DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDIO	CAID SERVICES
	MEDIC	ARE/MEDICAII	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: \$33Z
	PART I -	TO BE COMPL	ETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00995
1. MEDICARE/MEDICAID PROVIDER (L1) 245323 2.STATE VENDOR OR MEDICAID NO (L2) 677088600		3. NAME AND AD (L3) GOLDEN L1 (L4) 209 BIRCHV (L5) WALKER, M	IVINGCENTH WOOD AVEN	ER - WALI		 TYPE OF ACTION Initial Termination Validation 	 Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) 04/01/2006	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other er Complaint
6. DATE OF SURVEY 08/05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (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 0 15 ASC 16 HOSPICE	FISCAL YEAR END 12/31	ING DATE: (L35)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	40 (L18)	Compliance			And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Se 7. Medical Di	ervices Limit irector m Size
13.Total Certified Beds	40 (L17)		ents and/or Appli		* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDOW	'N				15. FACILITY MEETS		
18 SNF 18/19 SNF 40	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION 1	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY		Date:
Theresa Gullingsrud, I	HFE NEII	0	8/12/2014	(L19)	Enforcement S		09/15/2014 (L20)
PAR	Г II - TO BE	COMPLETED F	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
 19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Par 2. Facility is not Eligible 			PLIANCE WITH ITS ACT:	H CIVIL	 Statement of Finar Ownership/Contro Both of the Above 	ol Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	/FNT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 07/01/1986	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure 0	INVOLU	. ,
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspensio	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	ler Status Change
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00454					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)	07/16/2014		(L33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5323 August 15, 2014

Mr. Shane Roche, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Dear Mr. Roche:

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

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

Effective July 9, 2014 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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.

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 Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 15, 2014

Mr. Shane Roche, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

RE: Project Number S5323023

Dear Mr. Roche:

On June 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 30, 2014. 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 August 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 30, 2014, effective July 9, 2014 and therefore remedies outlined in our letter to you dated June 17, 2014, will not be imposed.

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

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

Sincerely, Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697 General Information: (651) 201-5000 * TDD/TTY: (651) 201-5797 * Minnesota Relay Service: (800) 627-3529 * www.health.state.mn.us For directions to any of the MDH locations, call (651) 201-5000 * An Equal Opportunity Employer

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 245323	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/5/2014
Name	of Facility		Street Address, City, State, Zip Code	
GC	DLDEN LIVINGCENTER - WALKER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700

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)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
IF) Prefix	E0224		Completed 07/09/2014		ID Prefix	50244		Completed 07/09/2014		ID Prefix	F0279		Completed 07/09/2014
				07/09/2014					07/09/2014					07/09/2014
	Reg. # LSC	483.13(a)				Reg. # LSC	483.15(c)(6)				Reg. # LSC	483.20(d), 483	.20(k)(1)	
	200										200			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0280		07/09/2014		ID Prefix	F0282		07/09/2014		ID Prefix	F0309		07/09/2014
	Reg. #	483.20(d)(3), 483	3.10(k)(2)			Reg. #	483.20(k)(3)(ii)					483.25		
	LSC					LSC					LSC			
				Correction					Correction					Correction
IC) Prefix	F0311		Completed 07/09/2014		ID Prefix	F0312		Completed 07/09/2014		ID Prefix	F0314		Completed 07/09/2014
	Rea #	483.25(a)(2)		-		Rea #	483.25(a)(3)		-		Rea #	483.25(c)		
	LSC					LSC					LSC			
					1									
				Correction					Correction					Correction
				Completed					Completed					Completed
IL) Prefix	F0315		07/09/2014		ID Prefix	F0329		07/09/2014		ID Prefix	F0356		07/09/2014
	Reg. # LSC	483.25(d)				Reg. # LSC	483.25(I)				Reg. # LSC	483.30(e)		
	190					LSC					130			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0364		07/09/2014		ID Prefix	F0371		07/09/2014		ID Prefix	F0441		07/09/2014
	-	483.35(d)(1)-(2)					483.35(i)					483.65		
	LSC					LSC					LSC			
Revie	wed By	/ F	Reviewed I	Зу	Dat	te:	Signature o	f Surve	yor:				Date:	
State	Agency	y	LB/mn	1	08	/15/20	14		3356	52			08/0	05/2014
Revie	wed By	/ F	Reviewed I	Зу	Da	te:	Signature o	f Surve	yor:				Date:	
CMS	RO													

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 245323	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/5/2014
Name	of Facility		Street Address, City, State, Zip Code	
GC	DLDEN LIVINGCENTER - WALKER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700

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		5/30/2	2014										YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00995	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/5/2014
Name	of Facility		Street Address, City, State, Zip Code	
GC	DLDEN LIVINGCENTER - WALKER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date (Y	'4) Item	(Y5) D	ate
ID Prefix	20005	Correction Completed 07/09/2014	ID Prefix	20255	Correction Completed 07/09/2014	ID Prefix	20505	Correction Completed 07/09/2014
Reg. # LSC	MN Rule 4658.0015	-	Reg. # LSC	MN Rule 4658.0070	-	Reg. # LSC	MN Rule 4658.0300 Subp.	1 A -I
ID Prefix Reg. # LSC	MN Rule 4658.0405 Subp.	Correction Completed 07/09/2014 2	•	20565 MN Rule 4658.0405 Subp.	Correction Completed 07/09/2014 3		20570 MN Rule 4658.0405 Subp.	Correction Completed 07/09/2014
ID Prefix Reg. # LSC	20830 MN Rule 4658.0520 Subp.	Correction Completed 07/09/2014	ID Prefix Reg. # LSC	20905 MN Rule 4658.0525 Subp.	Correction Completed 07/09/2014 4	0	20910 MN Rule 4658.0525 Subp.	Correction Completed 07/09/2014 5 A.I
ID Prefix Reg. # LSC	20915 MN Rule 4658.0525 Subp.	Correction Completed _07/09/2014	ID Prefix Reg. # LSC	20920 MN Rule 4658.0525 Subp.	Correction Completed 07/09/2014 6 B	ID Prefix Reg. # LSC	20960 MN Rule 4658.0600 Subp.	Correction Completed 07/09/2014
ID Prefix Reg. # LSC		Correction Completed _07/09/2014	ID Prefix Reg. # LSC	21390 MN Rule 4658.0800 Subp.	Correction Completed 07/09/2014 4 A-I	ID Prefix Reg. # LSC	21426 MN St. Statute 144A.04 Su	Correction Completed 08/05/2014 bd. 4
Reviewed By State Agency Reviewed By CMS RO	y LB/mr	n	Date: 08/15/201 Date:	Signature of Surve	33562		Date: 08/05 Date:	5/2014
	/: REVISIT REPORT (!	5/99)		Page 1 of 2			Event ID: S33712	

