to you. Please an adult and treat me tell me what you are going to . Explain all procedures and rming. Approach patient in a suring manner. Staff to sh contact if needed and ses before starting. Allow calm.	F 28	32		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONST			E SURVEY IPLETED
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER	CELSIOR		515 DIVIS	ADDRESS, CITY, STATE, ZIP CODE SION STREET SIOR, MN 55331		30,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	When asked if staff dignity the resident talk to you. After st they put me in the I and then I sit there room for a meal. I report bathroom because change me. I wet me changed, and then go number two in minferior to the other waiting for her brieff could not use the brie	d on 1/27/15, at 8:53 a.m. is treated her with respect and answered, "No. Staff don't aff get me up in the morning iving room to watch television until they take me to the dining never get to go to the they just lay me in bed and my pad while I am waiting to be I sit in the wet pad, and then I my pad. It makes me feel residents here" (regarding to be changed and that she athroom like her roommate. wish staff would not be so in they wash me up in the at 7:44 a.m. R19 was observed chair (w/c) in the dayroom. At 7:46 a.m. a nursing oproached R19 and stated, at," and before waiting for a lent, proceeded to push R19 in dining room. At 8:16 a.m. R19 in drinking a cup of coffee. At proached R19 from behind and hing to the resident, pulled her table and pushed her down. B turned R19's w/c around in her room, the resident's foot and the resident responded, "If you just look at her she will be know because she is in real ays says 'ow' no matter what, at a ther." NA-B and NA-A m the w/c to the bed with the I lift. Throughout the process	F 2	32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245332	B. WING	i		01/3	80/2015
	PROVIDER OR SUPPLIER	(CELSIOR		,	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 0.76	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	R19 grimaced and repeated, "owow-lowered onto the bestated, "My arm hu again." NA-B told Fyour arm." As NA-E and forth from side check the brief, and again, R19 grimaced Ouch! Ow! Ow!" Nation without inswas planning to as On 1/29/15, at 9:26 dayroom at a table person. A jigsaw pR19 stated, "The othen again stated, person did not add repeated a little loumember continued one of the other rea.m. without lookin stating, "We are washe continued to word on the resident R19's roommate the person when the resident R19's roommate the person on the resident R19's roommate the person when the resident she grimaler roommate states and room when the resident she grimaler roommate states and room when the resident she grimaler roommate states.	her face was tensed. She -ow" repeatedly and she was ed and held her arm as she rts. You've broken my arm ref. 19, "We are not even touching ref. 3 and NA-A rolled R19 back ref. to side to lower her pants and ref. 4 then to pull the pants up ref. 5 and cried out loudly, "Ouch! ref. 6 and cried out loudly, "Ouch! ref. 7 be delivered care in a hurried ref. 8 and R19 was again in the ref. 8 and resident next. ref. 6 a.m. R19 was again in the ref. 8 with two peers and one staff ref. 8 and ref. 8 and ref. 9 was on the table and ref. 9 was on the table and ref. 11 goes there. The staff ress the resident, who then ref. 11 goes there. The staff ref. 12 to ignore R19 while talking to ref. 19 while talking to ref. 19 while talking to ref. 19 while talking to ref. 10 a.m. NA-G and NA-E ref. 10 a.m. NA-G and NA-E ref. 10 a.m. NA-G and NA-E ref. 11 a.m. NA-G and NA-E ref. 12 the bed with the mechanical lift ref. 13 and ref. 14 was ref. 15 and ref. 16 was ref. 16 and ref. 17 was ref. 18 and ref. 19 was ref. 19 wa		282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245332	B. WING			01/3	0/2015
	PROVIDER OR SUPPLIER	KCELSIOR		5	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 31,74	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	any peace. I can't of was adjusted she of you stop? Will you replied, "We are all completed, R19 as turned on. R19's rourse you want you else will then have was wearing two volifted up R19's to do cried out. NA-E as asked R19 if she woresponded, "My ne jammed under my in here." NA-G did statement as she gand remote control off the overhead lift turned on, loud so there were gray jasscreen. R19's room to that" and got up the room without the requested. Following the care R19 "they don't lead to the puzzle table this more than the nurse will say pain, 'I just gave you also stated, "Now urinated in my parhere wet until they said she would like morning, but "toda had a white substand reported the Ner teeth that morning that morning that morning the teeth that morning that morning the substand reported the Ner teeth that morning the care that morning the substand reported the Ner teeth that morning that morning the substand reported the Ner teeth the Ner	age 35 even sleep." As R19's clothing cried out loudly asking, "Will stop?" NA-E and NA-G most done." When cares were sked to have her television commate then stated, "Of ou television on, and someone to get up and turn it off." R19 ery different socks. As NA-E on a boot the resident again ked, "Is that better?" NA-E also was comfortable. R19 eck hurts with that pillow head. I don't even want to be not respond to R19's gave the resident her call light I. R19 requested the staff turn ght. When R19's television was ratchy noises were heard, and gged lines across the TV mmate stated, "I have to listen and left the room. The NAs left urning off the light as R19 had observations at 10:15 a.m. isten to mejust like at the norning." R19 further stated, "Or to me when I tell her I have ou something for that." R19 with all that rolling around, I just and I will just have to stay get me upif they do." R19 et o get up at 8:00 a.m. every ay I got up at 7:25 a.m." R19 ance on her lower bottom teeth NA did not assist her to brush ning. R19 said she had her nents about her, which were		282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		515	EET ADDRESS, CITY, STATE, ZIP CODE DIVISION STREET CELSIOR, MN 55331	1 01/	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	typical. She added, off and they didn't." her eyes where she R19 added, "I want At 11:16 a.m. R19 ron with gray jagged the TV emitted irrita 2:41 p.m. R19 had room. R19's quarterly Min 1/3/15, indicated R' cognition, presente psychosis, and did extensive staff assi living. Diagnoses in hemiplegia (paralys depressive disorde generalized pain. On 1/28/15, at 10:3 never used the toile mechanical lift and R19 was completel sometimes reporter movement. NA-G fi scream out. She a look at her she will On 1/29/15, at 10:2 heard R19's roomm received care. R19 and was being trea medication) and M3 medication). On 1/28/15, at 10:3	"I asked them to turn my light She described an issue with a found the light bothersome. To be with my son and family." Temained in bed with the TV I lines across the screen and ating, scratchy sounds. At been moved to a different Immum Data Set (MDS) dated 19 had moderately impaired d no behavioral problems or not reject cares. R19 required stance for activities of daily adicated on the MDS included as on one side of the body), rs, spasm muscle and 8 a.m. NA-G reported R19 et, and instead used the the bed pan. NA-G also stated y incontinent, although d the need for a bowel urther stated, "She is known to lways says 'ow,' even if you	F 2	282			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		l		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/30/2015	
	PROVIDER OR SUPPLIER	CELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331	1 01/1	50/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	even if you look at I On 1/29/15, at 11:1 "guilts" her family semuch. She was un working. In addition derogatory commer roommate and state [R19's] roommate's the staff should not will offer her another staff should not staff should n	rer she will say ow." 7 a.m. the explained that R19 of they had not been visiting aware the TV was not in, she was unaware of the ints made by the R19's red, "This is concerning about a comments towards [R19] and ibe allowing it to happen. We rer room." In directed staff to "Evaluate of pain on numeric reptable level of pain is according to the resident. It in pain or uncomfortable, rery shift, Administer pain red, Evaluate characteristics aren of pain, Evaluate need to so prior to treatment or therapy, residently estimated to the pain worse, Observe for the extremities such as pain, the provide medications as ordered avaluate for effectiveness, acceutical interventions of rehavior and environment, stiffness, Observe for specific locations of pain, of interventions taken to relieve ient needs, Provide emotional	F2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1. W.9		0.45000					
		245332	B. WING			01/3	30/2015
	PROVIDER OR SUPPLIER	KCELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET KCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
F 282	incidences; once o 1/28/15, when R19 acceptable level of care plan. On 1/27/15, at 9:15 had any pain with r side, my left ankle	age 38 In 12/22/14, and twice on reported pain above R19's pain '5' indicated on R19's Is a.m. R19 was asked if she no relief R19 stated, "My left thurts right now, a '7 or 8' [out ated, "I don't feel my pain is	F 2	82			
W.	1/3/15, indicated R impaired. The quar indicated R19 had psychosis, no reject extensive staff assi (ADLs). The quarter indicated 'Yes' R19 R19 had not receive medication, and 'Yes' non-medication into quarterly MDS date reported 'frequently gave a 'moderate' in the staff of the	nimum Data Set (MDS) dated 19 was cognitively moderately terly MDS dated 1/3/5, also no behaviors, no delirium, no ction of cares, and R19 needed ist for activities of daily living erly MDS dated 1/3/15, further received pain regimen, 'No' red PRN (as needed) pain es' R19 had received ervention for pain. The ed 1/3/15, also indicated R19 y hurting' also indicated R19 for verbal descriptor of pain, R19's pain did not affect sleep es.					
F 309 SS=E	expected staff to for 483.25 PROVIDE (HIGHEST WELL BEACH resident must provide the necessor maintain the high mental, and psychological).	2 a.m. the DON stated he ollow the residents' care plans. CARE/SERVICES FOR SEING treceive and the facility must eary care and services to attain thest practicable physical, psocial well-being, in e comprehensive assessment	F3	809	F 309 -R48, R68, R26, R55, R46, R16 receiving person centered careAll the other residents on the ACU are receiving person centered careFacility will provide education to for proper interaction with patients have a diagnosis of Dementia, person centered language that ref understanding the cause of the beha	staff who in a lects	3/13/15

DEPART CENTE	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 02/17/2019 RM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) D.	O. 0938-0391 PATE SURVEY OMPLETED
' # g		245332	B. WING				1/30/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX	(CELSIOR		5	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331		1/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BF	(X5) COMPLETION DATE
F 309	Continued From pagand plan of care.	ge 39	F;	309	meeting the resident where they are in their disease process, and effective meeting the residents needs. ~ED or ACU Director to observe so interactions with residents to ensure the contractions.	vely taff	
	by: Based on observation review, the facility far demonstrated special knowledge which incomperson centered I R68, R26, R55, R46 on the dementia unitimpaired. In addition coordinate hospice is provided for 1 of 1 rehospice, to provide reviewed for behavior residents (R34) reviewed for behavior res	erns suggested a lack of entia related training among as were conducted on 1/26/15 7:30 p.m. in the dementia ursing assistant (NA)-J called ective tone, " [name of you trying to do? Remember as R48 was attempting to nt in his wheelchair. Staff a corrective tone "No, No that is sandwich" as R68 was		11	person center care 2x weekly audit report finding at QAPI monthly. -Facility has met with hospice servi and will provide them a folder where faxed hospice communication will put for hospice to file into patient characteristics of the into patient characteristics. -Staff re-educated on hospicommunication process. -DNS or designee to audit hospifolder and chart one time weekly assure compliance and propicoordination of care. Results of audit be reviewed at QAPI monthly. -R34s dialysis care plan has be reviewed and updated to reflect curre interventions and coordination services with dialysis. -Facility has implemented a dialyst referral sheet to send with patient each time they go to dialysis to enhance coordination of care. -DNS or designee to audit 2 randon care plans weekly to assure proper interventions in place and care incoordinated with outside services. -Staff educated on sending an receiving communication form to an from dialysis unit. -DNS or designee to audit 1x weekly and results to be reviewed at QAP monthly.	and ces all be art. ain ice ice to cer to en int of is ch ce m er is d d	
	you can't push him" a push another resider then said to R68 in a is [another resident's	as R48 was attempting to nt in his wheelchair. Staff a corrective tone "No, No that is] sandwich" as R68 was sandwich off the table.			rom dialysis unit. -DNS or designee to audit 1x weekly and results to be reviewed at OAP	v	

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES			P		: 02/17/2019 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		LE CONSTRUCTION	(X3) DAT	E SURVEY
' M'9		245332	B. WING	ì			
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/	30/2015
				8	515 DIVISION STREET		
GOLDEN	I LIVINGCENTER - EX	CELSIOR		1	EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	potential for abuse of ability, wandering, of hearing deficits." In "Please explain my understand what is communication plar "Impaired communiimpaired hearing." staff to "Anticipate patient to verbalize validate verbal and R68's care plan date diagnoses including indicated, "I am still surroundings and w comfortable in my n LTC [long term care directed staff to "He preferences for daily 1/19/15, also indicate related to wandering dementia unit." The "Involve the patient daily choices." At 5:12 p.m. NA-F stone while pointing tresident] use your service was potential for abuse of ability, history of war ability, difficulty cominterventions directed unable to verbalize, environment to me in the staff of the staff	y is at risk and there is a due to decreased cognitive ecreased physical ability, terventions directed staff to environment to me if I don't going on around me." The dated 6/20/14, also indicated cation due to confusion and The interventions directed satient needs, encourage needs, listen carefully, non-verbal expressions." ed 1/22/15, revealed dementia. The care plan adjusting to my new ould like help getting ew home. I am planning on here." The interventions Ip me maintain my viving." The plan dated ed "At risk for elopement grand move to secure interventions directed staff to in decision making regarding tated to R26 in a corrective to a spoon, "[Name of coon." ed 8/13/14, revealed dementia. The care plan vis at risk and there is a lue to decreased cognitive ndering, decreased physical municating needs." The d staff to "Anticipate needs if	F3	309	-R19 pain regimen reviewed physician and nurse practitionerStaff educated on use of medication and offering with signs symptoms of distressDNS or designee to audit for signs symptoms for R19 and 2 ran residents a week. Results to reviewed monthly at QAPIDNS or designee to perform direct audit on R19 weeklyStaff educated on signs and symptof pain and stopping cares wappropriate.	PRN s and s and dom be care	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/3	80/2015
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET XCELSIOR, MN 55331	1 01/0	0,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	5/22/12, also indicedue to confusion a directed staff to "Eneeds, Listen care verbal expression." At 5:39 p.m. NA-F don't worry. Just rattempting to clean NA-F then stated you to bed at 6:30 and relax. I will tu R55's care plan of diagnoses includicated, "Impairimpaired cognition directed staff to "Encourage patier dated 8/15/14, alse enter, Attempts to directed staff to "Imaking regarding." At 6:10 p.m. R46 nurse (RN)-C put nurse's face, star of resident aloud. RN-C responded "[Name of resident aloud. R46's care plan of diagnoses including disorder characters short term memoindicated, "Impairimpaired cognition impaired cognition in the staff to "Impairimpaired cognition in the staff to "Impairimpairimpaired cognition in the staff to "Impairimp	cated "Impaired communication and dementia." Interventions Encourage patient to verbalize efully, validate verbal and non s." F told R55 "[Name of resident] relax. I will get that" as R55 was at the dishes from the table. "[Name of resident] I will put 0 p.m. You can go to your room ck you in." ated 8/27/14, revealed ng dementia. The care planed communication due to n, confusion." Interventions Anticipate patient needs, at to verbalize needs". The planes o indicated "At risk for d to anger at placement in living to leave." The interventions nvolve the patient in decision a daily choices." walked up behind a registered ting his face in front of the tling the RN. RN-C stated name NA-J who was standing next to in a corrective tone to R46		309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015	
	PROVIDER OR SUPPLIER	(CELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331	917	56/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	staff to "Anticipate direct communicati The plan dated 11/5 for elopement relat center, wandering.' staff to "Involve the regarding daily cho At 6:30 p.m. NA-J t dining room to the nine residents were television. R16 rem room table with her p.m. R16 was clapp the television. R16 back to the televisic clapping until 7:30 entered and exited R16 was not provide television. R16's care plan dadiagnoses including care plan indicated diminished decision security issuers, pla Alzheimer's care undesigned for this poevidenced by Alzheinterventions direct through the ACU to deficits." The plan "Impaired communicognition." Interver "Anticipate patient"	patient needs, Use simple and on to promote understanding". 26/13, also indicated "At risk ed to attempts to leave living 'The interventions directed patient tin decision making ices." Turned on the television in the "I Love Lucy" show. A group of e seated in front of the lained seated at the dining back to the television. At 6:40 ping her hands as music from remained seated with her on and was periodically p.m. Although NA-J and RN-C the dining room several times, led assistance to face the "Due to cognitive loss, a making and safety and accement in the secure hit (ACU) with programs oppulation is needed as simer's disease." The ed staff to "Provide cues of minimize effects of cognitive dated 3/29/11, also indicated incation due to impaired intions directed staff to	F	809				
	3:57 p.m. The adm department manag	vas interviewed on 1/29/15, at ninistrator explained that all ers, including the director of the herself monitored interactions.						

STATEMENT AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245332	B. WING			0.1/0.2/0.2/-	
	PROVIDER OR SUPPLIER N LIVINGCENTER - E)	CELSIOR		515 [EET ADDRESS, CITY, STATE, ZIP CODE DIVISION STREET EELSIOR, MN 55331	<u> U1,</u>	/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BF	(X5) COMPLETION DATE
F 309	between staff and r The administrator fi "in the moment coa were observed, and meetings for all nur. The DON was inter a.m. and reported ti working to hire a dir The DON further ac training related to ac dementia in person be reviewed with dir further acknowledge assisted with reloca watched television. The Admission/Disc Unit dated 2009, inc admission to unit inc of Alzheimer's or oth was established, Th demonstrating beha dementia such as m (immediate, recent a disorientation to time attention span; moo exit-seeking; expres specific fantasy; cat The Guidelines for C Dementia dated 11/ "Staff interaction wit deficitsStaff will int manner that support resident's ability to s Staff must try to cha to control behavior to	esidents in the dementia unit. Jurther stated the facility does ching" for staff if concerns in the facility held monthly staff sing staff. Viewed on 1/30/15, at 9:50 me facility had been actively sector for the dementia unit. Sknowledged that dementia addressing residents with centered language needed to sect care staff. The DON sed that R16 should have been ting herself so she could have sharge Criteria Alzheimer Care slicated the criteria for cluded: "A primary diagnosis her related cognitive disorder e resident may be viors associated with semory dysfunction and remote); poor judgment, e; place, person, decreased diluctuations; wandering and sion of anxiety centering on astrophic reaction." Caregiver Interaction with 12/14, indicated the following: h patients who have cognitive eract with residents in a sidgnity and enhances the uccessfully participate in life. Inge their thinking from trying	F3	309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR** EXCELSIOR, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 44 F 309 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

disciplines were identified.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245332 B. WING			01/30/2015			
	PROVIDER OR SUPPLIER I LIVINGCENTER - E)	(CELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	01/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIAT	(X5) COMPLETION E DATE	
F 309	and had a hospice Staff indicated the bathing and activition NA-E said the nurshospice aide was consistently worked reviewed R23's hose unable to find a schedule to find a schedule should has LPN-B was unable hospice aides typic sign papers to comprovided care to the During interview or DON explained that aide schedule to the front desk and, "the DON proceeded to in a lateral file at the form from hospice name, the name of she would be comi include what service to the resident. The hospice chart with chart did not include noting what discipling provided for the rest those visits. On 1/20/15, at 8:30.	aide that came on Sundays. hospice aide assisted R23 with es of daily living. NA-D and e informed them when the oming. 1/29/15, at 9:43 a.m. a surse (LPN)- B who don the dementia unit, spice chart. LPN-B was nedule of services that was to from the hospice agency, blan of care. LPN-B further ad a hospice aide, the ave been in the chart, which to find. LPN-B stated the sally had facility nursing staff firm they were at facility and	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/:	30/2015
	PROVIDER OR SUPPLIER	KCELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331		9,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	A policy on hospice provided. Dialysis: R34 received dialys	age 46 otes faxed to the facility. e care was requested but not sis, however, conflicting ported by the resident, staff,	F	309			
	R34 was observed 3:51 p.m. He report day, and would be 11:00 a.m. The foll was observed at 1, was at dialysis.	in the resident's medical record care. while in bed on 1/27/15, at ted he had dialysis the next returning to the facility after owing morning R34's room /28/15, at 8:09 a.m. while R34 o water pitcher or other fluids hat time in his room.					
	he reported, "They [unknown] diet. I've about a month." H drinking whatever He explained his d replaced by an upp added that dressin	n R34 on 1/29/15, at 11:27 a.m. took me off the special be been on a regular diet for le also indicated he was fluids he wanted at present. ialysis shunt had recently been per chest access line. He g changes were performed by d said, "The nurses here don't t."					
	for end stage rena addition, the reside including type II dia R34's care plan da nutritional risk rela	ey dialysis three times weekly I disease (kidney failure). In ent had other diagnoses abetes. Ited 11/3/14, included a plan for ted to the need for extra protein als with poor intake, weight loss					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245332	B. WING		01	/30/2015	
	PROVIDER OR SUPPLIER	(CELSIOR		STREET ADDRESS, CITY, STATE, ZIP CO 515 DIVISION STREET EXCELSIOR, MN 55331		39,2310	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	since his last admis area. A handwritte [cubic centimeters] Goals for R34 incluand improved labor included diet as ord supplementation at monitor daily meal weights. For the refunction the plan (a for sodium and pot including laboratory ranges, and staff with site daily fistula/grainfection. "Diet and by Physician. Encountritional and hydromatic and hydromatic and sordered by change in clinical simple work as ordered by ch	age 47 ssion, and several opened skin in addendum read "1500 cc fluid Restriction [sic] 12/2014." Ided weight above 190 pounds ratory values. Interventions ders with extra protein and imeals. Staff were also to consumption and monthly esidents' alteration in kidney also dated 11/3/14) with a risk assium excess. Goals y values within therapeutic ere directed to "check access of fluid restrictions as ordered ourage patient to follow ration program interventions" For ere to complete laboratory of the physician and when a signs or symptoms was noted. For example, and the time was noted as "2 PM," munication form reviewing langes in condition to be sent its provider and the facility. Find on 1/29/15, at 2:41 p.m. over every example of the facility of the form of the facility of the form of the facility of the form of the facility of the facility of the facility and the typically in the form of	F 3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245332	B. WING		01,	/30/2015
	ROVIDER OR SUPPLIER	(CELSIOR		STREET ADDRESS, CITY, STATE, ZIF 515 DIVISION STREET EXCELSIOR, MN 55331	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	called us today to fistula tomorrow, a transportation come changed departure. Additionally, the AL longer on fluid rest a renal diet, "but Domino's [pizza]." During a telephone 1/30/15, at 11:55 as the was "[R34]'s necommunication be residential facility we "Usually I call with nursesome nursione does not, so we concerns." The diece of the concerns. The diece of the concerns of the may hospital." On 1/30/15, 2:01 pe (LPN)-F indicated measured by the coresident left for dien nurse was responsing the computer. It did not think the New and stated, "You're should maybe get when he gets up, them when he gets up, them when he gets was responsing the computer of the computer. It did not think the New and stated, "You're should maybe get when he gets up, them when he gets up, them when he gets up, them when he gets was responsing the computer of the computer. It did not think the New and stated, "You're should maybe get when he gets up, them when he gets up, them when he gets up, them when he gets up the control of the computer. It did not think the New and stated, "You're should maybe get when he gets up, them when he gets up, the measured by the control of the computer of the co	sus written information. "They say they would work on his and said they had called his pany to tell them too" (due to a time from the dialysis facility). DON reported R34 was no rictions, but was still prescribed he orders sandwiches out or exall to the dialysis facility on .m. a dialysis RN-A reported urse." She verified tween the dialysis and the was most often not written. concernsand talk to his ng homes send a sheetthis we call them or they call us with	F3	09		

				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245332	B. WING			01/	30/2015		
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	(CELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET (CELSIOR, MN 55331	1 01/	00/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 309	During an interview stated R34 had a fli supposed to give the added, "There is point sure where that Maybe the nurse come." The current physicial weights, and a dialy fluid restriction. Nur access site daily for bleeding. No notes access site was obshowever, in an inter LPN-F said it was because been restricted also noted the residaternoons, but the 12/20/14, indicated have been restricted also noted the residaternoons, but the indicated he had melaboratory results, a records were request the facility. Progress notes were through 1/30/15. Note all calls from the diswere recorded on the months on 1/24/15, 12/23/14. An eMAF Note was dated 11/ was to record the reshift related to edentissues), however, Facebox 12 and 13 and 14 and 15 and 15 and 16 a	on 1/30/15, at 2:10 p.m. NA-A uid restriction, and he was not be resident extra fluid. He up in the room sometimes. I'm fits within the fluid restriction. Duld answer that better than an orders included daily as is diet, but did not include a sing staff were to check the asymptoms of infection or were found to show the served by the nurses, wiew on 1/30/15, at 2:01 p.m.	F3	009					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET **GOLDEN LIVINGCENTER - EXCELSIOR** EXCELSIOR, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 50 F 309 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 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

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245332	B. WING			01/3	80/2015	
	PROVIDER OR SUPPLIER	CELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET XCELSIOR, MN 55331	1 0 1/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	hurting" also indicated verbal descriptor of pain did not affect of the control of pain did not affect of the control of pain did not affect of the control of pain did not affect of pain medication them very often." It want to lie down, the lie down of the lie down, the lie down of the lie down, the lie down of the	ted R19 gave a 'moderate' for f pain, and also indicated R19's sleep or limit day activities. 44 a.m. licensed practical nurse nonestly cannot tell if she is in cal. Morphine is scheduled also stated, "She can ask for on but she does not ask for LPN-A further stated, "She will nen want to get up. There is with her." 26 a.m. the DON stated R19 ramadol (pain medication) and c pain medication) and R19 ring cares. The MS Contin had		809				

	AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015	
	PROVIDER OR SUPPLIER	CELSIOR		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET XCELSIOR, MN 55331	1 01/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	which she sometim On 1/29/15, at 11:0 history of osteomye metatarsals (bones before R19 came in treatment that woul the treated ulcer he was from the osteo scheduled morphin On 1/29/15, at 2:38 asked for a pain pill p.m. and because shurting. RN-B also she asked for one." On 1/30/15, at 12:5 stated, "She is a veher pain. She will te therefore she does for pain." R19's Progress Not "[R19] cries and coduring cares and traat 11:30 a.m." Physician Progress "She is complaining problem that has detreatment in the pasand tense, looks as severe. Imp [imprescontrol. She has be years. Probably not much as she should Contin to 15 mg q8	es accepted. 9 a.m. RN-A stated R19 had a elitis (bone infection) in her in the foot). RN-A stated ato the facility she refused a d have removed the bone, and aled. RN-A thought R19's pain myelitis and R19 received e twice a day for it. p.m. RN-B stated R19 had at approximately 1:15 to 1:30 she reported her leg was really stated, "I was really surprised	F3	09				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		245332	B. WING				1/30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	(CELSIOR		STREET ADDRESS 515 DIVISION ST EXCELSIOR, N		=	1/30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EACH C	VIDER'S PLAN OF CORRECTIVE ACTION SHOEFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	suspect we may ne [twice daily] fairly so Neurontin [anticonvused for pain] beformuch it helped." Physician Progress indicated "Still majormeds, but at least sand sometimes corralso indicated "Lots she did not even waleast, the neurotropmetatarsal head is Severe spastic left P. [Plan] Meds left sopiods." Complete History a indicated "[R19] reputite a bit of pain modicated "[R19] medications becaus nurses.' Left pain modications becaus nurses.' Left pain modicated side from Stroke, Commentia with behalt Hypertension [high Physician Orders da PRN Oxycodone at 4/3/14, MS Contin Tamg (Morphine Sulfathree times a day, of Oxycodone HCL tatamouth every 2 hours break thru pain, ordered the sulfathree times and the sul	ed to go up to 30 or more bid con. We did have her on culsant medication commonly re, but I am not sure how Note dated 11/12/14, or chronic pain despite many the does get out of the room overses." The physician note of pain all of the left side, and ant me to take off her sock. At ic ulcer below the left 5th now closed. A. [Assessment] hemiplegia with chronic pain. Is ame with substantial chronic and Physical dated 12/4/14, norting left foot pain. Is on redications and appears says she doesn't ask for PRN as she 'never sees the redications unchanged." "Hemiplegia Nondominant chronic pain syndrome, and blood pressure]." ated 1/29/15, included: Offer least every 4 hours, ordered fablet Extended Release 15 the ER); Give 15 mg by mouth ordered 6/30/14, and olet 10 mg; Give 10 mg by see as needed for dyspnea and	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP C 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	<u> </u>	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E	BE	(X5) COMPLETION DATE
F 309	(electronic medication 12/22/14, with no P During the month or pain medications. R19's 1/15, EMAR is Oxycodone HCL 10 through pain twice of documented R19's knee pain, PRN effeleft extremities, with was rated a '6' on the both day and evening PRN pain medication R19's 1/15 care platestablish level of paraceptable level of paraceptable level of according to the respain or uncomfortal shift. Administer pain Evaluate characterispain, Evaluate needs to treatment or therapain worse. Observe extremities such as Provide medications evaluate for effective non-pharmaceutical calm behavior and evaluate or stiffness. Observe specific locations of	on administration record) on RN pain medication given. f 12/14, R19 received no PRN f 12/14, R19 received no R19 f 12/15, an extended for break during the month. The LPN pain on 1/29/15 was a '7' left fective, and on 1/27/15, an '8' n PRN effective. R19's pain no 1/15 EMAR on 1/28/15, on no shift on 1/28/15, with no findicated: Evaluate and find on numeric scale/resident's pain is verbalized as a '5' fident. Make sure I am not in findicated. Make sure I am not in findicated frequency/pattern of the provide medications prior f 12/15 and frequency/pattern of the provide medications prior f 13/15 and f 14/15 and f 14/	F 3				
	needed." On 1/30/15, at 8:52	a.m. the DON stated he liver care according to s.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	2) MULTIPLE CONSTRUCTION (X3) BUILDING			(3) DATE SURVEY COMPLETED	
W 19		245332	B. WING	•		01/	30/2015	
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331	1 01/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314 SS=D	Based on the compresident, the facility who enters the facility interventions included the compression of the facility interventions included the facility who entered the facility wh	prehensive assessment of a must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having elives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced lition, interview and document failed to implement ding timely repositioning for 1 of reviewed who were at risk for		314	F 314 -R23 assessment completed for titolerance. Care plan updated to retissue tolerance assessmentAll staff trained on following care and the importance of turn repositioning and offloadingOther residents receiving assists with repositioning and offloading their careplanDNS or designee to audit turn repositioning and offloading or residents weekly. Results of audits be reviewed at QAPI monthly.	plan ning, ance per ning, f 2	3(13/15	
	was not reposition continuous observa.m. until 9:27 a.m a.m. R23 was in a room. At 8:36 a.m. 8:37 a.m. a nursing and assisted resid in the dining room repositioning until At 9:27 a.m. R23 wassistance to trans Staff proceeded to from side to side in change incontinent.	d at risk for skin breakdown and ed every two hours during ation on 1/28/15, from 6:55 . (2 hours, 32 minutes). At 6:55 wheelchair seated in the dining. R23 was served breakfast. At g assistant (NA)-D sat down ent with eating. R23 remained with no assistance with she was wheeled to her room. was provided extensive assist resident with rolling to bed, to provide peri-care and t brief, no skin redness was skin was intact. NA-D and			4			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)

AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1		G		TE SURVEY MPLETED
		245332	B. WING	i		01	/30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR	•		STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	, 01	750/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 314	NA-E confirmed the wetness. R23's undated, Bradidentify pressure uld being at moderate rulcer. R23's care play present), directed strepositioning sched. R23's quarterly Mini 1/8/15, revealed dia and cerebral vascul required extensive atransfers, bed mobil The resident had seskills, unclear speed understand others of Area Assessment (Opressure ulcers date is an extensive assist locomotion, personal did not ambulate, skills by licensed staff. Proand wheelchair, barrineeded]." The Comprehensive on 1/8/15, indicated at moderate risk for and the plan include two hours. The undated care stresident at "risk for pron-ambulatory, required in the plan include two hours.	den assessment (tool used to cer risk) identified R23 as isk for developing a pressure an (effective 10/22/13 to taff to provide turning and ule per assessment. mum Data Set (MDS) dated gnoses including dementia ar accident (stroke). She assistance of two staff for ity and unable to ambulate. Everely impaired cognitive ch, could sometimes or be understood. The Care CAA) summary/analysis for ed 4/8/14, indicated "Resident est with transfers, bed mobility, all hygiene, eating. Resident cin checks with cares, weekly essure relieving device in bed rier cream applied PRN [as essures ulcer development do to reposition resident every meet for R23 identified the pressure sore," was uired the assistance for and total assistance with all	F3	314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/17/201 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245332 B. WING NAME OF PROVIDER OR SUPPLIER 01/30/2015 STREET ADDRESS, CITY, STATE, ZIP CODE **GOLDEN LIVINGCENTER - EXCELSIOR** 515 DIVISION STREET **EXCELSIOR, MN 55331** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 57 During an interview on 1/28/15, at 10:18 a.m. F 314 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 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." 483.25(d) NO CATHETER, PREVENT UTI, F 315 F 315 -R23 and R54 bowel and bladder diary RESTORE BLADDER F 315 SS=D completed and care plan updated to reflect assessment Based on the resident's comprehensive -All staff trained on following care plan assessment, the facility must ensure that a 3/13/15 and the importance of toileting patients resident who enters the facility without an

function as possible.

indwelling catheter is not catheterized unless the

who is incontinent of bladder receives appropriate

infections and to restore as much normal bladder

resident's clinical condition demonstrates that catheterization was necessary; and a resident

treatment and services to prevent urinary tract

per their plan of care.

their careplan.

monthly.