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00995	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/5/2014
Name	of Facility		Street Address, City, State, Zip Code	
GC	DLDEN LIVINGCENTER - WALKER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4)	ltem	(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction				Correction	n					Correction
			Completed				Complete						Completed
ID	Prefix	21540	07/09/2014		ID Prefix	21695	07/09/2014	4		ID Prefix	21870		07/09/2014
F	-	MN Rule 4658.1315 Subp.	2		-	MN Rule 4658.1415 Subp.	4			•	MN St. Statu	te 144.651 S	ubd. 1
	LSC	_	-		LSC					LSC			_
			Correction										
ID	Prefix	21942	Completed 08/05/2014										
F	Rea. #	MN St. Statute 144A.10 Su	- Ibd. {										
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			-	1									
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		5/30/2014					u Deficiênd	cies (CIVIS	-2007) Sent	to the Facility	YES	NO
STATE	FORM	I: REVISIT REPORT (5	5/99)			Page 2 of 2					Event ID:	S33Z12	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 15, 2014

Mr. Shane Roche, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Re: Reinspection Results - Project Number S5323023

Dear Mr. Roche:

On August 5, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on, May 30, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 eNotice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COMP						ID: S33Z Facility ID: 00995
1. MEDICARE/MEDICAID PROVIDER N (L1) 245323 2.STATE VENDOR OR MEDICAID NO. (L2) 677088600 677088600	0.	 NAME AND ADD (L3) GOLDEN LIV (L4) 209 BIRCHW (L5) WALKER, M 	VINGCENTER - OOD AVENUE V	WALKEF		6484	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006	NERSHIP	7. PROVIDER/SUPI 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other ter Complaint
 6. DATE OF SURVEY 05/30. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	/2014 (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 END 12/31	DING DATE: (L35)
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	40 (L18) 40 (L17)	X B. Not in Comp	ee With quirements Based On: cceptable POC	'aivers:	2. Technic 3. 24 Hou	cal Personnel ır RN RN (Rural SNF) fety Code	Following Requirement 6. Scope of 3 7. Medical I 8. Patient Ro 9. Beds/Roo (L12)	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDOWN	10.0315	KOP	IID		15. FACILITY MEE		(1.15)	
18 SNF 18/19 SNF 40 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 186	51 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVE	Y AGENCY API	PROVAL	Date:
17. SURVEYOR SIGNATURE	HFE NEII		7/02/2014	(L19)	18. STATE SURVE Enforcei			Date: 07/16/2014 (L20)
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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 17, 2014

Mr. Dan Stockdale, Administrator Golden Livingcenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

RE: Project Number S5323023

Dear Mr. Stockdale:

On May 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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>Electronic 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:

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 - 5th Street NW, Suite A Bemidji, Minnesota 56601-2933 Telephone: (218) 308-2104 Fax: (218) 308-2122 Email: <u>lyla.burkman@state.mn.us</u>

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 June 9, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 9, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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 pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0541

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

Sincerely,

Ane Klegepe

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

	-	AND HUMAN SERVICES			FORM APPROVED
CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES	1	OM	IB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (2	X3) DATE SURVEY COMPLETED
		245323	B. WING _		05/30/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - W	ALKER		209 BIRCHWOOD AVENUE WEST PO BOX 70 WALKER, MN 56484	0
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	0	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance.			
F 221 SS=D	on-site revisit of you validate that substa regulations has bee your verification.		F 22	1	7/9/14
	physical restraints i	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.			
	by: Based on observat review, the facility far restrictive restraint amount of time as r (R31) in the sample restraint device (lap Findings include: R31's order summar identified R31's diag	ary report dated 4/24/14, gnosis as Parkinson's disease, nations, anxiety, and		 Resident #31 use of a Physical Restraint has been re-assessed, and using the least restrictive device indii Staff are being trained on removing t device and on leaving it on for the sh time possible. Other residents that have the pote to be affected have been reviewed. Staff have been re-educated on the Physical Restraints. Monitoring to ensure compliance be completed by the DNS/Designee, through random audits of residents, 	cated. the nortest ential he will
	(DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

06/30/2014

PRINTED: 07/02/2014

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.

Electronically Signed

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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 1 F 221 through care observations and record R31's quarterly Minimum Data Set (MDS) dated review. The results of the audits will be 4/14/14, indicated R31 had severe cognitive reviewed at the monthly Quality impairment and required extensive assist with Assurance Meeting. transferring, dressing, eating and toileting. **R31's PHYSICAL RESTRAINT/DEVICE** SCREENING FORM dated 4/9/14, indicated the type of restraint/device recommended was a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair). R31 was also identified as not being able to independently remove the restraint on command. R31's care plan dated 4/9/14, directed staff to check on R31 every 30 minutes when the lap buddy (restraint) was in place, release the restraint every two hours and at meal time when under direct supervision of staff. On 5/29/14, at 12:46 p.m. R31 was observed wheeled into the dining room with the lap buddy secured to her wheelchair. During the noon meal observation from 12:46 p.m. through 1:30 p.m. R31 was continuously observed and the lap buddy was kept secured to R31's wheelchair. At R31's table licensed practical nurse (LPN)-A, nursing assistant (NA)-A and NA-B were observed to be seated at R31's table as they assisted residents with their meals. On 5/29/14, at 1:30 p.m. LPN-A confirmed R31's lap buddy had remained secured during the noon meal. LPN-A stated if it was up to her she would have removed the lap buddy during meal times, although she had only seen it on R31.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 2 of 54

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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 2 F 221 On 5/29/14, at 2:00 p.m. the assistant director of nursing (ADON) confirmed R31's lap buddy was considered a restraint. The ADON verified her expectation was for R31's lap buddy to be removed during meal time as the facility should be using the least restrictive restraint. On 5/30/14, at 11:23 a.m. the director of nursing services (DNS) confirmed R31's lap buddy should be off at meal times and the facility should be using the least restrictive type of restraint for the least amount of time. The facility's Restraint Devices, Physical policy [undated] specified the goal should be for removal of the restraint or use of the less restrictive measure. F 244 483.15(c)(6) LISTEN/ACT ON GROUP F 244 7/9/14 GRIEVANCE/RECOMMENDATION SS=E When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced bv: Based on interview and document review, the 1. Resident 38. food choices and facility failed to act upon resident grievances for concerns have been reviewed, is the last 5 of 5 resident council meetings regarding receiving food that is palatable. The food palatability. facility system for identifying and following up on grievances has been reviewed and revised, including food palatability Findings include: concerns. 2. Resident Council Meetings will be held

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: S33Z11

Facility ID: 00995

If continuation sheet Page 3 of 54

PRINTED: 07/02/2014 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED
		245323	B. WING _		05/30/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
GOLDEN	I LIVINGCENTER - W	ALKER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI E APPROPRIATE DATE
F 244		ge 3 ed on 5/28/14, at 1:30 p.m. and	F 24	44 monthly, and grievances b	prought forward
	stated the food qua (residents) have co	lity is horrible and they mplained numerous times. lity of the food is not palatable,		will be addressed by the II 3. The Therapeutic Recreation has been educated on ide	DT team. ation Director
	sometimes it is und over cooked and ju residents who cann	lercooked, sometimes it is st mush. R38 stated there are not always speak for		follow up on grievances bu Resident Council Meeting been educated on the Grie	. Staff have evance Process.
	the food. The resid anything from the c	u see that they are not eating ents have not heard or seen lietary department, many times		Identified Grievances are the Grievance Form, the f allocated to the appropriat	ollow up is e department
	don't have the food they did not get the delivered. R38 add	ed without notice because they item, and the comments are order in in time to be ed they have made numerous ne food quality and there is no		identified in the Grievance 4. The ED/Designee signs identified Grievances, the Designee logs all of the G Grievance Logs are review	off on all Social Services rievances. The
	follow up. R38 cont with no tuna, the ve at times mushy, me	inued there is tuna casserole egetables are overcooked and eat is overcooked and you 8 stated, "We have requested		Stand Up, and at the Mon Assurance Meeting.	
	that a member of th a meal with us and the quality of food t stated he was going	ne upper staff come and have do this weekly, so they see hat has not happened." R38 g to talk to the social service			
		t why all of the food documented in the resident			
	documentation incl 1/22/14, residents I	il minutes were reviewed and uded: prought up concerns that the od is not cooked thoroughly.			
	On 2/20/14, five rest that the food is colo 3/28/14, "Is there a	sidents brought up concerns I. ny diabetic desserts besides			
	Would like to have food. Does the Adn	pring menu coming here? a spring picnic with picnic ninistration here listen to your er was: No. Number of			

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 244 Continued From page 4 F 244 small. Please let kitchen know I don't want any more pasta. Meal items missing and food cold and late." 4/25/14, "Is there any diabetic desserts besides fruit? Would like to have Department heads eat with residents at least one time a week." 5/16/14. "Food items dropped or substitute the day of menu, i.e. salmon, over loaded on carbohydrates, Food over and under cooked-vegetables also meat." On 5/30/14, at 9:40 a.m. during an interview with the social service designee (SSD) regarding the resident council concerns regarding the unpalatable food that is being served, the SSD stated, " If there is a problem or complaint regarding the food, I just go to dietary and tell them verbally. I have not filled out any forms to give to the kitchen regarding the residents' concerns. I know the residents have had many complaints about the quality of the food." SSD added, "The dietary manager would have a monthly meeting and I would just step in and bring up complaints. I have never filled out the form to notify the kitchen of food concerns of the residents from the council meetings." When asked why all the food complaints are not documented in the minutes the SSD stated,"I would just go tell dietary the concerns." The SSD stated, "We have a form to fill out to go to the departments that the resident council had concerns with. I am the one who would fill out the form for the departments, I have not done that." The SSD verified, "The forms have not been filled out regarding the complaints the resident council has regarding the palatability of the food and the multiple complaints that were brought up in the resident council meetings regarding food guality." The SSD provided documentation titled,

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		AND HUMAN SERVICES			FORM	07/02/2014 APPROVED 0938-0391	
			. ,		(X3) DATE SURVEY COMPLETED		
		245323	B. WING		05/3	30/2014	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOLDEN	N LIVINGCENTER - WA	ALKER		09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	′00		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 279	plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including f under §483.10(b)(4 This REQUIREMEN by: Based on interview facility failed to dev measurable goals a the care and treatm (c-diff) infection for diagnosis of c-diff. Findings include: R22's MDS dated 4 extensive assist of toileting. The MDS sclerosis, intestinal fibrillation and hype Physicians orders of following medicatio treat range of bacted	ent that includes measurable etables to meet a resident's nd mental and psychosocial attified in the comprehensive t describe the services that are attain or maintain the resident's physical, mental, and being as required under revices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment th). NT is not met as evidenced v and document review, the elop a care plan with and interventions to address hent of Clostridium Difficile 1 of 1 resident (R22) with the 4/18/14, indicated R22 requires one for bed mobility and included diagnoses of multiple infections due to c-diff, atrial	F 279	 Resident 22 Clostridium has beer resolved. Other residents that are on Hosp Diagnosis of Clostridium Difficile caplans have been reviewed and reviindicated. Staff have been educated on developing comprehensive care plate. Monitoring by the DNS/Designeet through random weekly audits that plans are comprehensive. The result has audits will be reviewed at the Monthly Quality Assurance Meeting 	ans care care care ults of		

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 7 F 279 milligram tablet by mouth in evening for diarrhea related to intestinal infections due to c-diff. The orders included to monitor stools every day and night shift and follow up as needed if diarrhea continues, and infections disease consult in Bemidii for chronic urinary tract infections and c-diff. Provider progress notes dated 5/21/14, indicated: "infectious disease follow up for c-diff pt [patient] getting better, continue Vancomycin 125 milligrams by every six hours by mouth until 5/26/14, continue to monitor stool. Follow up as need or if diarrhea recurs. Patient should be able to leave room and go outside as long as continent." R22's current undated plan of care with print date of 5/29/14, lacked a problem statement, goal or any approaches related to the treatment and risks of c-diff. On 5/30/14, at 10:40 a.m. the assistant director of nursing (ADON) stated the c-diff infection should definitely be on the resident's care plan with interventions. The ADON verified that the resident's c-diff infection was not on the plan of care and should be. On 5/30/14, at 12:15 p.m. the director of nursing (DON) verified that R22's care plan should reflect the c-diff problem and appropriate interventions as well. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 7/9/14 PARTICIPATE PLANNING CARE-REVISE CP SS=D The resident has the right, unless adjudged incompetent or otherwise found to be

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					MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245323	B. WING			05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX 70 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	incapacitated under participate in planni changes in care an A comprehensive c within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	r the laws of the State, to ing care and treatment or	F 2	80			
	by: Based on observat review, the facility fa to include removal of meal times for 1 of with a physical rest Findings include: R31's order summa identified R31's dia depression, hallucir generalized muscle R31's quarterly Min 4/14/14, indicated F impairment and req	ary report dated 4/24/14, gnosis as Parkinson's disease, nations, anxiety, and			 Resident 31, care plan has been reviewed and revised as indicated fuse of ;physical restraints Other residents care plans are be reviewed and revised for accuracy. Staff have been educated on revi and revising carfe plan interventions they are identifiedand implemented. Monitoring for compliance will be completed by the DNS/Designee the random weekly care plan audits that interventions are current. The result these audits will be reviewed at the Monthly Quality Assurance Meeting 	or the eing iewing s as rough tt ts of	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING			05/	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - W	ALKER			209 BIRCHWOOD AVENUE WEST PO BOX NALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 9	F 2	280			
	SCREENING FORI type of restraint/dev buddy (a thick cush lap and is secured is wheelchair, which of to remove themselv was also identified independently remo R31's care plan dat check on R31 every buddy (restraint) wa reposition every two under direct superv R31's care plan dat area for utilization of buddy). However, to interventions which monitor R31 when to when to release the On 5/29/14, at 12:4 the dining room with wheelchair. During p.m. through 1:30 p observed and the la R31's wheelchair. On 5/29/14, at 1:30 lap buddy had rema meal. On 5/29/14, at 2:00 nursing (ADON) co considered a restra	ed 5/29/14, identified a focus of a physical restraint (lap the care plan lacked directed the staff when to the restraint was in place and					