-Other residents receiving toileting per

-DNS or designee to audit toileting for 2

random residents weekly. Results of

audits will be reviewed at QAPI

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	J. 0938-0391 ATE SURVEY
		0.45000					OMPLETED
NAME OF	PROVIDER OR SUPPLIER	245332	B. WING			0.	1/30/2015
GOLDE	N LIVINGCENTER - EX			515	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET CELSIOR, MN 55331		1/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 58	F3	:15			
t (Based on observation review, the facility factor improve continents who experienced a comprovide timely toil residents (R23) observed with meets assistance with meets and a	8/15, at 11:22 a.m. that R54 o hours. Although R54 eeded to urinate, she was ff assisted her to the toilet. f any attempts to assist R54 uently than every two hours. 8/15/14 identified a goal for of urinary tract infections included: "Evaluate timing may cause increased					

1	AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TI	DI C COMOTTO	<u>OMB N</u>	<u>0. 0938-039</u>
	AND I DAM	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) D	ATE SURVEY DMPLETED
1	NAME OF	PROVIDER OR SUPPLIER	245332	B. WING _			1/20/004 =
	GOLDEI	N LIVINGCENTER - EX		l	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	<u> </u>	1/30/2015
	(X4) ID PREFIX TAG	(LACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	711100	(X5) COMPLETION DATE
	in to the second	incontinence episodo of check and change (as needed). A revie did not reflect UTI's whistory prior to admiss to show the residents reviewed related to pincontinence as well of incontinence episodo reflected checking an intervention when a realthough the resident successfully use the test of the pincontinence of urine. MDS dated 11/13/14, indicated the incontinence to always it also had severe cognitive assistance who can be a trial bladder resident's reflect a trial bladder resident's resident of the assessment, hower occumentation to supposite the resident's resident of the interviewed on 1 resistant director of nurses unaware R54 had rinary incontinence. Side completing three-date remine residents' voten determined staff in the residents' voten determined staff in	esscheduled toileting plane every two hours and PRN" by of R54's medical record while at the facility or a sision. Evidence was lacking a medication timing had been otentially contributing to as her frequency and timing ides. The care planed changing the resident (an esident is totally incontinent), had the ability to oilet. mum Data Set (MDS) dated a resident had frequent A subsequent quarterly showed a decline in R54's incontinent of bladder. R54 tive impairment, required with toileting and transfers. decline, the MDS did not etraining program for R54. If form dated 11/13/14, we offered toileting ours and upon request. Ever, did not include ort the every two hour in the summary conclusion. In the summary conclusion. In the summary conclusion in the explained staff was to be badder assessment to the badder assessment to the summary to bladder assessment to the badder assessment to the badder assessment to the sum and the summary to bladder assessment to the badder assessment to be badder assessment to be supported to the summary to bladder assessment to be badder to be badder assessment to be badder to be bad	F 315	DEFICIENCY)		

SIALEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MI	II TIF	OLE CONCERNATION	<u>OMB </u>	<u>10. 0938-039</u>
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) E	DATE SURVEY
		8.4500-					OMPLETED
NAME OF	PROVIDER OR SUPPLIER	245332	B. WING				11/20/2045
GOLDE	N LIVINGCENTER - EX			5	STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 0	01/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ם חר	(X5) COMPLETION DATE
i i i i i i i i i	couple weeks prior in The ADON was unall showing R54's bladdestablished and an abased on her individuals of unaware wheth completed after the whether a trial for mobeen considered. When interviewed or director of nursing (Durinary incontinence pneumonia and did not the DON was unable showing R54's bladdestablished. The DON experienced any UTI's R23 was not provided established. The DON was unable showing R54's bladdestablished. The DON experienced any UTI's R23 was not provided established. The DON was unable showing R54's bladdestablished. The DON was unable showing R54's bladder session in a wheelchair seated aum. R23 was served nursing assistant (NA) resident with no assistant was wheeled to her roprovided extensive as with NA-D and NA-E. Sesident with rolling from the control of the	they had been "reminded." ble to provide documentation der patterns had been appropriate plan developed ual needs. The ADON was er a re-assessment had been MDS showed a decline, or ore frequent toileting had a 1/29/15, at 2:20 p.m. the DON) stated R54 declined in when she developed of wish to get out of bed. It to provide documentation er patterns had been N verified R54 had not so while at the facility. If assistance with toileting so during continuous 5, from 6:55 a.m. until 9:27 utes). At 6:55 a.m. R23 was do in the dining room. At 8:36 breakfast. At 8:37 a.m. and D-D sat down and assisted a sistance to transfer to bed staff proceeded to assist om side to side in bed, to change incontinent brief.	F	315			
l u	ie iesiueni nad Alzhe	imer's disease, and was and had no sensation of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245332 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR EXCELSIOR, MN 55331** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 315 | Continued From page 61 F 315 urine loss. Staff was directed to check and change resident every two hours and as needed.

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 quarterly MDS dated 1/8/15, revealed diagnoses including dementia, cerebral vascular accident and (stroke). She required extensive

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.

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245332	B. WING _		01/:	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	During an interview assistant director of nursing assistance resident and the car resident's reposition stated the NAs were guides, and "We also to keep on eye on comparison of the Incontinence M Guideline policy, da 1/19/15, indicated the "Prevent skin proble and excoriation, Avoinfection, Manage umaintain as much in possible." The guid is cognitively impair toilet training or is ure training than the rincontinent care procare plan team will a the program and macontinue, change or the quarterly MDS re 483.25(h) FREE OF HAZARDS/SUPERV	on 1/30/15, at 12:58 p.m. the finurses (ADON) reported the had care guides for each re guides identified the ning needs. The ADON further expected to follow the care so rely on the shift nurse to try tares." Idanagement/Bladder Function ted 1/13/15, reviewed on the procedure purpose was easied possibility of urinary rinary incontinence, restore of formal bladder function as elines indicated "If a resident ted and is unsuccessful at unable to participate in the esident should be placed on the gram." The interdisciplinary evaluate the effectiveness of the recommendations to discontinue the program with the eview."	F 32			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY MPLETED
" ## · 9		245332	B. WING			01	/30/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - E)	CELSIOR		STREET ADDRESS, CITY, STATE, 515 DIVISION STREET EXCELSIOR, MN 55331	ZIP CODE		30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	CTION SHOULD THE APPROPE	BF .	(X5) COMPLETION DATE
F 323	This REQUIREMENT by: Based on observatoreview the facility faccident hazard for reviewed for restrairecommended fall iresidents (R15, R6) miminize the risk of residents who resident was placed the mattress, between frame. On 1/27/15, at 11:55 assisted resident out wheelchair. NA-D are stated the pillow was as resident "slides of the slightly raised the expectation of the slightly raised th	ion, interview and document tiled to assess a potential 1 of 4 residents (R38) ints and failed to implement interventions for 2 of 4 reviewed for accidents and to injury or elopement for the 18 ed on the unit. on 1/27/15, at 11:00 a.m. meter defining mattress was it was up against the wall, and under the middle section of en the mattress and the bed. 5 a.m. NA-D and NA-F int of bed and into her ind NA-F was interviewed and so placed under the mattress but of bed." 7, 1/28/15, at 6:55 a.m. R38 d, with continued use of in bed, bed up against the wall on was placed under the elbed. The wedge cushion	F3	F 323 -The Facility will assorbed device as a potential utilize a perimeter despillow or wedge cush mattress of bed -Staff re-educated on I the ACU doors prior door, open slowly -ED or designee will aud-R38 wedge cushion and mattress discontinued. defining mattress assess for a restraint. for all resistant assessment or with perimeter defining or wedge cushion under the R6 and R15 fall care and updated with in prevent fallsOther residents with -DNS or designee to combart audits weekly to a restraint assessments completed and fall integrated in care plan. Resuwill be reviewed at QAPI	al restraint efining matter hion under looking throu to opening dit ACU door ad pillow un Perime ment comple idents. erform potent all reside mattress of be plans review terventions aplete 3 rando assure potent have be erventions a alts from aud	who ress, the ugh the rs der eter ted tial nts ow ed. red to	3/13/15

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				PRINTE FOR	D: 02/17/2015 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	O. 0938-0391 ATE SURVEY OMPLETED
NAME OF		245332	B. WING	à		0.	1/20/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX	CELSIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331		1/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETION DATE
	and NA-E further staby NA-D and NA-E I wheelchairleaning wedge cushion is plashe tried to get up, "and NA-E stated the out of bed independ in the past. Fall log i months was reviewed falling out of bed wa. R38's annual Minimut 11/7/14, revealed dia and arthritis. She re of one staff for transunable to ambulate. impaired cognitive sk sometimes understa. R38's care plan with present indicated R3 history of falls and ps The interventions indicated and bolster under 12/20/14). Further review of the assessment of the period (contour mattress) or pillow as a potential at The DON was interview. The DON was interview of the death of the past sindicated R38 utilized mattress and wedge of the bed due to histoself-transfers out of best self-transfers out of the self-transfers out of the self-transf	ated she was laid back down because she was "falling out"." Staff further stated the aced under her bed because will roll out of bed." NA-D resident was unable to get ently but had rolled out of bed incidents for the past six ed, and no incident of R38 is noted. Jum Data Set (MDS) dated agnoses including dementia, quired extensive assistance efers, bed mobility and The resident had severely kills, unclear speech, could ind others or be understood. Jum Data Set (MDS) dated agnoses including dementia, quired extensive assistance efers, bed mobility and the resident had severely kills, unclear speech, could ind others or be understood. Jum Data Set (MDS) dated agnoses including dementia, quired extensive assistance efers, bed mobility and the resident had severely kills, unclear speech, could indoor the resident had any falls and the past of the	F	323			

STATEMEN AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DAT	E SURVEY IPLETED
		245332	B. WING			04/	20/2045
	PROVIDER OR SUPPLIER N LIVINGCENTER - E)	KCELSIOR		STREET ADDRESS, CITY, STATE, Z 515 DIVISION STREET EXCELSIOR, MN 55331	IP CODE	1 01/	30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
	safe and the wedge resident safe and n DON further confirm the mattress preven The DON acknowled defining mattress, a had not been assess hazard for R38. R15 was reportedly her bed on 1/24/15, the assistant directed 1/26/15, at 6:05 p.m had been attempting injured from the fall. On 1/28/15, at 7:26 sitting at a table in the was wearing stocking a.m. R15 was lying observation, a nursing she had just assisted and to lie down. Nat sometimes got out of times she asked for the following morning was propelling herse her feet and pulling moved toward the disocks and shoes. On 1/28/15, at 9:37 nurse (LPN)-A state self-transferring if we transfer herself[R1 to the bed pretty good bed to the chair] the self-transferring if we transfer herself[R1 to the bed pretty good bed to the chair]	e cushion was used keep tot allow her to roll of bed. The med the wedge cushion under need R38 from self-transfers. Edged the use of the perimeter and pillow or wedge cushion used as a potential accident of found sitting on the floor by at 10:50 a.m. according to or of nursing (ADON) on an The ADON explained R15 g to self-transfer, and was not a.m. R15 was observed the dining room. The residentings with no shoes. At 8:40 in bed. At the time of the lang assistant (NA)-B explained at the resident to use the toilet also reported R15 of bed on her own, and other	F3	123			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY IPLETED
		245332	B. WING		·	01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - E)	(CELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET EXCELSIOR, MN 55331	1 01/	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	night when I worker room thinking it was R15 usually tried to she was looking for bathroom. LPN-A served at 10:00 a.m. On 1/29/15, at 9:33 at the facility for ser NA-G explained that socks and shoes. An only wear socks and the socks were nort utilize gripper socks were nort utilize gripper socks. NA-E all gripper socks. NA-E all gripper socks. On 1/29/15, at 2:24 worked the night sh self-transferred. LF her shoes and sock shoes back on. The intermittent confusion in the socks LPN-ishould have gripper fall."	d she was sitting in the dining is breakfast." LPN-A stated get herself out of bed when ice cream or had to use the said ice cream snacks were in and 3:00 p.m. a.m. NA-G who had worked weral years was interviewed. It sometimes R15 wore both At other times she preferred to don't shoes. NA-G confirmed mal socks and the resident did ocks. Who worked at the facility for stated sometimes R15 wore and other times just wore her iso stated he had never put in a stated he had never put in a stated he had never put in a stated R15 removed is and would also put her ite resident was experiencing on, and was getting days and with the residents in socks at night so they don't	F	323			
	falls, and needed or transfers. R15, how transferred herself.	explained R15 was at risk for ne staff to assist her with ever, sometimes "forgot" and LPN-D verified R15 usually ersonal socks when she was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		245332	B. WING			01.	/30/2015
	PROVIDER OR SUPPLIER			515	REET ADDRESS, CITY, STATE, ZIP CODE 5 DIVISION STREET CELSIOR, MN 55331	1 01/	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	R15 indicated the r 11/24/14, at 9:15 a indicated R15 "slid bunched at edge, oresident was confuget up for lunch." Oidentified as "Stock Specific Recomme "Gripper socks at a response on the reideagripper socks not indicated the regetting up to eat, at up and she was "stapplied." A Minnesota Incide R15 indicated the r 10:50 a.m. R15 was between the bed at NA, the w/c brakes thought R15 "may be slipped and fell on factor was identified on." Specific Recor "Put brakes on, end light with transfer." "Resident stated the bed." A corresponding read "[R15] likes to Assist of 1 with transfer daily living]. A subsequent programicated the reside ADLs and transfer resides and tran	ent Report dated 11/24/14, for resident experienced a fall on .m. A description of the fall from bed to floorcovers were only socks on." It was noted the sed and stated she "wanted to Contributing factors were sing feet, bunched bedding." Indation/Intervention were for all times." R15's family port was noted as, "Good s." A corresponding progress resident reported she was and the bedding was bunched ocking footedgripper socks on the floor of curtain. According to the were not on, and it was nave tried to self-transfer and her buttocks." A contributing das "Brakes on w/c were not mmendation/Intervention were, courage resident to use call The summary indicated at she was trying to get out of ding progress note on 1/14/15, transfer self from w/c to bed. Insfers and ADLs [activities of the ses note dated 1/29/15, ent required assistance with all ing. She was able to make as the but also had some	F3	323			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		E SURVEY MPLETED
		245332	B. WING			01/	30/2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		515 D	ET ADDRESS, CITY, STATE, ZIP CODE IVISION STREET ELSIOR, MN 55331	1 01/	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BF	(X5) COMPLETION DATE
	confusion. R15's falls care planteded staff assistatinterventions, hower socks at all times as 11/24/14 fall. In add the care plan to ensapplied and to encounter he has been applied and to encounter he has been as recommend. On 1/28/15, at 10:09 nursing (ADON) expethe day after a residing on fall interventions, The ADON also said listed on the back of RN-A then verified to the back of R15's cate 12/23/14) was dated. Contributing Factors not identified and the followed through. Refor 2 staff assist within R6's progress not plan was observed to prevent slipping. On 1/26/15, at 5:47 when asked if R6 has the ADON answered.	n dated 1/24/15, indicated R15 ance with transfers. The ver, did not include gripper is recommended after the ition, staff were not directed in ure R15's w/c brakes were urage the resident to call for led after the 1/24/15 fall. 9 a.m. the assistant director of blained that all managers met ent fell to brainstorm, decide and update the care plan. In interventions were also seach resident's care plan. The latest fall intervention on the latest fall intervention on the latest fall intervention decide and (page 2, print date)	F3	23			
	her walker, and lost R6's annual MDS da was cognitively mod- behaviors. The annu	her balance. ited 11/21/14, indicated R6 erately impaired with no al MDS also indicated R6 aff assist with all ADLs. The					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X	(3) DATE SU COMPLE	
		245332	B. WING			04 /20 <i>/</i>	2015
	PROVIDER OR SUPPLIER I LIVINGCENTER - EX	CELSIOR		STREET ADDRESS, CITY, STATE, ZIP 515 DIVISION STREET EXCELSIOR, MN 55331	CODE	01/30/2	2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIA	E CO	(X5) MPLETION DATE
F 323	only able to stabilized during transitions are to let and surface to and chair or w/c. On 1/28/15, at 7:56 in her room next to to apply transfer belethen held onto R6's back of R6's pants with R6 to stand up and R6's stocking feet with under her during the legs and swung their throughout the transistockings were observed bottom of her socks. On 1/28/15, at 8:25 with one staff assist. R6 could stand, but 10:36 a.m. NA-G also wear slippers or sho NA-G further stated,	indicated R6 was not steady, with staff assist for balance and walking, moving on and off surface transfer between bed a.m. R6 was sitting in her w/c her bed. NA-B was observed to around R6's waist. NA-B left arm and pulled up on with her right hand and lifted turn and sit on side of bed. Here observed to slip out from the transfer . NA-B lifted R6's me into bed. NA-B hurried fer. R6's white personal erved to be blackened on the	F3	23			
	NA-B lifted up R6's laround R6 to sit up of applied transfer belt helped R6 to stand. wearing gripper sock white personal socks very shaky, and NA-NA-B held under R6'	ea.m. R6 was lying in bed. egs from the bed and swung on the side of the bed. NA-B to R6 and NA-B and NA-A R6 at the time was not as, was wearing her own as. R6 leaned on the walker, B stated, "Get your balance." s arm and NA-A held onto R6 walked with walker, very					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/17/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 245332 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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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

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

further instruction from DON."