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 10 F 280 removed during meal time as the facility should be using the least restrictive restraint. ADON confirmed the interventions to monitor R31 every 30 minutes when the restraint was in place and to release the restraint every two hours and during meal time had not been carried over from 4/9/14's care plan to the current care plan dated 5/29/14. The facility's Restraint Devices, Physical policy [undated] directed staff to develop or review resident care plan for type of restraint device, reason for use, monitoring of resident and frequency and length of time restraint device is released. No facility policy or procedure for care plan development, revision and review was provided. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 7/9/14 SS=E PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced bv: Based on observation, interview and document 1. Resident's 45 and 26 are receiving review, the facility failed to follow the resident's care per care plan for repositioning, and care plan for 2 of 2 residents (R45, R26) for incontinence care. Resident 39, is timely repositioning and incontinence care, for 1 receiving care per care plan for of 1 resident (R26) resident requiring assistance ambulation assistance and fluid with eating, for 1 of 1 resident (R39) reviewed for restriction. Resident 26, is receiving care dialysis with a fluid restriction, and for 1 of 1 per care plan for eating assistance. resident (R39) who required assistance with 2. Other residents are receiving care per

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X					(X3) DATE SURVEY COMPLETED		
		245323	B. WING	;		05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - W	ALKER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 12	F	282			
	nursing (ADON) sta checked every 2 ho	p.m. the assistant director of ated R45's brief was to be ours. The ADON verified the ollowed for incontinence care.					
	reposition R26 ever addition, R26's inco checked and chang	ed 12/4/13, directed staff to ry 2 hours and as needed. In intinence brief was to be jed and R26 was to be offered hours and as needed.					
	up and dressed, se propelling herself, v and into the hallway observed until 10:00	a.m. R26 was observed to be ated in a wheelchair and ria her feet, out of her room y. R26 was continuously 3 a.m. during which time she opel herself throughout the					
	not been toileted or	a.m. NA-C stated R26 had repositioned, to her pproximately 7:00 a.m. when ng cares.					
	her room by nursing	3 p.m. R26 was returned to g assistant NA-A and licensed N)-A for toileting and es.					
	was up in her chair until 10:00 a.m. with	B a.m. NA-A confirmed R26 from approximately 7:00 a.m. hout repositioning or toileting. 6 should have been checked very 2 hours.					
		2 a.m. DON stated she would have been toileted and					

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		AND HUMAN SERVICES				FORM	07/02/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING			05/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	No food or drink wa On 5/29/14, at 12:5 (RD) stated she had however, R26 refus had not "physically" if R26 had been off stated she did not k should have offered breakfast meal. On 5/29/14, at 1:01 did not eat much, h have provided her a On 5/29/14, at 1:11 served the breakfas She further stated F " and would not sta LPN-B verified she or drink for breakfas want any", R26 sai when asked, LPN-E attempted to offer F breakfast time. LPN should have been of FLUID RESTRICTI R39 was admitted of included end stage diabetes, hypertens Current physician of fluid restriction of 13 to provide 780 ml o 720 ml from meals to check meal tray, sheet and fluids giv	as offered to R26. 6 p.m. consulting dietician d offered R26 to eat, sed. The RD confirmed she ' assisted R26. When asked ered finger foods, the RD know. The RD stated staff d R26 food and drink for the p.m. LPN-C confirmed R26 owever, stated staff should a breakfast meal. p.m. LPN-B verified she had st meal in the dining room. R26 " absolutely would not eat had not offered R26 any food st and stated R26 "did not d no when offered. However, 8 confirmed she had not R26 any food or drink at N-B stated food probably offered.	F 2	82			

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 15 F 282 Dietary to send 240 ml/meal. Nursing no more than 260 ml/8 hour shift. Restriction is 1500/day. R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml, 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions. On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the ADON stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." The ADON verified the care plan was not followed for fluid restrictions.

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Facility ID: 00995

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PRINTED: 07/02/2014 FORM APPROVED OMB NO 0938-0391

		AND HUMAN SERVICES				FORM	0: 07/02/2014 APPROVED 0: 0938-0391	
				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245323	B. WING			05	/30/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOLDEN	LIVINGCENTER - W	ALKER			209 BIRCHWOOD AVENUE WEST PO BO NALKER, MN 56484	(700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ige 16	F 2	282				
	(DON) stated they s R39's excess fluid p restriction. The DO	0 p.m. the director of nursing should not be contributing to problem with his fluid N verified R39's plan of care wed for fluid restriction.						
	has a physical func impairment related improve current lev	dated 2/2/14, indicated R39 tioning deficit related mobility to weakness, with a goal to rel of physical functioning. were rehab therapy services						
	dated 2/21/14, indic ambulate 100-150 f Goal: Maintain curr	nmunication to Nursing form cated current functional status, feet with wheeled walker. ent level of mobility. Approach: belt and assist of one and <i>w</i> .						
	March 5, 2014 to M staff to ambulate R and follow with forw 125-150 feet as res	Records were reviewed from lay 30, 2014, and instructed 39 with gait belt, assist of one, vard wheeled walker. Ambulate sident allows one time a day to vel of mobility. The flow e following:						
	ambulate, 21 oppor	, out of 27 opportunities to rtunities were blank. For 6 of 39 was ambulated 70, 125, 80,						
	ambulate, 25 oppor	out of 30 opportunities to rtunities were blank. For 5 of 39 was ambulated 140, 100,						

If continuation sheet Page 17 of 54

		AND HUMAN SERVICES					FORM	07/02/2014 APPROVED 0938-0391
			· · /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245323	B. WING				05/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER	•		S	REET ADDRESS, CITY, STATE, ZIP (CODE		
GOLDEN	LIVINGCENTER - W	ALKER			9 BIRCHWOOD AVENUE WEST ALKER, MN 56484	PO BOX 7	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 17	F 2	82				
	ambulate, 28 oppor	out of 30 opportunities to rtunities were blank. For 2 of 39 was ambulated 76 and 60						
	restorative nursing "Sometimes he refu what days those are blanks indicated R3 services. NA-B was to R39 and ambula hallway, about 100 enough it is too war spouse was presen stated, "That is the ambulate since he	0 a.m. NA-B who provides services to R39 stated, uses but I could not tell you e." NA-B verified that any 39 did not receive ambulation s observed to apply a gait belt te from room and down feet. R39 stated, "That is rm in here today." R39's at during ambulation and first time I have seen him came here. But maybe they e when I am not here."						
	"[R39] should be re and if he is refusing he is not ambulating	4 a.m. the ADON stated, ceiving ambulation services, staff should be reporting that g." The ADON verified the ollowed for ambulation.						
	should be following and providing resto The NA should be r not ambulating. The	0 p.m. the DON stated, "Staff the resident's plan of care rative ambulation at ordered. reporting to me if a resident is a DON verified R39's plan of followed for ambulation.						
F 309 SS=D	provided.	vas requested but not CARE/SERVICES FOR EING	F 3	09				7/9/14

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		AND HUMAN SERVICES				FORM	07/02/2014 APPROVED 0938-0391
		. ,			(X3) DATE SURVEY COMPLETED		
		245323	B. WING			05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	provide the necessa or maintain the high mental, and psycho accordance with the and plan of care.	ge 18 receive and the facility must ary care and services to attain nest practicable physical, bsocial well-being, in e comprehensive assessment	F3	809			
	Based on observat review, the facility fa and follow fluid rest physician for 1 of 1 dialysis services. Findings include: R39's Diagnoses R R39's Diagnoses R R39's diagnoses in stage renal disease Data Set (MDS) dat moderate cognitive treatments, required ambulation in his ro staff assist for eatin had not ambulated Current physician of fluid restriction of 19 to provide 780 ml of 720 ml from meals to check meal tray, sheet and fluids giv fluids ingested each Dietary to send 240	tion, interview and document ailed to monitor fluid intake rictions as directed by the resident (R39) receiving eport dated 1/16/14, indicated ncluded diabetes with end a. R39 's quarterly Minimum ted 4/18/14, indicated R39 had impairment, received dialysis d limited staff assistance for bom and supervision with one ng. The MDS indicated R39 outside of his room. arders dated 4/23/14, indicated 500 milliliters (ml)/day. Nursing ver 3/shifts, dietary to provide (or 240 ml per meal). Nursing review intake and output en to resident. Total volume of n shift must be recorded. 0 ml/meal. Nursing no more shift. Restriction is 1500/day.			 Resident 39 fluid restrictions are monitored per physician order. There are currently no other residents on fluid restriction. If other residents receive a physician order for fluid restriction, a monitoring system will into place. Staff have been educated on the monitoring of residents on fluid restriQctions. Monitoring to ensure compliance completed by the DNS/Designee th random audits of the resident curre fluid restriction, and of any other rest that may be started on fluid restricti The results of these audits will be reviewed Monthly at the Quality Assurance Meeting. 	dents s be put will be rough ntly on sidents	

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 19 F 309 R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml. 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions. On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the assistant director of nursing (ADON) stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." She added, "We should not be providing two 720 ml water containers at bedside, that's almost twice what he should be getting from nursing." The ADON verified the care plan was not followed for

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	07/02/2014 PPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		(X3) DATE		
		245323	B. WING		05/3	0/2014
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W/	ALKER		09 BIRCHWOOD AVENUE WEST PO BOX 70 VALKER, MN 56484	00	
(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 B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa fluid restrictions.	-	F 309			
	(DON) stated they s R39's excess fluid p restriction. The DO	0 p.m. the director of nursing should not be contributing to problem with his fluid N verified R39's plan of care ved for fluid restriction.				
F 311 SS=D	provided.	licy was requested but not IMENT/SERVICES TO IN ADLS	F 311		2	7/9/14
	services to maintair	he appropriate treatment and o or improve his or her abilities ph (a)(1) of this section.				
	by: Based on observat review, the facility fa appropriate ambulation (R39) who required Findings include: R39's plan of care of has a physical func- impairment related improve current lev Interventions listed as ordered. R39's Therapy Com dated 2/21/14, indic	NT is not met as evidenced ion, interview and document ailed to provide the tion services to maintain or ability for 1 of 1 resident assistance with ambulation. dated 2/2/14, indicated R39 tioning deficit related mobility to weakness, with a goal to el of physical functioning. were rehab therapy services		 Resident 39 is receiving appropriambulation assistance per care plan Other residents that require assis with ambulation, are receiving assiss per care plan. Staff have been educated on provambulation assistance for residents care plan. Monitoring to ensure compliance completed by the DNS/Designee thr random direct care observations, that residents are receiving ambulation assistance per care plan. The result these audits will be reviewed Monthl the Quality Assurance Meeting. 	n. stance tance viding per will be rough at ts of	

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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 311 Continued From page 21 F 311 Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow. R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. On 5/30/14, at 10:00 a.m. nursing assistant (NA)-B who provides restorative nursing services to R39 stated, "Sometimes he refuses but I could not tell you what days those are." NA-B verified that any blanks indicated R39 did not receive ambulation services. NA-B was observed to apply a gait belt to R39 and ambulate from room and down hallway, about 100 feet. R39 stated, "That is enough it is too warm in here today." R39's spouse was present during ambulation and stated, "That is the first time I have seen him ambulate since he came here. But maybe they

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 311 Continued From page 22 F 311 are doing it at a time when I am not here." On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not provided. F 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312 7/9/14 DEPENDENT RESIDENTS SS=D A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced bv: Based on observation, interview and document 1. Resident 26 is receiving assistance review, the facility failed to provide assistance with eating per care plan. with eating for 1 of 1 resident (R26) who required 2. Other residents identified as needing assistance with eating for 1 of 2 dining assistance with eating, are receiving observations. eating assistance per care plan. 3. Staff have been educated on providing Findings include: eating assistance per care plan. 4. Monitoring to ensure compliance will be R26's quarterly Minimum Data Set (MDS) dated completed by the DNS/Designee through

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 312 Continued From page 23 F 312 2/24/14, indicated R26 had severe cognitive weekly random audits during meal times, impairment and required extensive assistance of that residents are receiving assistance per care plan. The results of these audits will one with eating. reviewed Monthly at the Quality R26's Diagnosis Report dated 2/20/14, indicated Assurance Meeting. R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff R26 required eating assistance of 1. The Change of Condition Nutrition Assessment dated 5/20/14, identified nutritional interventions to include: staff to assist and encourage resident at meals. On 5/29/14, R26 was continuously observed from 7:00 a.m. until 10:03 a.m. -At 7:00 a.m. R26 was observed in her own room, seated on the edge of a low bed. -At 7:07 a.m. R26 was observed to be up and dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. -At 7:45 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered food or beverage. -At 8:50 a.m. licensed practical nurse (LPN)-B stated R26 was resistive when staff try to feed her and usually did not eat so, "we just give her supplements." -At 9:12 a.m. R26 was observed to be in the