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245332	B. WING	ì		04	/20/204E
	PROVIDER OR SUPPLIER	CELSIOR		STREET ADDRESS, CITY, STATE, ZI 515 DIVISION STREET EXCELSIOR, MN 55331	P CODE	1 01/	30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BF	(X5) COMPLETION DATE
	[physical therapy/od dated 1/15/15. R6's physical functioning impairment, Mobility limitations'Transfer assistance of 1." The Minnesota Incid 1/14/15, at 6:15 p.m contributing factors Recommendations/ Prevent Reoccurrer evaluation by therap really use a walker'. The rehabilitation di 2:44 p.m. R6 had re 1/16/15. Rehab director further to attempt a second with R6 but had not the refusal had not the refusal had not the refusal had not the refusal for a Observations reveal implement safety me for injury and potent residing on the secut the facility's memory indicating directing proceeding procedured to the two docvisibility into the hall slowly opened the	ccupational therapy evaluation] care plan indicated 'I have a deficit related to: Self care v impairment, ROM er, Toileting, Locomotion dent Report for R6's fall on a did not identify any for R6's fall. The Specify Interventions Taken to be indicated 'Further by to investigate if resident can be rector stated on 1/29/15, at fused a PT evaluation on ctor stated the resident had come back next week." The er stated therapy was planning time for a therapy evaluation yet done it. The director said been documented no provided. The rehab director DON and RN-A were aware	F3	323			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION			E SURVEY IPLETED
		245332	B. WING			04/	20/2045
	PROVIDER OR SUPPLIER N LIVINGCENTER - EX			STREET ADDRESS, CITY, STATE, ZIP (515 DIVISION STREET EXCELSIOR, MN 55331	CODE	UI/.	30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD F	BF	(X5) COMPLETION DATE
	Residents were known sometimes seeking could have been hit opening door. Elever ambulatory, and sew wheelchairs. On 1/28/15, at 7:20 informing another statementia unit, and statementia (ADON) rattlooking pushed the cobservations of statementia unit, and were 7:22 The administratifiest looking 7:25 A laundry staff without looking and with her back side as in after herself. 7:30 A dietary staff purposefully looked "Good" as she slowly 7:31 The Minimum Entered as she looked crack between the dotresidents, but then intered the adjacent working. 7:35 MDS nurse agalooking and just push 7:40 An unknown nu could not be determine sidents before entered the adjacent working.	exit. In addition, a resident or pushed over by the en residents on the unit were wen were mobile in a.m. as one surveyor was urveyor of the code for the extressing the importance of ring the unit (because he other side of the door and door), the assistant director of her abruptly and without door to the unit open. If entering the unit were then as follows: tor entered the unit without person entered the unit without person (dietary)-A very through the crack and stated, y entered. Data Set (MDS) nurse and straight ahead toward the coors nursing distinctly checked for estead of entering the unit aroom where surveyors were usin entered, but without ining the door open rsing assistant entered, but it ned whether he checked for	F3	23			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245332	B. WING _		04	/20/2045
	PROVIDER OR SUPPLIER V LIVINGCENTER - EX	(CELSIOR		STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVISION STREET EXCELSIOR, MN 55331	1 01/	/30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BF	(X5) COMPLETION DATE
	7:50 MDS nurse en residents 7:53 A second unkr unclear if he checke 7:59 A housekeepe without looking whil 8:02 An unknown si looking at green but 8:03 Dietary-A agair door before entering commented on how to opening the door to be. You could tak 8:08 The same NAN entered and carefull On 1/30/15 at 9:43 at (DON) was interview related to the entrand DON said they had at to residents on the dobefore entering, but sign was still on the expectation was for of the door, open slocart through. He ack been safe to just entresident on the other was then viewed on maintenance then streplacing it with a do	coking and was pulling a cart tered without first checking for mown NA entered, but was ad for residents or (hskp)-A entered backward a pulling a housekeeping cart taff person entered while atton versus through doorway or looked carefully through and looked at 7:40 again by looked at 7:40 again by looked at 7:40 again by looked and the director of nursing looked and the director of nursing looked and the director of look was not sure whether the look and the look through the crack by looked at look through the crack by looked and the look through or pull a looked lo	F 32			
SS=E	The facility must em	PIGG RECORDS, JGS & BIOLOGICALS ploy or obtain the services of st who establishes a system	F 43 ⁻			

AND PLAN	I OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY
i: #19		245332	B. WING	i		. (
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	01 P CODE	1/30/2015
GOLDE	N LIVINGCENTER - EX	CELSIOR		515 DIVISION STREET EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological labeled in accordance professional principle appropriate accessionstructions, and the applicable. In accordance with a facility must store all locked compartment controls, and permit have access to the key access t	t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be be with currently accepted es, and include the bry and cautionary expiration date when a state and Federal laws, the drugs and biologicals in its under proper temperature only authorized personnel to	F4	F 431 -Facility has removed any outdated medications in areas, including multi-dos-Other storage areas were medications are dated appropriatelyDNS or designee to audit storage areas 2 times we for expired or imprope medications. Audit re reviewed at QAPI montly-Education provided to proper labeling of opene and disposal of expired medications.	an all storage e vials. reviewed and and stored dit medication ekly to check er labeling of esults will be . D. Nurses on ed medications	3/13/15
	permanently affixed controlled drugs listed Comprehensive Dru Control Act of 1976 a abuse, except when package drug distrib quantity stored is mit be readily detected. This REQUIREMENT by: Based on observation review, the facility fail vials were dated when of the vaccine contermines.	compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced on, interview and document led to ensure multi-dose on opened to ensure efficacy of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility of the facility of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility of the facility uses single unit ution systems in which the nimal and a missing dose can opened to ensure efficacy of the facility of the facili		*		

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF	DDO) VID TO	245332	B. WING	i		01	/30/2015
GOLDEI	PROVIDER OR SUPPLIER V LIVINGCENTER - EX			STREET ADDRESS, CITY, STATE, 515 DIVISION STREET EXCELSIOR, MN 55331	ZIP CODE	1 01	/50/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(TION SHOULD THE APPROPE	RF	(X5) COMPLETION DATE
	been vaccinated. Findings include: On 1/29/15, at 9:17 facility's medication licensed practical nutre and south refragulti-dose vial whose FLULAVAL 2014, 20 milliliters (ml)/ 10 do the cap off), but it laward handwritten open dainclude an expiration was not a concern. If vaccine. On 1/29/15 during an interview rand he could not find LPN-B indicated he of an open date was the director of nursing on 1/29/15, at 9:48 a know the facility policy vials off the top of his indicated he had call representative and washould have been dispierced. At 10:50 a.m facility's policy for FL open multi-dose vial days. The DON verification in the countre of the	a.m. observations of the storage was conducted with a urse (LPN)-B. cation room housed both the igerated medications. One se label indicated it contained 15 Formula flu vaccine, 5 ses was found open (i.e. with cked the expected ite. The printed label did in date, "2015 June," which no box was found for the indicated at a great a.m. LPN-B verified in open date was present, if the box for the vaccine. It is a problem. Ing (DON) was interviewed in the stated he did not cy for open dates on vaccine is head. At 9:54 a.m. he is the facility's pharmacy was told the vaccine vial scarded 28 days after being in the DON presented the ULAVAL, which indicated an should be discarded after 28 ited in an interview at 10:52	F 4	DEFICIEN	CY)		
	used." The DON retu the vial had been dis	count that as opened and urned at 10:58 a.m. to say carded.					

STATEMENT AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DAT	E SURVEY IPLETED
		245332	B. WING	i		01/	20/2015
GOLDEN	PROVIDER OR SUPPLIER N LIVINGCENTER - EX			STREET ADDRESS, CITY, STATE, Z 515 DIVISION STREET EXCELSIOR, MN 55331	IP CODE	1 01/	30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 431	reviewed and read,	tion for FLULAVAL was "How Supplied/Storage and tered, a multi-dose vial should	F4	31			

CENTERS FOR MEDICARE & MEDICAID SERVICES F 5332025

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245332 01/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 DIVISION STREET GOLDEN LIVINGCENTER - EXCELSIOR** EXCELSIOR, MN 55331 FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID * (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** 1000 x 6.15 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. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Excelsion 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. MAR - 6 2015 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:

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

Gexputive Director

2.4.16

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.

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED				
#19		245332	B. WING	_		01/2	28/2015			
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 15 DIVISION STREET		9			
GOLDEN	LIVINGCENTER - EX	CELSIOR		E	XCELSIOR, MN 55331					
(X4) ID PREFIX DAT	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÛ PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE			
K 000	Continued From pa Marian.Whitney@s	tate.mn.us	K	000			(8			
	DEFICIENCY MUS FOLLOWING INFO									
	A description of v to correct the defici	what has been, or will be, done ancy.								
	2. The actual, or pro	oposed, completion date.					El			
	3. The name and/or responsible for correprevent a reoccurre	r title of the person ection and monitoring to nos of the deficiency.			•		_			
ž	Type II(222) construction and is further facility has a fir detection in the concorridor that is mondepartment notifical	g was determined to be of action. It has a partial ly fire sprinklered throughout, e alarm system with smoke ridors and spaces open to the itored for automatic fire tion. The facility has a and had a census of 48 beds arvey.			.)					
K 072 SS=F	NOT MET as evide NFPA 101 LIFE SA Means of egress ar of all obstructions of use in the case of f furnishings, decora	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD e continuously maintained free ir impediments to full instant lire or other emergency. No tions, or other objects obstruct ress from, or visibility of exits.		072	K 072 Facility is going to remove all wheeled storage from the corridors by March 11th, 2015.					

FORM APPROVED

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245332	B WING	8 WING			28/2015
7.11.11.12	PROVIDER OR SUPPLIER	CELSIOR		5	TREET ADDRESS, CITY, STATE, ZIP CODE 116 DIVISION STREET EXCELSIOR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 072	Continued From particles STANDARD is Based on observat has egress corridor LSC 7.1.10. These with the convenient patients in an emerging Findings include: On facility tour betwon 01/28/2015, observated storage in a corridors. The facility waiver for wheeled storage in this deficient practice.	ge 2 s not met as evidenced by: ion and interview, the facility obstructions which violates obstructions could interfere and effective removal of gency situation. een 9:30 AM and 11:00 AM ervation revealed that there is several of the resident y does not have a categorical		072	DEFICIENCY)		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Golden LivingCenter - Excelsior February 17, 2015 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 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

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

winnesot	a Department of Healtr	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00988	B. WING		01/30/2015
					1 01/00/2010
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ALE, ZIP CODE	
GOLDEN I	LIVINGCENTER - EXCEL	SIOR	SION STREET		
		EXCELSI	OR, MN 55331	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
2.000	Initial Courses at		2,000		
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	ALIEN				
	NH LICENSING CO	ORRECTION ORDER			
		 -			
	In accordance with M	innesota Statute, section			
		on order has been issued			
		If, upon reinspection, it is			
		ncy or deficiencies cited			
		ed, a fine for each violation			
		assessed in accordance			
		es promulgated by rule of			
	the Minnesota Depart	tment of Health.			
	Determination of whe	ther a violation has been			
	corrected requires co				
		ule provided at the tag			
	•	number indicated below.			
	When a rule contains	several items, failure to			
		e items will be considered			
		ack of compliance upon			
	re-inspection with any	/ item of multi-part rule will			
	result in the assessme	ent of a fine even if the item			
		ng the initial inspection was			
	corrected.				
	V				
	•	earing on any assessments			
		non-compliance with these			
		a written request is made to n 15 days of receipt of a			
	notice of assessment	•			
	HOUSE OF GOOGSTHEIR	Tot Hon-compilation.			
	INITIAL COMMENTS	:			
		nt of Health is documenting		Minnesota Department of Health is	
		correction Orders using		documenting the State Licensing	
	federal software. Tag	•		Correction Orders using federal softw	are.
	_	a state statutes/rules for		Tag numbers have been assigned to	
	Nursing Homes.			Minnesota state statutes/rules for Nurs	sing
				Homes.	
	The assigned tag nun	nber appears in the far left			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015	
	ROVIDER OR SUPPLIER	SIOR 515 DIVISIO	RESS, CITY, STA ON STREET R, MN 55331	ITE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 000	column entitled "ID F statute/rule out of con "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested Mc Time period for Corre PLEASE DISREGAR FOURTH COLUMN W "PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR	Prefix Tag." The state Inpliance is listed in the Inpliance is listed in th	2 000	The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION IN VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	" //rule iich er the ors G OF	
2 505		Subp. 1 A-E Use of s. For purposes of this part, ave the meanings given.	2 505			
	method or physical or material, or equipmer	nt attached or adjacent to at the individual cannot				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 2 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	DF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		EIED
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR 515 DIVISI	ON STREET			
	EIVIII OCEIVIER - EXOLE	EXCELSIO	DR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETE DATE
2 505	Physical restraints incleg restraints, arm resor vests, and wheelch restraints also include definition of a restraint so tightly that a reside move; bed rails; chair placing a resident in a wall that the wall prevising. Bed rails are crestrict freedom of moused solely to assist thelp the resident get is not used as a restraint on clothing that trigge staff that a resident is not, in and of themsel movement and should restraints. B. "Chemical resipsychopharmacologic discipline or convenient reat medical symptom C. "Discipline" mouring home for the penalizing a resident. D. "Convenience solely to control resident with a lesser in the resident's best	access to one's body. clude, but are not limited to, straints, hand mitts, soft ties nair safety bars. Physical expractices which meet the ent, such as tucking in a sheet ent confined to bed cannot as that prevent rising; or a wheelchair so close to a rents the resident from considered a restraint if they ever ent. If the bed rail is the resident in turning or to bout of bed, then the bed rail laint. Wrist bands or devices are electronic alarms to warn leaving a room or area do lives, restrict freedom of d not be considered traints" means any coding that is used for ence and is not required to ms. eans any action taken by the purpose of punishing or "means any action taken ent behavior or maintain a amount of effort that is not	2 505			
	unexpected situation serious and urgent na This MN Requiremen by:	cessary to alleviate an or sudden occurrence of a ature. t is not met as evidenced an interview and document				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 3 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00988	B. WING		01	/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	SION STREET			
	Т	EXCELS	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 505	Continued From page	e 3	2 505			
	device as potentially (R38) who utilized a p	led to assess the use of a restraining for 1 of 1 resident perimeter defining mattress e cushion under the mattress				
	Findings include:					
	while in bed. A perim on the bed and the be A pillow was placed bed frame in the midd On 1/27/15, at 11:55	n 1/27/15, at 11:00 a.m. neter defining mattress was ed was up against the wall. beneath the mattress and dle section of the bed. a.m. nursing assistants sisted R38 out of bed and				
	into her wheelchair. No interviewed and expla					
	was again observed i defining mattress was was against the wall. placed between the n	1/28/15, at 6:55 a.m. R38 n bed. The perimeter s on the bed and the bed A wedge cushion was nattress and bed frame in the bed. The wedge cushion t side of the bed.				
	reason the resident was because she had been get out of bed, so the before 7:00 a.m. NA-explained they had as because she was "fall was "leaning." The Noushion was used be	ed. The NAs reported the vas partially dressed was en awake and was trying to enight shift staff got her up				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 4 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.11.27 27.11	or connection	IDEITH IO/HIOH HOMBER.	A. BUILDING: _	A. BUILDING:		
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET R, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 505	Continued From page	e 4	2 505			
	unable to rise independently, she had rolled out of bed in the past according to NA-D and NA-E. 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.					
	11/7/14, revealed diag and arthritis. Extensiv of one staff for transferesident was unable to severely impaired cog speech, and could so					
	5/22/14, 8/21/14, and potential restraint use 11/6/12 to present) no due to a history of fall medication use. The to utilize a contour ma	interventions directed staff attress on the bed, and on was made to the care plan a bolster cushion				
	had been completed					
	1/30/15, at 9:35 a.m. had any falls from the R38 utilized the perim	g (DON) was interviewed on He verified R38 had not be bed in the past six months. neter defining mattress and the mattress of the bed due				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 5 of 62

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015	
NAME OF D			DDEGG OITY OTA	TE 7/D 00DE	1 01/00/2010	
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA SION STREET	ITE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 505	Continued From page	9 5	2 505			
	of bed. The DON also independently get out the wedge cushion was resident safe" and no The DON further contunder the mattress properties of the provide assessment had not be suggested by the same of the provide education to a constitutes a restraint could randomly audit devices that potential been assessed to ensure the provide restrictive restraint us	knowledged a restraint been completed. OD OF CORRECTION: The DON) or designee, could hursing staff about what the DON or designee, resident records to ensure lay restrain a resident have sure safe and least				
2 555	MN Rule 4658.0405 S Plan of Care; Develop	Subp. 1 Comprehensive oment	2 555			
	must develop a compleach resident within some completion of the condessessment as define comprehensive plant by an interdisciplinary attending physician, a responsibility for the rappropriate staff in distinct the resident's needs,	reprehensive resident and in part 4658.0400. The of care must be developed of team that includes the a registered nurse with resident, and other asciplines as determined by and, to the extent coarticipation of the resident,				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 6 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00988	B. WING		01	/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	SION STREET OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 555	Continued From page	e 6	2 555			
	representative.					
	by: Based on observation review the facility fail plan the use of perimo of 4 residents (R5, R6 restraints.	t is not met as evidenced n, interview and document ed to identify on the care eter defining mattress for 3 16, R28) reviewed for				
	Findings include:					
	The care plan did not mattress for R5, R16,	identify the use of perimeter and R28.				
	8:00 a.m. with nursing NA-E. R5 sat up in be herself twice to get own attress of the bed, so closet with her walker	rere observed on 1/28/15, at g assistants (NA)-D and ed independently, scooted wer the edge of the perimeter stand up and walk to her independently. NA-D stated etting in and out of bed				
	11/28/14, revealed did depression and psych limited assistance of o transfers and supervision	notic disorder. She required one staff for bed mobility, sion for walking. The impaired cognitive skills,				
	present, indicated at i	fective date 3/3/14, to risk for falls due to history of terventions did not include attress.				
		served on 1/28/15, at 10:26				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 7 of 62