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 312 Continued From page 24 F 312 activity area watching the birds with a visitor -At 9:20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -At 9:30 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited with her 1:1. No food or drink was offered to R26. On 5/29/14, at 12:56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD stated staff should have offered R26 food and drink for the breakfast meal. On 5/29/14, at 1:01 p.m. LPN-C confirmed R26 did not eat much, however, stated staff should have provided her a breakfast meal. On 5/29/14, at 1:11 p.m. LPN-B verified she had served the breakfast meal in the dining room. She further stated R26 "absolutely would not eat" and would not stay still for long enough to eat. LPN-B verified she had not offered R26 any food or drink for breakfast and stated R26 "did not want any," R26 said no when offered. However, when asked, LPN-B confirmed she had not attempted to offer R26 any food or drink at breakfast time. LPN-B stated food probably should have been offered. On 5/29/14 at 1:16 p.m. the RD stated she could

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIP		(X3) DATE	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	B	COM	PLETED
		245323	B. WING			05/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ALKER			209 BIRCHWOOD AVENUE WEST PO BOX 70 WALKER, MN 56484	3OX 700	
(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 26	F 3	314	L		
	review, the facility f were identified at ri received timely rep assessed needs fo reviewed for position Findings include: R45's progress not R45 was admitted ulcer (PU) (full thick actual depth of the by slough and/or es right and left heel. I (partial thickness los shallow open ulcer without slough), an thickness tissue los visible but bone, te exposed. Slough m obscure the depth coccyx/sacral area notes indicated R4 healed. R45's significant cf (MDS) dated 4/25/ cognitive impairme R45 was diagnosed diabetes. The Activ Assessment (CAA) required extensive and transfers. Staff during cares for sign	tes dated 3/12/14, indicated with an unstageable pressure kness tissue loss in which ulcer is completely obscured schar in the wound bed) to the R45 also had three stage II oss of dermis presenting as a with a red pink wound bed, d an "almost" stage III (full ss. Subcutaneous fat may be ndon or muscle are not nay be present but does not of tissue loss), PUs on the . On 5/20/14, the progress 5's coccyx area remained hange Minimum Data Set 14, indicated R45 had severe nt. The MDS also indicated d with Alzheimer's disease and rity of Daily Living Care Area) dated 5/5/14, indicated R45 assistance with bed mobility f were to observe R45's skin gns of breakdown.			1. Residents 45,26 care plans have reviewed and revised for positioning assistance, and are receiving repositioning assistance per care pl 2. Other residents identified at risk f breakdown care plans have been reviewed and revised, and are receive repositioning assistance per care pl 3. Staff have been educated on proviepositioning for residents per care 4. Monitoring to ensure compliance completed by the DNS/Designee the random weekly audits of direct care observations that repositioning is be provided per care plan. The results these audits will be reviewed Month the Quality Assurance Meeting.	an. for skin iving an. viding plan. will be rough eing of	
	The Tissue Toleran	nce (ability of skin to withstand tion form dated 3/11/14,					

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 27 F 314 indicated R45 was at high risk for skin breakdown and required every two hour repositioning. R45's care plan dated 3/31/14, indicated R45 was to be repositioned hourly and as needed. The nursing assistant (NA) group care sheets indicated R45 was to be repositioned every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m. At 6:50 a.m. R45 was observed up in his wheelchair in the hallway. At 6:58 a.m. R45 was observed in the dining room. At 7:40 a.m. R45 wheeled himself from the dining room down the hallway towards his room. At 8:03 a.m. the director of nursing services (DNS) brought R45 into his room. From 8:08 a.m. until 9:12 a.m. R45 remained in his wheelchair in his room. At 9:12 a.m. R45's clip wheelchair alarm sounded and NA-A entered the room and opened the drapes. NA-A did not provide any cares for R45. At 9:20 a.m. R45 remained up in the wheelchair. At 9:25 a.m. R45 stated his bottom was sore from sitting up. At 9:36 a.m. NA-B and NA-C stood R45 with a gait belt and walker for few minutes to relieve pressure from bottom. The wheelchair was observed to have a cushion on the seat. At 9:39 a.m. NA-C stated R45 was to be repositioned every 2 hours. At 9:55 a.m. NA-C stated R45 was placed in the wheelchair at 7:55 a.m. according to her NA group sheet that she had written on. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m. (2 hours & 46 minutes since repositioning). NA-C stated they were "short" and there were only 2 NAs working on the floor as the third NA did baths and restorative/rehab for the residents.

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER WALKER, MN 56484** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 28 F 314 NA-C stated normally they track their own group of residents. NA-C stated she must have written the time done incorrectly for R45. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. At 11:25 a.m. NA-A removed R45's brief and a slight redness was noted behind R45's right thigh. NA-B stated the redness would be from being seated in the wheelchair. R45's skin on the buttocks/coccyx area was noted to be intact with no PU. NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing. At 1:15 p.m. the assistant director of nursing (ADON) stated she was not aware the NAs were working "short" today. The ADON stated there would normally be three NAs working the floor. and in addition, there would be a restorative/rehab NA. The ADON stated the last she knew R45 was to be repositioned every hour and as needed. The ADON stated the previous interim DNS wanted R45 to be on an every hour repositioning schedule, even though there was not a Tissue Tolerance Assessment which reflected hourly. On 5/30/14, at 11:13 a.m. the ADON stated R45 was at risk for PU development since he had been admitted with multiple PUs. The ADON verified the care plan was not followed for repositioning. The ADON added R45 had been on an hourly repositioning schedule since he was admitted, and she did not know why the NA group sheet read every 2 hours. In addition, the ADON

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 29 F 314 stated R45 should have been reassessed for PU development when his significant change MDS was completed on 4/25/14. The policy Clinical Guideline for Preventative Skin Care dated 4/24/06, indicated residents should be assessed for risk of skin breakdown when there was a change in their condition. R26's quarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility and transfer. R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff to monitor R26 for positional changes with staff assist of 1-2 with turning and repositioning every 2 hours and as needed for the prevention of pressure ulcers. The undated East Group 3 sheet directed staff R26 required assistance of one for turning and repositioning every 2 hours and as needed. On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. At 9:55 a.m. NA-C stated R26 had not been repositioned, to her knowledge, since

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 30 F 314 approximately 7:00 a.m. when she provided morning cares. At 10:03 p.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for repositioning. R26's brief was removed and skin was observed to be intact. On 5/29/14, at 11:33 a.m. NA-A confirmed R26 was up in her chair from approximately 7:00 a.m. until 10:00 a.m. without repositioning. NA-A confirmed R26 should have been checked and repositioned every 2 hours. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. A policy for turning and repositioning for the prevention of pressure ulcers was requested but none was provided. F 315 483.25(d) NO CATHETER, PREVENT UTI, F 315 7/9/14 **RESTORE BLADDER** SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary: and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document 1. Residents 26, 45 care plans have been

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			O	FORM. MB NO.	07/02/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		PLE CONSTRUCTION		E SURVEY PLETED
		245323	B. WING	;		05/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ALKER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	provide any cares. A in the wheelchair. A stood R45 with a ga pressure to R45's b checked. At 9:39 a. placed in the wheel surveyor told NA-C wheelchair at 6:50 a since toileting or ref NA-C stated R45 km bathroom so his bri was stood. At 11:03 a.m. NA-A sounded, she went he needed the toile NA-A stated her gro assist with toileting NA-A stated her gro assist with toileting NA-A stated R45 km bowel movement. N R45's answer when bathroom. RN-A sta checked since he w that morning. At 11:24 a.m. NA-A with the gait belt to R45 was placed in brief was changed of urine. At 11:25 a and R45 had been 35 minutes since the stated they were "s NA which was their stated when they an not have their own becomes confusing	At 9:20 a.m. R45 remained up t 9:36 a.m. NA-B and NA-C ait belt and walker to relieve bottom. R45's brief was not m. NA-C stated R45 was chair at 7:45 a.m. The that R45 was in the a.m. (2 hours & 46 minutes positioning). At 9:55 a.m. new when he needed the ef was not checked when he stated when R45's clip alarm in the room, and asked R45 if t. NA-A stated R45 said no. bup sheet directed staff to every 2 hours and as needed. new when he needed to have a NA-A stated they do accept a he stated he did not need the ated R45's brief had not been vas placed in the wheelchair and NA-B transferred R45 bed. NA-A stated right before the wheelchair at 6:50 a.m. his as R45 had been incontinent m. NA-A removed R45's brief incontinent of urine (4 hours & the last brief change). NA-A hort" a 6:00 a.m. to 10:00 a.m. busiest time of the day. NA-B re "short" then each NA does group of residents and it	F	315			

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 315 Continued From page 33 F 315 nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care. An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided. R26's guarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility, transfer, and toilet use. R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff to check and change R26 every two hours and as needed, as well as offer to toilet R26 every two hours and as needed for urge incontinence. The undated East Group 3 sheet directed staff R26 required toileting every 2 hours and as needed for incontinence. On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself out of her room and into the hallwav. On 5/29/14, at 9:55 a.m. NA-C stated R26 had not been toileted, to her knowledge, since approximately 7:00 a.m. when she provided morning cares. R26 was continuously observed until 10:03 a.m.

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 315 Continued From page 34 F 315 during which time she was observed to propel herself throughout the facility. At 10:03 a.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for toileting and repositioning services. NA-A reported R26's incontinence brief was wet and stated R26 was to be toileted every two hours and as needed. NA-A indicated R26 was last toileted at approximately 7:10 a.m. according to her care sheet. On 5/29/14 at 11:33 a.m. NA-A confirmed R26 was up in her wheelchair from approximately 7:00 a.m. until 10:00 a.m. without repositioning or toileting. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided. F 329 483.25(I) DRUG REGIMEN IS FREE FROM F 329 7/9/14 UNNECESSARY DRUGS SS=D Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a

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		AND HUMAN SERVICES				FORM	07/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	nge 35 r must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical the who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F	329			
	by: Based on interview facility failed to ensi- interventions were a administering an ar (Lorazepam) for 1 of drug regimen was r Findings include: R45's significant ch (MDS) dated 4/25/1 cognitive impairmen R45 was diagnosed diabetes. R45 was on 4/18/14, diagnos the physician's orde The care plan dated history of anxiety ar The Behavior Mont	hti-anxiety medication of 5 residents (R45) whose reviewed. hange Minimum Data Set 14, indicated R45 had severe nt. The MDS also indicated d with Alzheimer's Disease and admitted to hospice services sed with failure to thrive per			 Resident 45 medication regiment been reviewed, to include non pharmacological interventions. Other resident's drug regimen reare are being followed to include non pharmacological interventions. Staff have been educated on attempting non pharmacological interventions prior to the initiatino of psychoactive medication. Monitoring to ensure compliance completed by the DNS/Designee th weekly audits of current and new medication orders. The results of th audits will be reviewed at the Month Quality Assurance Meeting. 	views f a will be rough nese	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/02/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	a generalized anxie The current Physici read, Lorazepam 0. hours as needed fo administration try no interventions first: (stimulation (2) Hand address pain, toileti hot/cold (4) then try According to the me records for April and received the Loraze 5/8/14, 5/14/14, 5/1 On 5/29/14, at 1:53 nursing (ADON) sta nurses do not docu that they tried the n interventions prior t ADON stated the ne on the Behavior Mo non-pharmacologic the Lorazepam adm On 5/30/14, at 11:19 was no documentat the Lorazepam on s non-pharmacologic prior. At 11:53 a.m. nursir would ask for his m	 by disorder. an's Orders dated 5/28/14, 5 milligrams (mg) every 8 r anxiety or agitation. Prior to on-pharmacological 1) Remove resident from d massage (3) Unmet need, ing, hunger/thirst, is resident the Lorazepam. edication administration d May 2014, MAR, R45 epam on 4/14/14, 4/27/14, 7/14, 5/20/14, and 5/26/14. p.m. the assistant director of ated 90% of the time the ment in the progress notes on-pharmacological o giving the Lorazepam. The urses should be documenting onthly Flow Sheets the al interventions tried prior to ninistration. 5 a.m. the ADON stated there tion that prior to R45 receiving seven occasions that al interventions were tried 	F 3	29			
	On 5/29/14, at 1:53 nursing (ADON) sta nurses do not docu that they tried the n interventions prior t ADON stated the nu on the Behavior Mo non-pharmacologic the Lorazepam adm On 5/30/14, at 11:14 was no documentat the Lorazepam on s non-pharmacologic prior. At 11:53 a.m. nursir would ask for his m change clothes to g	 p.m. the assistant director of ated 90% of the time the ment in the progress notes on-pharmacological o giving the Lorazepam. The urses should be documenting onthly Flow Sheets the al interventions tried prior to ninistration. 5 a.m. the ADON stated there tion that prior to R45 receiving seven occasions that al interventions were tried ng assistant (NA)-A stated R45 other, and would be looking to go to a wedding or a funeral. bulk be able to re-direct R45 					

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 37 F 329 The undated Behavior Management policy directed staff to use non-pharmacological interventions, prior to considering initiation of any psychoactive medications. 483.30(e) POSTED NURSE STAFFING F 356 F 356 7/9/14 INFORMATION SS=C The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request. make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