A. BUILDING:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
00988 B. WING 01/30/201	88600	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 DIVIDION STREET	OF PROVIDER OR SUPPLIER	
GOLDEN LIVINGCENTER - EXCELSIOR 515 DIVISION STREET EXCELSIOR, MN 55331	DEN LIVINGCENTER - EXCEL	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	
2 555 Continued From page 7 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	hand held assistance. capable of getting in a independently. A peri observed on the bed. R16's quarterly MDS of diagnoses including A depression, anxiety are required extensive assimbility, limited assist walking. The resident cognitive skills, unclear understand others and understand others and understood. R16's care plan with expresent, indicated at rivandering and use of interventions did not in mattress. R28's cares were obsequently assisted by sitting up in bed, stood independently. NA-D getting in and out of bed in a disease. She required one staff for bed mobilitransfers and walking, impaired cognitive skill understand others. R28's care plan effect indicated at risk for fall wandering, use of medicated at risk for fall wandering use of	

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 8 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00988	B. WING		01	/30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEI	_SIOR	SION STREET IOR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 555	Continued From page	e 8	2 555			
	1/30/15, at 9:46 a.m. perimeter mattresses residents who had exbed. The DON further R28 were all able to their beds. The DON perimeter mattresses as fall interventions or plans. The Falls Managemet 1/22/15, indicated "Fappropriate intervent plan is updated." SUGGESTED METHEM Director of Nursidevelop, review, and procedures to ensure appropriate to ensure appropriate to ensure appropriate staff on the and could develop mongoing compliance.	s were implemented for operienced a fall from the er stated that R5, R16, and transfer independently from added that the use of a should have been identified on R5, R16, and R28's care ent Guidelines policy dated following a resident fall items are implemented, care and of care Plans are developed a care of residents. The redesignee could educate all the policies and procedures, onitoring systems to ensure				
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care personnel involved in the				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 9 of 62

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$15 DIVISION STREET EXCELSIOR MN \$5331 [MA1] D [MA2] D [MA1] D [MA2] D [MA1] D	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 515 DIVISION STREET EXCELSIOR (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG THIS MIN 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 1 of 2 residents (R23) reviewed for uninary incontinence and to ensure repositioning was provided as directed by the care plan for 1 of 1 of 2 residents (R23) 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 pressure sucer development and the plan included to reposition resident was at risk for pressures ulcer selection was non-ambulatory. It was also noted the resident was at 7 risk for pressures one," was non-ambulatory, required the assistance for wheelchair mobility and total	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 515 DIVISION STREET EXCELSIOR (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG THIS MIN 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 1 of 2 residents (R23) reviewed for uninary incontinence and to ensure repositioning was provided as directed by the care plan for 1 of 1 of 2 residents (R23) 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 pressure sucer development and the plan included to reposition resident was at risk for pressures ulcer selection was non-ambulatory. It was also noted the resident was at 7 risk for pressures one," was non-ambulatory, required the assistance for wheelchair mobility and total							
CALID SUMMARY STATEMENT OF DEFICIENCES DISTRICT			00988	B. WING		01/3	0/2015
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CALLED CONTROL SUMMARY STATEMENT OF DEFICIENCES ID CALLED COMPLETE TAGE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 tolleting 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 gressure uclers. In addition, the care plan was not followed for 1 of 3 residents (R79) 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 at "risk for pressure sore," was non-ambulatory, tequired the assistance for wheelchair mobility and total	001.55	I BUBLOOFNITED EVEN	515 DIVIS	ION STREET			
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility falled to ensure tolleting 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 3 residents (R23) reviewed for pressure uclers. 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 tolleting 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, required the assistance for wheelchair mobility and total	GOLDEN	LIVINGCENTER - EXCEL	SIOR EXCELSION	OR, MN 55331			
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) 2 565 Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure tolleting was provided as directed by the care plan for 1 of 2 residents (R23) reviewed for unimary incontinence and to ensure repositioning was provided as directed by the care plan for 1 of 3 residents (R23) reviewed for for pressure uclers. In addition, the care plan was not followed for 1 of 3 residents (R23) 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, required the assistance for wheelchair mobility and total	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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 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 non-ambulatory, required the assistance for wheelchair mobility and total	PREFIX	,		PREFIX	CROSS-REFERENCED TO THE APPROP		
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 non-ambulatory. It was also noted the resident was at "risk for pressure suce," was non-ambulatory, required the assistance for wheelchair mobility and total	2 565	Continued From page	9	2 565			
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		TAGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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					

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 10 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET		
			OR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 565	Continued From page	2 10	2 565		
2 303	assisted resident with the dining room with runtil she was wheeled R23 was provided ext transfer to bed with N proceeded to assist reto side in bed, to provincontinent brief. NA-lincontinent brief show. During an interview of NA-D, who consistent unit, reported he and morning cares and us indicated R23 was as a.m. NA-D acknowled assistance with toiletin for greater than two h. During an interview of assistance haresident and the care resident's toileting and ADON further stated to follow the care guides shift nurse to try to ke.	eating. R23 remained in no assistance with toileting of to her room. At 9:27 a.m. tensive assistance to A-D and NA-E. Staff esident with rolling from side ride peri-care and change D and NA-E confirmed the red wetness. In 1/28/15, at 10:18 a.m. thy worked on the dementia NA-E were running late with sually done by 9:00 a.m. and sisted out of bed at 6:45 dged R23 was not provided and and repositioning needs ours. In 1/30/15, at 12:58 p.m. the urses (ADON) reported the red care guides for each guides identified the drepositioning needs. The the NAs were expected to s, and "We also rely on the	2 303		
	"Prevent skin problem and excoriation, Avoid infection, Manage urin maintain as much nor possible." The Prevention of Pre	ns such as pressure areas dipossibility of urinary mary incontinence, restore of small bladder function as essure Ulcer policy (dated 1/26/15), indicated the			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 11 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		7. SSIESING.				
		00988	B. WING		01/	30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET			
			OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 11	2 565			
	The procedure details	lopment of pressure ulcers." s directed staff to "Establish ning schedule in bed and dent needs."				
	maintain my dignity. In needed. Provide non-interventions of redire environment. Help me as needed. Please all capable of doing at meven if it doesn't mak remember that I am a accordingly. Please to do before you begin. reason before perform calm, positive, reassuidentify self with each explain all procedures unhurried environment communication. Answand repeat as necessineeds. Encourage patisten carefully, valid expressions. Maintain Monitor for ability to me report significant finding	ecting, calm behavior and e with reminders and cues low me to do what I am ny own pace in my own way e sense to you. Please an adult and treat me ell me what you are going to Explain all procedures and ming. Approach patient in a uring manner. Staff to a contact if needed and as before starting. Allow calm,				
	When asked if staff tr dignity the resident at talk to you. After staf they put me in the livi and then I sit there ur room for a meal. I net bathroom because th	on 1/27/15, at 8:53 a.m. eated her with respect and nswered, "No. Staff don't if get me up in the morning ng room to watch television ntil they take me to the dining wer get to go to the ey just lay me in bed and pad while I am waiting to be				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 12 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	A. B.		A. BOILDING.			
		00988	B. WING		01/3	80/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR 515 DIVIS	ION STREET			
		EXCELSION	OR, MN 55331			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	Continued From page	e 12	2 565			
	go number two in my inferior to the other re waiting for her brief to could not use the bat R19 also stated, "I wi	sit in the wet pad, and then I pad. It makes me feel esidents here" (regarding to be changed and that she hroom like her roommate. It is staff would not be so they wash me up in the				
	sitting in her wheelch watching television. assistant (NA)-B appropriate of the watching television. assistant (NA)-B appropriate of the was in the day room as the hallway. As NA-B the hallway outside houmped the wall and "Ow." NA-B stated, "say that. It's hard to ke pain,. She just always even if you just look as transferred R19 from aid of a mechanical li R19 grimaced and he repeated, "owowolowered onto the bed stated, "My arm hurts again." NA-B told R19 your arm." As NA-B as and forth from side to check the brief, and the again, R19 grimaced Ouch! Ow! Ow!" NA-I	air (w/c) in the dayroom At 7:46 a.m. a nursing roached R19 and stated, " and before waiting for a nt, proceeded to push R19 in ning room. At 8:16 a.m. R19 drinking a cup of coffee. At bached R19 from behind and ng to the resident, pulled her ble and pushed her down turned R19's w/c around in er room, the resident's foot the resident responded, If you just look at her she will know because she is in real as says 'ow' no matter what, at her." NA-B and NA-A the w/c to the bed with the ft. Throughout the process er face was tensed. She w" repeatedly and she was and held her arm as she as. You've broken my arm 9, "We are not even touching and NA-A rolled R19 back o side to lower her pants and hen to pull the pants up and cried out loudly, "Ouch! B delivered care in a hurried action or telling R19 how she				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 13 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE :		
		A. BUILDING: _				
		00988	B. WING		01/3	30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		515 DIVIS	ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	SIOR EXCELSION	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 13	2 565			
	was planning to assis	st the resident next.				
	On 1/29/15, at 9:26 a dayroom at a table w person. A jigsaw puz R19 stated, "The orat then again stated, "It person did not addres repeated a little loude member continued to one of the other resid a.m. without looking a stating, "We are water she continued to world on 1/29/15, at 10:01 assisted R19 onto the when the resident cric R19's roommate ther [expletive] wrong with turned from side to si	a.m. R19 was again in the lith two peers and one staff stale was on the table and linge piece goes there," and goes there." The staff lies the resident, who then er, "It goes there." The staff lignore R19 while talking to lents at the table. At 9:29 at R19 the staff answered by thing. We will get there," as ke with the other resident.				
		While lying on her back R19				
	•	ut, "Help!" NA-E responded,				
	"One more time." As NA-G washed and dried the resident she grimaced and continued to call out.					
		loudly enough for the				
		ın't believe this. I can't have				
		en sleep." As R19's clothing				
		ed out loudly asking, "Will				
	you stop? Will you sto	op?" NA-E and NA-G ost done." When cares were				
	· ·	d to have her television				
		mmate then stated, "Of				
		television on, and someone				
		get up and turn it off." R19				
		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					

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 14 of 62

Minnesota Department of Health

STATEMENT	a Department of Healtr FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			, 551EBII10			
		00988	B. WING		01/3	30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET DR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	in here." NA-G did no statement as she gav and remote control. R off the overhead light turned on, loud scratch there were gray jagge screen. R19's roomm to that" and got up and the room without turniverquested. Following the care ob R19 "they don't lister puzzle table this morn the nurse will say to not pain, 'I just gave you salso stated, "Now with urinated in my pants a here wet until they ge said she would like to morning, but "today I had a white substance and reported the NA of her teeth that morning roommate's comment typical. She added, "I off and they didn't." Sher eyes where she for R19 added, "I want to At 11:16 a.m. R19 reron with gray jagged liii	hurts with that pillow ad. I don't even want to be t respond to R19's e the resident her call light t19 requested the staff turn When R19's television was thy noises were heard, and	2 565	DEFICIENCY)		
	2:41 p.m. R19 had be room. R19's quarterly Minim	een moved to a different num Data Set (MDS) dated had moderately impaired				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 15 of 62

TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 565 Continued From page 15 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),		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
GOLDEN LIVINGCENTER - EXCELSIOR SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			00988	B. WING		01/30/2015	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 15 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),	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 565 Continued From page 15 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),	GOLDEN	LIVINGCENTER - EXCEL	SIOR				
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),	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
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."	2 565	cognition, presented in psychosis, and did not extensive staff assistativing. Diagnoses indi hemiplegia (paralysis depressive disorders, generalized pain. On 1/28/15, at 10:38 never used the toilet, mechanical lift and the R19 was completely isometimes reported to movement. NA-G furt scream out. She alway look at her she will satisfied to a complete the staff should not be will offer her another in R19's 1/15 care plan.	no behavioral problems or of reject cares. R19 required ance for activities of daily cated on the MDS included on one side of the body), spasm muscle and a.m. NA-G reported R19 and instead used the e bed pan. NA-G also stated ncontinent, although he need for a bowel her stated, "She is known to ays says 'ow,' even if you by ow." a.m. the DON stated he had the left the room when R19 lostly had pain with cares, dowith tramadol (pain Contin (narcotic pain) a.m. NA-G stated, "She is she she always says 'ow,' reshe will say ow." a.m. the explained that R19 they had not been visiting ware the TV was not she was unaware of the shade by the R19's, "This is concerning about comments towards [R19] and the allowing it to happen. We room."	2 565			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 16 of 62

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED	
			B. WING				
		00988	B. WING		01	/30/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE			
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET				
	OLIMANA DV. OT		OR, MN 55331	DDOV/DEDIO DI ANI OF	COORDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 565	Continued From page	e 16	2 565				
	Make sure I am not in Assess for pain every medication as ordered and frequency/pattern provide medications provide medications provide medications provide medications provide medications provide medications provides and eval provide non-pharmac redirecting, calm behavior for pain or sticomplaints of pain, spresponse to nursing in	cording to the resident. In pain or uncomfortable, It shift, Administer pain It d, Evaluate characteristics In of pain, Evaluate need to It orior to treatment or therapy, It the pain worse, Observe for In extremities such as pain, It wide medications as ordered It attachment or therapy, It is a such as pain, It is a such as pain					

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 17 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETE				
		00988	B. WING		01	/30/2015
	ROVIDER OR SUPPLIER	SIOR 515 DIVIS	DDRESS, CITY, STAT SION STREET IOR, MN 55331	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	psychosis, no rejectice extensive staff assist (ADLs). The quarterly indicated 'Yes' R19 re R19 had not received medication, and 'Yes non-medication intervolunterly MDS dated reported 'frequently higave a 'moderate' for and also indicated R or limit day activities. On 1/30/15, at 8:52 a expected staff to follow the composition of the	on of cares, and R19 needed for activities of daily living y MDS dated 1/3/15, further eceived pain regimen, 'No' d PRN (as needed) pain 'R19 had received vention for pain. The 1/3/15, also indicated R19 rurting' also indicated R19 rverbal descriptor of pain, 19's pain did not affect sleep	2 565			
2 570	Plan of Care; Revision. Subp. 4. Revision. care must be reviewed interdisciplinary team physician, a registere for the resident, and disciplines as determinand, to the extent president.	A comprehensive plan of ed and revised by an a that includes the attending ed nurse with responsibility other appropriate staff in ined by the resident's needs,	2 570			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 18 of 62

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	Y
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00988	B. WING		01/30/20 ²	15
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
001 DEN	INVINOSENTED EVOE	515 DIVIS	ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	EXCELSION	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COI	(X5) MPLETE DATE
2 570	Continued From page	e 18	2 570			
	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.					
	by: Based on observation review, the facility fail					
	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.					
	he reported, "They to [unknown] diet. I've be about a month." He adrinking whatever flui He explained his dialy replaced by an upper added that dressing of	een on a regular diet for				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 19 of 62

Minnesota Department of Health

Minnesot	a Department of Healtr	1				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			D WING			
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331			
			UK, WIN 55551	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
IAG	1,2002,110111 0111		IAG	DEFICIENCY)		
2 570	Continued From page 19		2 570			
	R34's care plan dated	d 11/3/14, included a plan for				
	-	to the need for extra protein				
		with poor intake, weight loss				
		on, and several opened skin				
		addendum read "1500 cc				
		uid Restriction [sic] 12/2014."				
		ed weight above 190 pounds				
		ory values. Interventions				
	included diet as orders with extra protein and supplementation at meals. Staff were also to					
		nsumption and monthly				
	_	dents' alteration in kidney				
	_	o dated 11/3/14) with a risk				
	for sodium and potass					
		alues within therapeutic				
		e directed to "check access				
	site daily fistula/graft/					
	,	uid restrictions as ordered				
	by Physician. Encour					
		ion program interventions"				
	· ·	e to complete laboratory				
	-	physician and when a				
		ns or symptoms was noted.				
	, ,	it daily" (shunt function) and				
		ort abnormal findings to the				
	· '	me was noted as "2 PM,"				
		nication form reviewing				
		nges in condition to be sent				
		provider and the facility.				
	bottioon the diaryolo p	ordination and the racinty.				
	A nursing assistant (N	IA)-H was interviewed on				
		and reported an awareness				
	-	a renal diet, and went to				
		Vednesday, and Friday.				
		been on a fluid restriction,				
		plained that information				
	regarding R34's care					
	assignment sheet.	The field of the fact				
	acoigninent oncet.					
	During an interview o	n 1/29/15, at 3:41 p.m. the				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 20 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
	00988	B. WING		01	01/30/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	·		
	515 DIVIS	SION STREET				
GOLDEN LIVINGCENTER - EXCELSION	OR	OR, MN 55331				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
called us today to say the fistula tomorrow, and sa transportation company changed departure time Additionally, the ADON of longer on fluid restriction a renal diet, "but he or Domino's [pizza]." During a telephone call to 1/30/15, at 11:55 a.m. a she was "[R34]'s nurse." communication between residential facility was more "Usually I call with concentration one does not, so we call concerns." The dialysis She also indicated R34, runs, and we educate his heart and he may have the hospital." On 1/30/15, 2:01 p.m. a (LPN)-F indicated R34's measured by the day should may be get a syst when he gets up. Becauthem when he gets backgrown as transportation of the computer of the control of the computer of the comput	sing (ADON) reported in the facility and the cally in the form of viritten information. "They hey would work on his id they had called his to tell them too" (due to a from the dialysis facility). reported R34 was no institute the standard of the standard of the dialysis facility on dialysis RN-A reported in the dialysis and the most often not written. The corner of the standard o	2 570				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 21 of 62

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
		00988	B. WING		01/	30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET OR, MN 55331			
040.45	CLIMMADY CT	ATEMENT OF DEFICIENCIES		DDOV/IDEDIS DI ANI O	AF CORRECTION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From page	e 21	2 570			
	really tired."					
	stated R34 had a flui supposed to give the added, "There is pop not sure where that fi	n 1/30/15, at 2:10 p.m. NA-A d restriction, and he was not resident extra fluid. He in the room sometimes. I'm ts within the fluid restriction. Id answer that better than				
	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.					
	indications, but the m 12/20/14, indicated th have been restricted also noted the reside afternoons, but the re indicated he had mor laboratory results, as	ained conflicting fluid intake nost recent change dated the resident's fluids should to 1500 ccs. The care plan that dialysis in the esident and staff both had ning dialysis. Weights and well as intake and output the deduction of the side of the staff both had ning dialysis.				
	through 1/30/15. Note (all calls from the dial were recorded on two months on 1/24/15, a 12/23/14. An eMAR- Note was dated 11/10 was to record the res shift related to edema	-Medication Administration 0/14, at 10:23 and noted staff idents daily weight every				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 22 of 62

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	
7.1.12 1 2.1.1	5. GOTHLEG TOTAL	.52.111.107.1101.1101.1521.11	A. BUILDING: _			
		00988	B. WING		01/	30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	515 DIVIS	ION STREET			
GOLDLIA	LIVINGOLIVILIK - LXCLI	EXCELSI	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From page	e 22	2 570			
	the NAs were able to not reflect infomation fistula for thrill or brui location of the dialysi R34 from the arm fist indicated in any of the attempts and/or care noted. R15's fall intervention 1/24/15, were not upon A Minnesota Incident R15 indicated the result 1/24/14, at 9:15 a.m. indicated R15 "slid frobunched at edge, only resident was confused get up for lunch." Con identified as "Stocking Specific Recommended "Gripper socks at all the response on the reposition of indicated the resident getting up to eat, and	weigh him. The notes did related to checking the t, nor was the change in a access site as reported by ula to a chest catheter e notes. In addition, of the access site was not as from 11/24/14, and dated on R15's careplan. Report dated 11/24/14, for ident experienced a fall on . A description of the fall om bed to floorcovers were y socks on." It was noted the d and stated she "wanted to intributing factors were g feet, bunched bedding." ation/Intervention were for				
	R15 indicated the res 10:50 a.m. R15 was to between the bed and NA, the w/c brakes w thought R15 "may ha slipped and fell on he	Report dated 1/24/15, for cident fell on 1/24/15, at found sitting on the floor curtain. According to the ere not on, and it was tried to self-transfer and or buttocks." A contributing				
	on." Specific Recomr "Put brakes on, enco	as "Brakes on w/c were not nendation/Intervention were, urage resident to use call ne summary indicated				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 23 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00988	B. WING		01/30/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - EXCEL	SIOR 515 DIVIS	DRESS, CITY, STA ION STREET DR, MN 55331	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 570	bed." A correspondir read "[R15] likes to tr Assist of 1 with transf daily living]. R15's falls careplan of needed staffs' assistatinterventions, however socks at all times as a 11/24/14 fall. In additing the care plan to ensural applied or to encoural help as recommende. On 1/28/15, at 10:09 nursing (ADON) explication of the day after a reside on fall interventions at The ADON also said listed on the back of RN-A then verified the intervention on the back of the intervention on the back of explained that socks and shoes and to only wear socks with confirmed the socks with gripper socks. NA-E who had worke years also stated on sometimes R15 wore times just wore her or the socks with the socks and shoes and the socks are socks.	she was trying to get out of a progress note on 1/14/15, ansfer self from w/c to bed. Fers and ADLs [activities of a lated 1/24/15, indicated R15 ance with transfers. The er, did not include gripper recommended after the on, staff were not directed in a re R15's w/c brakes were ge the resident to call for d after the 1/24/15 fall. a.m. the assistant director of ained that all managers met not fell, to brainstorm, decide not update the careplan. Interventions were also each resident's care plan. In er most recent fall ack of R15's care plan (page) had been on 6/24/14. a.m. NA-G who had worked aral years was interviewed. In sometimes R15 wore both at other times she preferred thout shoes. NA-G were normal socks and not at the facility for several 1/29/15, at 9:52 a.m. shoes and socks, and other with socks. NA-E also stated d R15 to wear gripper socks,	2 570			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 24 of 62

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		515 DIVIS	ION STREET		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
2 570	Continued From page	e 24	2 570		
		.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." At 2:29 p.m. LPN-D explained R15 was at risk for				
		e staff to assist her with			
		ver, sometimes "forgot" and			
	transferred herself. L	PN-D verified R15 usually			
	•	rsonal socks when she was			
	lying in bed.				
	SUGGESTED METH	OD OF CORRECTION: The			
		ON) or designee, could			
		ent policies and procedures			
	related to care plan re	evisions. The DON or			
	•	ide training for all nursing			
	staff related to the tim	•			
		assessment and assurance			
	committee could perfe	orm random audits to			
	ensure compliance.				
	TIME PERIOD FOR	CORRECTION: Twenty-one			
	(21) days.	· y			
2 830	MN Rule 4658.0520	Subp. 1 Adequate and	2 830		
	Proper Nursing Care;				
	0.1				
		eneral. A resident must			
	custodial care, and su	and treatment, personal and			
		preferences as identified in			
		esident assessment and			
			1		

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 25 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00988	B. WING		01	/30/2015
	ROVIDER OR SUPPLIER	SIOR 515 DIV	ADDRESS, CITY, STATE SION STREET SIOR, MN 55331	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	plan of care as desci 4658.0405. A nursing of bed as much as po written order from the	ribed in parts 4658.0400 and g home resident must be out ossible unless there is a attending physician that the in bed or the resident	2 830			
	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.					
	sitting at a table in the was wearing stocking a.m. R15 was lying in observation, a nursing she had just assisted and to lie down. NA-E	bed on her own, and other				
	was propelling hersel her feet and pulling o	g at 9:28 a.m. the resident f in her wheelchair by using n the hand rail as she ning room. She was wearing				
	nurse (LPN)-A stated self-transferring if we transfer herself[R15	.m. a licensed practical , "We monitor [R15's] see it. I have seen her 5] can transfer from the chair d, but can't transfer from the				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 26 of 62

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	, , , , , , , , , , , , , , , , , , , ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00988	B. WING		01	/30/2015
	ROVIDER OR SUPPLIER	SIOR 515 DIVIS	DRESS, CITY, STATON STREET OR, MN 55331	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	bed to the chairI thin has been getting mornight when I worked sroom thinking it was been getting from thinking it was been getting to get the was looking for it bathroom. LPN-A saserved at 10:00 a.m. On 1/29/15, at 9:33 a at the facility for seve NA-G explained that socks and shoes. At only wear socks and the socks were normanot utilize gripper sock and the socks were normanot utilize gripper socks. NA-E who several years also stashoes and socks, and own socks. NA-E also gripper socks on R15 socks. On 1/29/15, at 2:24 p worked the night shift self-transferred. LPN her shoes and socks shoes back on. The intermittent confusion nights mixed up. Who gripper socks LPN-C should have gripper sfall."	nk it is her coordination. She e confused lately. Monday she was sitting in the dining breakfast." LPN-A stated et herself out of bed when se cream or had to use the had ice cream snacks were and 3:00 p.m. Im. NA-G who had worked ral years was interviewed. Sometimes R15 wore both other times she preferred to not shoes. NA-G confirmed all socks and the resident did ks. In worked at the facility for atted sometimes R15 wore do ther times just wore her to stated he had never put as the resident had her own Im. LPN-C stated she and R15 sometimes C also stated R15 removed and would also put her resident was experiencing and was getting days and en asked whether R15 wore answered, "All the residents tocks at night so they don't	2 830			
	falls, and needed one transfers. R15, however transferred herself. L	xplained R15 was at risk for staff to assist her with ver, sometimes "forgot" and PN-D verified R15 usually sonal socks when she was				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 27 of 62

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01/30/2013
	LIVINGCENTER - EXCEL	515 DIVISIO	ON STREET	,	
COLDEN	ENTINGUERTER - EXCEE	EXCELSIO	R, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 27	2 830		
	lying in bed.				
	R15 indicated the res 11/24/14, at 9:15 a.m indicated R15 "slid fro bunched at edge, only resident was confuse get up for lunch." Coridentified as "Stocking Specific Recommend "Gripper socks at all tresponse on the repoideagripper socks." not indicated the resid getting up to eat, and	Report dated 11/24/14, for ident experienced a fall on . A description of the fall om bed to floorcovers were y socks on." It was noted the d and stated she "wanted to ntributing factors were g feet, bunched bedding." ation/Intervention were for imes." R15's family rt was noted as, "'Good A corresponding progress dent reported she was the bedding was bunched king footedgripper socks			
	R15 indicated the res 10:50 a.m. R15 was f between the bed and NA, the w/c brakes w thought R15 "may ha slipped and fell on he factor was identified a on." Specific Recomn "Put brakes on, encoulight with transfer." Th "Resident stated that bed." A corresponding read "[R15] likes to transfer the control of	ve tried to self-transfer and r buttocks." A contributing as "Brakes on w/c were not mendation/Intervention were, urage resident to use call me summary indicated she was trying to get out of g progress note on 1/14/15, ansfer self from w/c to bed. Fers and ADLs [activities of			
	indicated the resident	ss note dated 1/29/15, required assistance with all g. She was able to make out also had some			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 28 of 62

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00000	B. WING		04/20/2045
NAME OF P	ROVIDER OR SUPPLIER	00988 STREET ADD	RESS, CITY, STA	TE ZIR CODE	01/30/2015
		515 DIVISIO	ON STREET	, E, ZII 600E	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	R, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 830	Continued From page	28	2 830		
	confusion.				
	needed staff assistan interventions, however socks at all times as in 11/24/14 fall. In additing the care plan to ensurapplied and to encoun help as recommended On 1/28/15, at 10:09 nursing (ADON) explainted the day after a reside on fall interventions, at The ADON also said listed on the back of each of the said on	er, did not include gripper recommended after the on, staff were not directed in re R15's w/c brakes were rage the resident to call for d after the 1/24/15 fall. a.m. the assistant director of ained that all managers met int fell to brainstorm, decide and update the careplan. Interventions were also each resident's care plan. The latest fall intervention on the plan (page 2, print date)			
		ted by the resident, staff, the resident's medical record			
	3:51 p.m. He reported day, and would be ref 11:00 a.m. The follow was observed at 1/28	nile in bed on 1/27/15, at the had dialysis the next turning to the facility after ing morning R34's room 1/15, at 8:09 a.m. while R34 time in his room.			
	he reported, "They to [unknown] diet. I've be about a month." He a	een on a regular diet for			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 29 of 62

Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		00988	B. WING		01	/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
		515 DIVIS	ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	SIOR EXCELSION	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From page	: 29	2 830			
	replaced by an upper added that dressing of	vsis shunt had recently been chest access line. He hanges were performed by aid, "The nurses here don't				
	nutritional risk related and refusal of meals was since his last admission area. A handwritten a [cubic centimeters] flug Goals for R34 include and improved laboration included diet as order supplementation at magnitor daily meal coweights. For the resident since the supplementation at magnitude and improved laboration at magnitude diet as order supplementation at magnitude and supplementation and supplementation at the supplementation and supplementation and supplementation and supplementation and supplementation are supplementation and supplementation and supplementation are supplementations.	I 11/3/14, included a plan for to the need for extra protein with poor intake, weight loss on, and several opened skin addendum read "1500 cc tid Restriction [sic] 12/2014." In dweight above 190 pounds ory values. Interventions is with extra protein and eals. Staff were also to insumption and monthly dents' alteration in kidney of dated 11/3/14) with a risk sium excess. Goals				
	including laboratory v ranges, and staff were site daily fistula/graft/e infection. "Diet and fl by Physician. Encour nutritional and hydrati Additionally, staff wer work as ordered by the change in clinical sign "Monitor thrill and bru to document and report physician. Dialysis tir with a written communication weights and any charmonic site of the communication o	alues within therapeutic e directed to "check access catheter" for signs of uid restrictions as ordered				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 30 of 62

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		00988	B. WING		01	/30/2015
	ROVIDER OR SUPPLIER	SIOR 515 DIVIS	DRESS, CITY, STA SION STREET OR, MN 55331	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	and reported an awar a renal diet, and went Wednesday, and Frid been on a fluid restrict explained that informs was noted on the NA During an interview of assistant director of more communication between dialysis center was ty telephone calls versus called us today to sa fistula tomorrow, and transportation compachanged departure times Additionally, the ADO longer on fluid restriction a renal diet, "but he Domino's [pizza]." During a telephone call a transportation between the was "[R34]'s nurse communication between the was "Usually I call with conursesome nursing one does not, so we concerns." The dialyst She also indicated R3 runs, and we educate heart and he may have hospital."	d on 1/29/15, at 2:41 p.m. reness R34 was prescribed at to dialysis on Monday, lay. NA-H stated R34 had retion, "but not now." He ation regarding R34's care assignment sheet. In 1/29/15, at 3:41 p.m. the reported reactive information. "They reported work on his reported R34 was no rep	2 830			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 31 of 62

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015	
GOLDEN LIVINGCENTER - EXCELSIOR 515 DIVIS			RESS, CITY, STA ON STREET R, MN 55331	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 830	resident left for dialys nurse was responsibl in the computer. How did not think the NAs and stated, "You're rig should maybe get a swhen he gets up. Bed them when he gets be returned he was likely really tired." During an interview o stated R34 had a fluid supposed to give the added, "There is pop not sure where that fir Maybe the nurse coulme." The current physician weights, and a dialyst fluid restriction. Nursi access site daily for sibleeding. No notes we access site was obse however, in an intervit LPN-F said it was bei R34's care plan containdications, but the me 12/20/14, indicated the have been restricted also noted the resider afternoons, but the reindicated he had more laboratory results, as	shift staff either before the is or upon his return. The e for recording the weights ever, she added that she were taking the weight daily, ght, they're not all there. We ystem to get them only cause it's often hard to get ack." LPN-F said when R34 or to be "really hungry and in 1/30/15, at 2:10 p.m. NA-A directriction, and he was not resident extra fluid. He in the room sometimes. I'm its within the fluid restriction. It answer that better than in orders included daily is diet, but did not include a nig staff were to check the ymptoms of infection or ere found to show the rived by the nurses, ew on 1/30/15, at 2:01 p.m. nig completed. Sined conflicting fluid intake ost recent change dated he resident's fluids should to 1500 ccs. The care plan	2 830			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 32 of 62

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00988	B. WING		01/30/2015
	ROVIDER OR SUPPLIER	SIOR 515 DIVISI	DRESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 830	through 1/30/15. Note (all calls from the dial were recorded on two months on 1/24/15, a 12/23/14. An eMARNote was dated 11/10 was to record the res shift related to edematissues), however, R3 the NAs were able to not reflect information fistula for thrill or bruit location of the dialysis R34 from the arm fist indicated in any of the attempts and/or care noted. R19 On 1/27/15, at 9:15 a had any pain with no side, my left ankle hu of 10]" R19 also state well controlled." No supporting docume electronic medication (EMAR) for R19's phy Oxycodone (narcotic every 4 hours. In add needed (PRN) pain mincidences; once on 1/28/15, when R19 reacceptable level of pacare plan.	reviewed from 11/2/14 es reflected communication ysis center to the facility) o days during the three and two notes dated -Medication Administration 0/14, at 10:23 and noted staff idents daily weight every a (excess fluid in the 04 had left for dialysis before weigh him. The notes did a related to checking the t, nor was the change in s access site as reported by ula to a chest catheter	2 830		
	was cognitively mode				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 33 of 62

Minnesota Department of Health

	a Department of Fleatt		(VO) MULTIPLE	CONCEDITORIO	Total BATE 6	NIDVEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		00988	B. WING		01/3	80/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
			SION STREET	,		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331			
	OLIMANA DV OT		<u> </u>	DROWNERN BLANCE CORRECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
2 830	Continued From page	23	2 830			
2 000	Continued From page	5 00	2 000			
		delirium, no psychosis, no				
		d R19 needed extensive				
		es of daily living (ADLs). The				
		1/3/15, further indicated				
		ain regimen, "no" R19 had				
		needed) pain medication,				
	•	ceived non-medication				
		The quarterly MDS dated				
		R19 reported "frequently				
	_	d R19 gave a 'moderate' for				
		ain, and also indicated R19's				
	pain did not affect sle	ep or limit day activities.				
	Op 1/27/15 at 10:44	a mulicanood practical pures				
		a.m. licensed practical nurse				
		nestly cannot tell if she is in				
		II. Morphine is scheduled so stated, "She can ask for				
		but she does not ask for				
		N-A further stated, "She will				
		n want to get up. There is				
	always something wit	- ·				
	aiwaya sometiing wit					
	On 1/29/15, at 10:26	a.m. the DON stated R19				
		nadol (pain medication) and				
		pain medication) and R19				
	, , ,	g cares. The MS Contin had				
	"helped improve" R19					
	. '	•				
	On 1/29/15, at 10:54	a.m. a registered nurse				
		d not ask for PRNs, but "if				
	1 -	es have pain she will take a				
		ed R19 yelled out with				
		tated, "I heard her yelling				
		ed, "I don't know if she has				
		nink she gets so anxious."				
		t probably R19 did have pain				
	_	tle. RN-B stated she had				
		edications, repositioned her				
		leep. RN-B also stated, "I				
	think her pain is more	because of movement and				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 34 of 62

NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE ### STATE ### S	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EXCELSIOR STREET ADDRESS, CITY, STATE, 2P CODE 515 DIVISION STREET EXCELSIOR, MN 55331 PROVIDERS PLAN OF CORRECTION CRAH DIVINGON THE PROVIDER OF A CONTROL OF THE PROVIDERS PLAN OF CORRECTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CONSECUTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION CRAH CORRECTIVE ACTION IS NO ULL DIVINGUIS DE CONSECUTION IN THE CONSECUTION IN THE CONSECUTION IS NO ULL DIVINGUIS DE CONSECUTION IN THE CONSEC			00988	B. WING		01/3	80/2015
CALL	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 34 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 new." 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."	GOLDEN	LIVINGCENTER - EXCEL	SIOR				
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 metatarsais (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."	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
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	2 830	I did ask the nurse privation parmacy now PRN pain medication PRN Oxycodone [nar At 11:00 a.m. LPN-D often, and if she hear asked R19 if she war which she sometimes On 1/29/15, at 11:09 history of osteomyelit metatarsals (bones in before R19 came into treatment that would the treated ulcer heal was from the osteomy scheduled morphine on 1/29/15, at 2:38 p asked for a pain pill a p.m. and because she hurting. RN-B also stated asked for one." On 1/30/15, at 12:58 stated, "She is a very her pain. She will tell therefore she does not for pain." R19's Progress Notes "[R19] cries and complete during cares and transat 11:30 a.m."	actitioner for a new script has so we can have some for her, and she can have a cotic pain medication]. stated she worked with R19 d R19 complaining she ited a PRN pain medication, accepted. a.m. RN-A stated R19 had a is (bone infection) in her in the foot). RN-A stated to the facility she refused a have removed the bone, and ed. RN-A thought R19's pain yelitis and R19 received twice a day for it. m. RN-B stated R19 had t approximately 1:15 to 1:30 te reported her leg was really ated, "I was really surprised p.m. the MDS Coordinator reliable reporter, and knows you everything, and of need a staff assessment stated 8/20/14, indicated plains of pain especially sfers. Had PRN Oxycodone	2 830			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 35 of 62

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET		
			OR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 35	2 830		
	severe. Imp [impressicontrol. She has beer years. Probably not gmuch as she should. Contin to 15 mg q8h encourage her to ask suspect we may need [twice daily] fairly soo Neurontin [anticonvul used for pain] before, much it helped." Physician Progress Nindicated "Still major meds, but at least she and sometimes convealso indicated "Lots of she did not even wan least, the neurotropic metatarsal head is not Severe spastic left here	n on Oxycontin for several letting or asking for PRN's as Plans: Increased the MS [every 8 hours] and for breakthrough meds. I d to go up to 30 or more bid lin. We did have her on sant medication commonly but I am not sure how			
	indicated "[R19] report quite a bit of pain me comfortable. [R19] sa	d Physical dated 12/4/14, rting left foot pain. Is on dications and appears lys she doesn't ask for PRN			
	Diagnoses included " Side from Stroke, Chi	dications unchanged." Hemiplegia Nondominant ronic pain syndrome, ioral disturbance, and			
	Physician Orders date PRN Oxycodone at le 4/3/14, MS Contin Ta	ed 1/29/15, included: Offer east every 4 hours, ordered blet Extended Release 15 ER); Give 15 mg by mouth			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 36 of 62

Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
			7 ti BoleBirto			
		00988	B. WING		01/30	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E. ZIP CODE		
			SION STREET	_,		
GOLDEN	LIVINGCENTER - EXCEL	.SIOR	IOR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	36	2 830			
	-	et 10 mg; Give 10 mg by as needed for dyspnea and				
	(electronic medication 12/22/14, with no PR	a '6' on R19's 12/14, EMAR n administration record) on N pain medication given. 12/14, R19 received no PRN				
	Oxycodone HCL 10 n through pain twice du documented R19's pa knee pain, PRN effect left extremities, with F was rated a '6' on the	dicated R19 had received ng as needed for break ring the month. The LPN ain on 1/29/15 was a '7' left tive, and on 1/27/15, an '8' PRN effective. R19's pain 1/15 EMAR on 1/28/15, on shift on 1/28/15, with no given.				
	establish level of pair acceptable level of pair acceptable level of pair according to the residual pain or uncomfortable shift. Administer pain Evaluate characterist pain, Evaluate need to treatment or therappain worse. Observe extremities such as p Provide medications evaluate for effectives non-pharmaceutical in calm behavior and error stiffness. Observe specific locations of pinterventions taken to	indicated: Evaluate and on numeric scale/resident's ain is verbalized as a '5' lent. Make sure I am not in e. Assess for pain every medication as ordered. ics and frequency/pattern of o provide medications prior by. Evaluate what makes the for sensory changes to ain, warmth, redness. as ordered by physician and ness. Provide nterventions of redirecting, avironment. Monitor for pain for complaints of pain, iain, response to nursing a relieve pain. Anticipate e emotional support as				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 37 of 62

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00988	B. WING		01/30/2015	
	ROVIDER OR SUPPLIER LIVINGCENTER - EXCEL	SIOR 515 DIVIS	DDRESS, CITY, STA SION STREET OR, MN 55331	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
2 830	expected staff to deliveresidents' care plans. SUGGESTED METH The director of nursin and revice policies are assessments, monito provide staff education resident related to fall designee could ensure is coordinated and ap An audit tool could be of the audit brought to review.	.m. the DON stated he	2 830			
2 900	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that: A. a resident who without pressure sore unless condition demonstrate authenticates, that the B. a resident who receives necessary to	ent assessment, the director ust coordinate the sing care plan which enters the nursing home es does not develop s the individual's clinical es, and a physician ey were unavoidable; and o has pressure sores reatment and services to vent infection, and prevent	2 900			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 38 of 62

Minnesota Department of Health

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		00988	B. WING		01/3	30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
		515 DIVIS	ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From page	e 38	2 900			
	by: Based on observation review, the facility fail repositioning for 1 of dependent on staff for Findings include: R23 was assessed at was not repositioned continuous observation a.m. until 9:27 a.m. (2 a.m. R23 was in a whom. At 8:36 a.m. R28:37 a.m. a nursing a and assisted resident in the dining room wit repositioning until shat 9:27 a.m. R23 was assistance to transfer Staff proceeded to as from side to side in be change incontinent be observed and the skir NA-E confirmed the inwetness. R23's undated, Brade identify pressure ulce being at moderate risulcer. R23's care plar present), directed star repositioning schedul R23's quarterly Minim	4 residents (R23) who were r repositioning. 2 risk for skin breakdown and every two hours during on on 1/28/15, from 6:55 2 hours, 32 minutes). At 6:55 deelchair seated in the dining 23 was served breakfast. At ssistant (NA)-D sat down with eating. R23 remained the no assistance with e was wheeled to her room. It is provided extensive to be by NA-D and NA-E. It is ist resident with rolling ed, to provide peri-care and rief, no skin redness was in was intact. NA-D and incontinent brief showed en assessment (tool used to r risk) identified R23 as k for developing a pressure in (effective 10/22/13 to eff to provide turning and e per assessment.				
		noses including dementia				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 39 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET			
			OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 900	Continued From page	e 39	2 900			
	required extensive as transfers, bed mobility. The resident had seve skills, unclear speech understand others or Area Assessment (CA pressure ulcers dated is an extensive assist locomotion, personal did not ambulate, skir by licensed staff. Presand wheelchair, barrieneeded]." The Comprehensive son 1/8/15, indicated Fat moderate risk for p	ssistance of two staff for y and unable to ambulate. erely impaired cognitive				
	resident at "risk for pr non-ambulatory, requ	ired the assistance for nd total assistance with all				
	NA-D, who consistent unit, reported he and morning cares. They 9:00 a.m. NA-D repo out of bed at 6:45 a.m	n 1/28/15, at 10:18 a.m. tly worked on the dementia NA-E were running late with were usually finished by rted R23 had been assisted n. and acknowledged she istance with repositioning n two hours.				
	assistant director of n nursing assistants util resident, which identif	/30/15, at 12:58 p.m. the surses (ADON) reported the lized care guides for each fied each resident's The ADON further stated the				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 40 of 62

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET R, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 900	ADON further indicate nurse to try to keep of the Prevention of Pre 1/8/15 last reviewed 1 procedure purpose who breakdown and devel The procedure details a turning and position chair to meet the residual to meet the residual residents at risk for they are receiving the treatment/services to from developing and the pressure ulcers. The designee, could cond delivery of care; to enservices are impleme pressure ulcer development.	o follow the care guides. The ed, "We also rely on the shift in eye on cares." essure Ulcer policy (dated 1/26/15), indicated the eas, "To prevent skin opment of pressure ulcers." directed staff to "Establish ing schedule in bed and dent needs." OD OF CORRECTION: g or designee, could review in pressure ulcers to assure inecessary prevent pressure ulcers to promote healing of director of nursing or uct random audits of the sure appropriate care and inted; to reduce the risk for	2 900		
2 910	MN Rule 4658.0525 S Incontinence	Subp. 5 A.B Rehab -	2 910		
	have a continuous promanagement to reduce unnecessary use of comprehensive reside home must ensure the A. a resident who without an indwelling	e. A nursing home must ogram of bowel and bladder be incontinence and the atheters. Based on the ent assessment, a nursing at: e enters a nursing home catheter is not catheterized clinical condition indicates			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 41 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00988	B. WING		01	/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEI	LSIOR	SION STREET SIOR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	that catheterization w B. a resident who receives appropriate prevent urinary tract		2 910			
	by: Based on observation review, the facility fail to improve continence who experienced a d					
	(NA)-A assisted the r 1/28/15, at 11:26 a.m resident's incontinent amount of urine she NA-A reported that R	while a nursing assistant resident with toileting on an an an are the torief was wet with a small woided on the toilet, as well. 154 was frequently wet at the assist her to use the toilet.				
	NA-C stated R54 coushe needed to use the her brief would alread NA-B reported on 1/2 was toileted every two reported when she neal ready wet when standard NA-B was unaware to the she	1/28/15, at 10:21 a.m. uld verbally tell staff when the toilet, but when toileted, dy be wet. 28/15, at 11:22 a.m. that R54 to hours. Although R54 the eded to urinate, she was aff assisted her to the toilet. of any attempts to assist R54 quently than every two hours.				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 42 of 62

Minnesota Department of Health					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00988	B. WING		01/30/2015
NAME OF D	ROVIDER OR SUPPLIER	QTDEET AF	DRESS, CITY, STA	TE ZIR CODE	-
NAME OF FI	NOVIDER OR SUFFLIER			TE, ZIF GODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET		
			OR, MN 55331		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	I
				DEFICIENCY)	
2 910	Continued From page	- 42	2 910		
	Continued From page	5 12			
		8/15/14 identified a goal for			
		e of urinary tract infections			
	• •	s included: "Evaluate timing may cause increased			
	urinationevaluate from				
		sscheduled toileting plan			
	· ·	every two hours and PRN"			
		w of R54's medical record			
	did not reflect UTI's w	hile at the facility or a			
	history prior to admiss	sion. Evidence was lacking			
		medication timing had been			
	•	otentially contributing to			
		as her frequency and timing			
	of incontinence episo				
		d changing the resident (an esident is totally incontinent),			
	although the resident	· · · · · · · · · · · · · · · · · · ·			
	successfully use the t				
	daddeddiany add the t	ionot.			
	R54's admission Mini	imum Data Set (MDS) dated			
		ne resident had frequent			
	incontinence of urine.	. A subsequent quarterly			
		showed a decline in R54's			
		incontinent of bladder. R54			
		nitive impairment, required			
		with toileting and transfers.			
	•	s decline, the MDS did not			
	renect a trial bladder	retraining program for R54.			
	A Bladder Assessmer	nt form dated 11/13/14,			
	indicated R54 was to				
		hours and upon request.			
	The assessment, how				
	·	pport the every two hour			
		in the summary conclusion.			
		1/28/15, at 10:46 a.m. the			
	assistant director of n	nursing (ADON) stated she			

Minnesota Department of Health

was unaware R54 had experienced a decline in

STATE FORM 6899 RZGO11 If continuation sheet 43 of 62

Minnesota Department of Health

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE S	SLIDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPL	
			A. BUILDING: _			
		00988	B. WING		01/3	30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		515 DIVIS	ION STREET			
GOLDEN	LIVINGCENTER - EXCEL	SIOR EXCELSION	OR, MN 55331			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
				DEFICIENCY)		
2 910	910 Continued From page 43		2 910			
	urinary incontinonce	She explained staff was to				
		She explained staff was to lay bladder assessments to				
		oiding patterns. It had				
		f had not been completing				
		y should have been, and a				
		ey had been " reminded."				
		le to provide documentation				
	showing R54's bladde					
		propriate plan developed				
		al needs. The ADON was				
	also unaware whethe	r a re-assessment had been				
	completed after the M	IDS showed a decline, or				
	whether a trial for mo	re frequent toileting had				
	been considered.					
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4/00/45 -4-0-00				
		1/29/15, at 2:20 p.m. the				
	urinary incontinence	ON) stated R54 declined in				
	_	ot wish to get out of bed.				
		to provide documentation				
	showing R54's bladde					
		N verified R54 had not				
	experienced any UTI'					
	,	,				
	R23 was not provided	I assistance with toileting				
	needs every two hour	•				
		5, from 6:55 a.m. until 9:27				
		ites). At 6:55 a.m. R23 was				
		d in the dining room. At 8:36				
		breakfast. At 8:37 a.m.				
)-D sat down and assisted				
	_	R23 remained in the dining				
		nce with toileting until she				
		oom. At 9:27 a.m. R23 was sistance to transfer to bed				
	· ·	Staff proceeded to assist				
		om side to side in bed, to				
		change incontinent brief.				
		rmed the incontinent brief				
	showed wetness.	g are moonanone bildi				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 44 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
		00988	B. WING		01/	30/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From page	e 44	2 910			
	the resident had Alzh and was incontinent of sensation of urine los check and change re needed.	sment dated 1/8/15, noted neimer's disease/ dementia, of bladder and had no is. Staff was directed to sident every 2 hours and as				
	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.					
	present, directed staft toileting plan of check and as needed, use of	effective date 10/21/13, to f to provide scheduled and change every 2 hours of briefs/pads for on and monitor for signs and				
	· ·	eet for R23 directed staff to nce with ADL's (activities of ambulatory.				
	who consistently wor	/28/15, at 10:18 a.m. NA-D, ks on the dementia unit, E were running late with				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 45 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET		
	OLUMBA DV OT		OR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 910	Continued From page	e 45	2 910		
	indicated R23 was as a.m. NA-D acknowle	sually done by 9 a.m. and sisted out of bed at 6:45 dged R23 was not provided ng needs for greater than 2			
	assistant director of n nursing assistance have resident and the care resident's repositioning stated it is expected to by the nursing assista	ng needs. The ADON further he care guides are followed ance. The ADON further ly on the shift nurse to try to			
	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."				
	The director of nursin educate employees reresidents with toileting of timely care in order and develop interventions.	OD OF CORRECTION: g or designee, could esponsible for assisting g needs on the importance r to promote need to assess tions to prevent urinary tract or of nursing could inservice			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 46 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - EXCEL	SIOR 515 DIVIS	DDRESS, CITY, STA SION STREET IOR, MN 55331	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
2 910	orders for intermittent complaince. The dred inservice all employed monitoring, evaluating and audit for complain	ible to follow physcian catherization and audit for etor of nusring could es responsible for g and assessing urine output	2 910		
21395	All persons providing volunteers, with a cor listed in part 4605.704 lesions must not be p nursing home unless person's condition will without endangering the residents and other standards policies required in pattern F, must address persons from work are	services, including municable disease as 40 or with infected skin ermitted to work in the it is determined that the I permit the person to work the health and safety of taff. The employee health art 4658.0800, subpart 4, grounds for excluding and for reinstating persons to unicable disease or infected	21395		
	by: Based on interview, a facility failed to initiate and tuberculosis (TB of 6 newly hired nursi whose personnel reco prevention practices.	t is not met as evidenced and document review, the e tuberculin skin test (TST)) symptom screening for 2 ng assistants (NA-D, NA-E) ords were reviewed for TB. This had the potential to sidents who resided in the			

Minnesota Department of Health STATE FORM

RZGO11 If continuation sheet 47 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00988	B. WING		01	/30/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - EXCEL	SIOR 515 DIVIS	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21395	Continued From page	e 47	21395			
	and NA-E's personne they had received the TB symptom screenir to having direct contarequired.					
	(DON) verified both N TB symptom screenir personnel files as the DON said he expecte first step TST and syr prior to direct care with	p.m. the director of nursing IA-D and NA-E's TST and ng forms were not in their y should have been. The ad all employees have had a mptom screening completed th residents, and then two step TST would need to be				
	Testing (TST) for Scru (HCW's) directed staff pre-employment scre history and symptom two-step TST; "First stand results read prior residents/patients." To previous TST results and results read prior residents patients. To previous TST results as eline or if previous greater than 12 month recommend two step SUGGESTED METH	ening which included a screen and to administer step must be administered to first day of working with the policy further directed "if all recommend two-step is negative TST results and this before new employment, baseline TST."				
	TB practices are follo appropriately screene audit tool could be de is followed.	nurse could ensure current wed and all staff are ed and tested for TB. An eveloped to ensure the plan CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 48 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - EXCEL	SIOR 515 DIVISI	ORESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21665	functional, comfortabl environment, allowing personal belongings t	t provide a safe, clean, e, and homelike physical g the resident to use to the extent possible.	21665		
	by: Based on observatior review, the facility fail were maintained in a	t is not met as evidenced n, interview and document ed to ensure resident room personalized homelike sidents (R23, R28, R43) ementia unit.			
	p.m. The room was b one blanket laying at	erved on 1/26/15, at 4:28 are. The bed was made with the foot of the bed, and a at pad placed on the center			
	1/8/15, revealed diagonal cerebral vascular acconstance she required extensive perform activities of diresident had severely	num Data Set (MDS) dated noses including dementia, ident, (stroke) and anxiety. We assistance from staff to aily living (ADLs). The impaired cognitive skills, id sometimes understand od.			
	indicated the resident hearing and vision, as not always was under directed staff to antici Care Conference Sur	pate the resident's needs. A			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 49 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00988	B. WING		01	/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	·	
GOI DEN	LIVINGCENTER - EXCEL	SIOP 515 DI	VISION STREET			
GOLDLIN	LIVINGOLIVILIK - LACEL	EXCEL	SIOR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21665	Continued From page	e 49	21665			
	and met."					
	(NA)-D and NA-E we any pictures or other room. The NAs then and located a framed	i.m. a nursing assistant re asked about the lack of personal items in R23's looked around R23's room photograph, religious animal and dead plant urtain.				
		erved to be bare on 1/27/15, d was made, but there was 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.					
	indicated impaired co hearing. The care pla patient needs. A qual	ctive 5/23/14 to present) ommunication, cognition, and an directed staff to anticipate rterly Psychosocial Progress indicated "staff anticipate				
	and asked about lack					
		erved to be bare on 1/26/15 was made and two folded foot of the bed.				
		nge MDS dated 11/28/14, ncluding dementia and				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 50 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00988	B. WING		01/30/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ION STREET DR, MN 55331			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	ETE
21665	Continued From page	2 50	21665			
	schizophrenia. She required extensive assistance for ADLs. R43 also had severely impaired cognitive skills, unclear speech, but could usually understand others or be understood.					
	indicated the resident communication with e speech and was not a were directed to antio Psychosocial Progres indicated "Res [reside	ctive date 3/4/13 to present) had impaired cognition and episodes of disorganized always understood. Staff ipate her needs. A quarterly is note dated 12/5/14, ent] is severely impaired, eet all needs."				
	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					
	administrator, director of maintenance, and housekeeping. R23, observed, and were a items. The administrathree rooms were not	R28, and R43's rooms were ill bare of any personal ator and DON verified all homelike, and would have be have a homelike feel. The hey could ask family				
	A policy was requested provided by the facility SUGGESTED METH					
	licensed social worke					

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 51 of 62

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00988	B. WING		01/30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		515 DIVIS	ION STREET		
GOLDEN	LIVINGCENTER - EXCEL	SIOR EXCELSION	OR, MN 55331		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21665	Continued From page 51		21665		
	could be encouraged belongings of residen admitted, they could I personalize the reside could be conducted to environment is maintage.	to bring personal ts. As new residents are be encouraged to ent's room. Periodic audits			
21800	MN St. Statute144.65 Residents of HC Fac. Subd. 4. Informatio		21800		
	residents shall, at adrare legal rights for the stay at the facility or the treatment and mainted that these are describilities set for case of patients administrate and in section statement shall also operson 16 years old operson 16 years	mission, be told that there eir protection during their hroughout their course of nance in the community and bed in an accompanying the applicable rights and of the in this section. In the tted to residential programs 253C.01, the written describe the right of a per older to request release as 53B.04, subdivision 2, and and telephone numbers of izations that provide services for patients in			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 52 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		-120
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOI DEN	LIVINGCENTER - EXCEL	SIOR 515 DIVIS	ION STREET			
COLDEN	EIVINGOEIVIER - EXGEE	EXCELSION	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21800	Continued From page	: 52	21800			
	person, consistent wi	th chapter 13, the Data ction 626.557, relating to				
	by: Based on interview at facility failed to ensuring right to request a dendiscontinued was pro	t is not met as evidenced and document review, the e appropriate notice of the hand bill when Medicare was vided as required for 2 of 3 reviewed for liability notice.				
	Findings include:					
	a hospital stay related	n 8/27/14, and was				
		n 10/21/14, and was				
	10123 was reviewed lacked documentation been provided a 48-h before Medicare non-	id Services (CMS) form for R56 and R61. The form in showing R56 and R61 had our notice as required coverage date.				
	Set/Medicare coordin	p.m. the Minimum Data ator stated she should have ne CMS form 10123 two eir services ended.				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 53 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIBER.	A. BUILDING: _		GOIVII EETEB
		00988	B. WING		01/30/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	.SIOR	ION STREET		
		EXCELSIO	OR, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21800	Continued From page 53		21800		
		tice notification to resident on-coverage was requested			
	The director of nursin develop and impleme to ensure residents redenial and appeal rigil educated. Monitoring implemented to ensure	re ongoing compliance, and			
	committee.	re reported to the quality CORRECTION: Fourteen			
	(14) days.				
21805	MN St. Statute 144.6 Residents of HC Fac.		21805		
	residents have the rig courtesy and respect	treatment. Patients and that to be treated with for their individuality by ons providing service in a			
	by: Based on observation review, the facility fail manner that enhance resident (R19) review	red for behavioral status and I dining experience in 1 of 2 ally affecting the 18			

Minnesota Department of Health STATE FORM

RZGO11 If continuation sheet 54 of 62

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′	A. BUILDING:		COMPLETED	
			A. BOILDING.				
			B. WING				
		00988	B. WING		01/	/30/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
COLDEN	INVINCENTED EVEL	515 DIVIS	ION STREET				
GOLDEN	LIVINGCENTER - EXCEL	EXCELSION	OR, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE	
				DEFICIENCY)			
21805	Continued From page	: 54	21805				
	When asked if staff tredignity the resident are talk to you. After staff they put me in the living and then I sit there un room for a meal. I new bathroom because the change me. I wet my changed, and then I se go number two in my inferior to the other rewaiting for her brief to could not use the bath R19 also stated, "I wis	on 1/27/15, at 8:53 a.m. eated her with respect and aswered, "No. Staff don't feet me up in the morning and room to watch television will they take me to the dining wer get to go to the ey just lay me in bed and pad while I am waiting to be sit in the wet pad, and then I pad. It makes me feel sidents here" (regarding to be changed and that she arroom like her roommate. It is shown that the short staff would not be so they wash me up in the					
	sitting in her wheelcha watching television. A assistant (NA)-B appr "Okay it's time to eat," reply from the residenther w/c toward the dir was in the day room of 8:28 a.m. NA-B approviate and approviate and the hallway. As NA-B the hallway outside he bumped the wall and "Ow." NA-B stated, "I say that. It's hard to k pain,. She just always even if you just look a transferred R19 from aid of a mechanical life."	7:44 a.m. R19 was observed air (w/c) in the dayroom At 7:46 a.m. a nursing roached R19 and stated, " and before waiting for a at, proceeded to push R19 in ning room. At 8:16 a.m. R19 drinking a cup of coffee. At roached R19 from behind and and to the resident, pulled her ble and pushed her down turned R19's w/c around in ter room, the resident's foot the resident responded, af you just look at her she will now because she is in real as says 'ow' no matter what, at her." NA-B and NA-A the w/c to the bed with the fit. Throughout the process or face was tensed. She					

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 55 of 62

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_			
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOI DEN	LIVINGCENTER - EXCEL	SIOR 515 DIVISIO	ON STREET			
OOLDEN	EIVIII OOLII EK EKOLL	EXCELSIO	R, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21805	Continued From page	e 55	21805			
	repeated, "owow-ow-lowered onto the bed stated, "My arm hurts again." NA-B told R15 your arm." As NA-B a and forth from side to check the brief, and the again, R19 grimaced Ouch! Ow! Ow!" NA-E fashion without instru was planning to assist On 1/29/15, at 9:26 and dayroom at a table with person. A jigsaw puz R19 stated, "The orang then again stated, "It person did not address repeated a little louded member continued to one of the other residual." We are water stating, "We are water stating, "We are water stating."	w" repeatedly and she was and held her arm as she . You've broken my arm 9, "We are not even touching and NA-A rolled R19 back side to lower her pants and then to pull the pants up and cried out loudly, "Ouch! B delivered care in a hurried ction or telling R19 how she				
	when the resident cric R19's roommate then [expletive] wrong with turned from side to sic out, "Ow! Ow!" The re stated, "Oh my god!" grimaced and cried or "One more time." As resident she grimaced Her roommate stated	a.m. NA-G and NA-E be bed with the mechanical lift ed out, "Ouch! My knee." stated, "There is nothing your legs." As R19 was de she grimaced and cried esident's roommate then While lying on her back R19 ut, "Help!" NA-E responded, NA-G washed and dried the d and continued to call out. loudly enough for the n't believe this. I can't have				
		en sleep." As R19's clothing ed out loudly asking, "Will				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 56 of 62

Minnesota Department of Health

	a Department of Fleatt				Taus	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SUR	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLET	ED
		00988	B. WING	B. WING		2015
					1	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN LIVINGCENTER - EXCELSIOR 515 DIVIS			ION STREET			
00252.1		EXCELSI	OR, MN 55331			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				,		
21805	Continued From page	e 56	21805			
	you stop? Will you sto	on?" NA E and NA C				
		ost done." When cares were				
	-					
	•	d to have her television				
		mmate then stated, "Of				
		television on, and someone				
		get up and turn it off." R19				
		different socks. As NA-E				
		a boot the resident again d, "Is that better?" NA-E also				
		-				
	asked R19 if she was					
	responded, "My neck					
	-	ad. I don't even want to be				
	in here." NA-G did no					
		e the resident her call light				
		119 requested the staff turn				
		. When R19's television was				
		chy noises were heard, and				
	there were gray jagge					
		ate stated, "I have to listen				
		d left the room. The NAs left				
		ing off the light as R19 had				
	requested.					
	Fallowing the care ob	convetions at 10:15 a.m.				
	_	servations at 10:15 a.m. "7 1/2" of of 10 (10 being				
		, "I don't even have a PRN				
	,					
	· · · · · · · · · · · · · · · · · · ·	dication." R19 said her TV				
		on channel 11, but said, "I				
	1	out my TV as they don't				
		at the puzzle table this stated, "Or the nurse will				
	_	her I have pain, 'I just gave at.'" R19 also stated, "Now				
	, ,					
		ound, I just urinated in my				
		ave to stay here wet until				
	, , ,	y do." R19 said she would				
		a.m. every morning, but				
		5 a.m." R19 had a white				
	substance on her low					
	reported the NA did h	ot assist her to brush her				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 57 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
		00988	B. WING		01	/30/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCE	LSIOR	SION STREET OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	teeth that morning. Froommate's commer typical. She added, "off and they didn't." Sher eyes where she R19 added, "I want to the R19 added, "I want t	R19 said she had her also about her, which were I asked them to turn my light She described an issue with found the light bothersome. To be with my son and family." I mained in bed with the TV ines across the screen and ing, scratchy sounds. At een moved to a different I mum Data Set (MDS) dated the had moderately impaired no behavioral problems or of reject cares. R19 required cance for activities of daily icated on the MDS included is on one side of the body), is, spasm muscle and I a.m. NA-G reported R19, and instead used the ne bed pan. NA-G also stated incontinent, although the need for a bowel ther stated, "She is known to ways says 'ow,' even if you	21805			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 58 of 62

Minnesota Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/3	0/2015
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
GOLDEN L	IVINGCENTER - EXCEL	SIOR	ON STREET R, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	her roommate. On 1/29/15, at 10:35 a worker (LSW) stated soncerns about R19 a LSW stated, "As far a roommate are getting anything." On 1/29/15, at 11:17 a she and R19 had disc past when openings of those rooms had all b had. R19's roommate discharging soon, so the window. The admiget a compatible room explained that R19 "g not been visiting much was not working. In a the derogatory commonommate and stated [R19's] roommate's context the staff should not be will offer her another of 1/30/15, at 12:58 p stated, "She is a very her pain. She will tell therefore, she does not for pain." R19's current care pla maintain my dignity. Fineeded. Provide non-interventions of redire environment. Help me	a.m. the licensed social she had not heard of any and her roommate. The s I know [R19] and her along. I am not aware of a.m. the administrator stated cussed a room change in the occurred, but the size of een the same as what she was planning on possibly R19 could move to ministrator said they could mate for her, as well. She wills her family so they had he. She was unaware the TV addition, she was unaware of eents made by the R19's period it is concerning about comments towards [R19] and a allowing it to happen. We coom." p.m. the MDS coordinator reliable reporter and knows you everything and ot need a staff assessment	21805			

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 59 of 62

Minnesota Department of Health						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	= IED
			B WING	B. WING		0/004=
		00988	B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			ON STREET	,		
GOLDEN LIVINGCENTER - EXCELSIOR						
		EXCELSIO	OR, MN 55331			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
21805	Continued From page	59	21805			
		e sense to you. Please				
	remember that I am a	in adult and treat me				
	accordingly. Please to	ell me what you are going to				
	do before you begin.	Explain all procedures and				
	reason before perform	ning. Approach patient in a				
	calm, positive, reassu	iring manner. Staff to				
		contact if needed and				
		s before starting. Allow calm,				
	unhurried environmer					
		ver questions as needed				
		sary. Anticipate patient				
		tient to verbalize needs.				
		ate verbal and non verbal				
		n eye contact if possible.				
	_	nake needs known and				
		ngs. Use simple and direct				
	communication to pro	mote understanding."				
		.m. the DON stated he				
	expected staff to follo	w the residents' care plans.				
	_	ovide a dignified dining				
	experience for reside	nts 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				
		o.m. all residents in the				
	·	ved their meal. At 5:50 p.m.				
	nursing assistants (N					
	_	f the table using the busing				
	_	ents remained in the dining				
		registered nurse (RN)-C				
	· · · · · · · · · · · · · · · · · · ·	-				
		ing the tables. The table				
		staff tapped the plastic				
	powis on the edge of	the cart to remove the food.				
	0 4/00/47 / 5 5 5					
		.m. the meal service was				
	again observed in the	dementia unit. The tables				

Minnesota Department of Health

STATE FORM 6899 RZGO11 If continuation sheet 60 of 62

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00988	B. WING		01/30/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET			
	-	EXCELSIO	OR, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
21805	Continued From page	e 60	21805			
	licensed practical nur off the tables using the residents remained in R9 and R23 continue	the dining room, and R11,				
	at 8:00 a.m. and outs	ide of the unit the breakfast n 7:30 a.m. to 9:00 a.m.				
	1/29/15, at 9:24 a.m. breakfast on the dem enough space for all of together at the same of open breakfast had concern and residents requested or needed, not provide condimenthe residents "touch esalt and sugar packet centerpieces were no because the residents 10:16 am. the RD state discrete and quite what tables. If residents we cart should not have I linstead, staff could haven residents were carried them to the business of the same staff could haven residents were carried them to the business and staff could haven residents were carried them to the business and same staff could haven residents were carried them to the business and same staff could haven residents were carried them to the business and same staff could have same staff could have same staff could have same same same same same same same sam	time. The RD indicated lack I not been brought up as a swere provided late trays if The RD indicated staff did to on the tables, because everything" and open and eat s. The RD further stated t placed on the tables swould remove them. At ted staff should have been en clearing dishes from the vere still eating, the busing been used at the table. ave removed the dishes finished eating, and then using cart.				
	unit was interviewed of LPN-B explained the open breakfast on the were residents who we time allowed all of the and prevented them food. Centerpieces we	tly worked on the dementia on 1/29/15, at 9:53 a.m. reason they did not offer an equit was because there randered a lot. Having a set e residents to eat together, rom eating each others' rere not used, as the ttempted to eat them, and				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 61 of 62

Minnesota Department of Health

Minnesot	a Department of Health	<u>n</u>	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00988	B. WING		01/30/2015
			1		,
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	LIVINGCENTER - EXCEL	SIOR	ON STREET		
00252.1		EXCELSION	OR, MN 55331		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ -7
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORI GIVE	100 IDENTIFY TING IN GRANATION)	TAG	DEFICIENCY)	UATE
21805	Continued From page	e 61	21805		
	I PN-B had seen resid	dents attempting to eat			
		e residents were on special			
		iments were not offered.			
		mionio word not onorda.			
	The Guidelines for Ca	aregiver Interaction with			
		ved 11/12/14), indicated the			
	,	action with patients who have			
	cognitive deficitsSta	aff will interact with residents			
	in a manner that supp	oorts dignity and enhances			
	the resident's ability to	o successfully participate in			
		change their thinking from			
		vior to understanding and			
		behind the behavior. Always			
		can understand what your			
		abilities, not limitations, The			
		neself does not always effect			
		and others." For activities of			
	daily living the policy resident be in control.				
	resident be in control.	•			
	SUGGESTED METH	OD OF CORRECTION: The			
		rs and director of nursing			
		olicies and procedures			
		on of dignified care and			
		could be re-educated on			
		tem for evaluating and			
		implementation of these			
		eloped, with the results of			
		ought to the facility's Quality			
	Assurance Committee				
		CORRECTION: Twenty-one			
	(21) days.				

Minnesota Department of Health

STATE FORM RZGO11 If continuation sheet 62 of 62