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		AND HUMAN SERVICES			FORM	07/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING		05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W	ALKER		09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	Continued From pa	ige 38	F 356			
	by:	NT is not met as evidenced tion, interview, and document		1. The system for posting of nursir	ng	
	information on the r the potential to affe	ailed to post the required nurse staff posting. This had ct all 28 residents residing in nembers and any visitors who nformation.		 hours has been reviewed and revis 2. The required information for nurs hours is posted daily. 3. Staff have been educated on the current requirements for posting of 	sing	
	Findings include:			nursing hours. 4. Monitoring to ensure compliance completed by the DNS/Designee th		
	wall across from the 5/27/14. However, to documented. The se actual hours worker Evening shift, and N indicated there was (LPN) on duty for 12 indicated for the LP	p.m. the nurse posting on the e nurses station was dated the facility's census was not shifts were not delineated for d. The posting read, Day shift, Night shift. The Day shift one licensed practical nurse 2 hours. There were no hours N on the Evening shift. There nurse (RN) hours indicated for shift.		completed by the DNS/Designee th daily audits of the posted hours. Th results of these audits will be review Monthly at the Quality Assurance N	e ved	
	indicated the Day s p.m., the Evening s p.m. and the Night a.m. The Day shift 2 LPNs for 22 hours	a.m. the nurse posting hift was 6:00 a.m. to 2:00 hift was 2:00 p.m. to 10:00 shift was 10:00 p.m. to 6:00 indicated one RN for 6 hours, s, and 2 nursing assistants The Evening shift read 2				
	not dated and there	a.m. the nurse posting was was no facility census as one RN indicated with no ied.				
	On 5/30/14, at 9:39	a.m. the nurse posting				

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245323 ALKER		S S	LE CONSTRUCTION	FORM OMB NC (X3) DA CO 05	D: 07/02/2014 M APPROVED D. 0938-0391 TE SURVEY MPLETED 5/30/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 356	indicated one RN for On 5/30/14, at 9:39 services (DNS) state on the nurse postin postings were revie -5/30/14, the DNS state accurate as there we hours, and the post The DNS stated the responsible for post nursing schedule. The DNS stated the nursi assistant director of RN was designated schedule. The DNS not know the ADON DNS stated the Eve accurate as it indicated DNS was on duty for -The DNS stated the to 2:00 p.m. as the shifts would be 8:00 a.m. to 5:00 p.m. - The DNS verified indicated for the Da stated she was on of assessment RN, we hours. The DNS stated the to RN hours indicated DNS stated the ADON and the DNS worke -The DNS stated she was on of and the DNS worke -The DNS stated she and the DNS stated she and and the DNS worke -The DNS stated she and and the DNS worke	a.m. the director of nursing ted she did not include herself g. The four days of nurse wed with the DNS. stated the posting was not vere 2 RNs on duty for 16 ing indicated 1 RN for 6 hours. e night nurse would be ting the hours according to the The DNS stated she did not put ng schedule. In addition, the f nursing (ADON) who was an d as "other" on the nursing 5 stated the night nurse would J was the RN on duty. The ening shift for 5/30/14, was not ated 1 RN for 2 hours, and the or part of the Evening shift. the RNs did not work 6:00 a.m. posting indicated, as their 0 a.m. to 4:00 p.m. or 9:00 there were no RN hours ay shift on 5/27/14. The DNS duty along with the hich would be 2 RNs for 15 ated the night nurse would not formation. There were no LPN we for the Evening shift. The ON would be 2 hours on duty ed 8 hours. ne would be adjusting the ne NAs work 10:00 p.m. to ght shift, and the nurse works		356			

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245323	B. WING _		05/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/	ALKER		209 BIRCHWOOD AVENUE WEST PO BOX 70 WALKER, MN 56484	00	
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	Continued From pa	ge 40	F 35	6		
F 364 SS=E	indicated the follow posted on a daily bas shift. -Center/location nat -Current date -Total number and a licensed and unlice resident care, includ -Resident census 483.35(d)(1)-(2) NL PALATABLE/PREFI Each resident recei food prepared by m value, flavor, and ap palatable, attractive temperature. This REQUIREMEN by: Based on observat	actual hours worked by nsed staff responsible for ding RNs, LPNs and CNAs. JTRITIVE VALUE/APPEAR, ER TEMP ives and the facility provides nethods that conserve nutritive ppearance; and food that is	F 36	4 1. Residents 9, 6, 16, 11, 14,18, 33 10, 8, 15, 61, 29, 26, 22, 38 are all	3, 45,	7/9/14
	palatable and at the (R38, R18) resident interviewable, and f R16, R11, R14, R33 R29, R26, R22) wh interviewable, and v main dining room. I serve eggs prepare	e right temperature for 2 of 2 ts in the dining room who were for 14 of 14 residents (R9, R6, 3, R45, R10, R8, R15, R61, o were identified as not who received their meals in the n addition, the facility failed to ed to a resident's request for 1 who ate breakfast in their room.		 receiving food that is palatable and right temperature. Resident 9 is receiving food that is palatable and right temperature. Resident 9 is receiving foo is palatable and at the right temperature. 2. Other residents are receiving foo is palatable and at the right temperature. The facility system of monitoring dir services has been reviewed and rev. 3. Staff have been educated on promeals that is palatable and at the right temperature. The Registered Dietitic going to conduct a Food Council for residents to participate in. Dining Services and the residents to participate in. 	eiving od that ature. ning vised. viding ght an is r	

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		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245323	B. WING		05/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GOLDEN	I LIVINGCENTER - W	ALKER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	D BOX 700	
(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 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 364	Continued From pa	age 41	F 364	4		
	observed in the din residents that were dining room, and 1 on the other half of On 5/27/14, at 5:29 The menu was tun bread, and green b "And that was supp R38 stated, "I had cafeteria." R38 stat made from "scratch they did not know v to request. At 5:40 p.m. the su tray to eat the mea casserole, the garli green beans and c At 5:46 p.m. the co to put the alternate was ham/potatoes. for tuna and she ha casserole. At 5:55 meat sandwiches s tuna in the cassero On 5/29/14, at 8:37 wheelchair eating to served two fried eg "hII" out of the eg eggs over easy an were observed to b	 P.m. the meal was served. a casserole, a slice of garlic beans. At 5:37 p.m. R18 stated, bosed to be garlic toast?" better food in the high school ted the tuna casserole was not h." Both R18 and R38 stated what the alternative meal was rveyor requested a sample I. There was no tuna in the ic toast was tough, and the asserole were tasteless. bok (C)-A stated she had forgot meal on the board, however, it C-A stated the recipe called ad forgot to put the tuna in the p.m. C-A offered the residents since she had forgot to put the le. Y a.m. R9 was up in his breakfast in his room. R9 was tous and the gs. R9 stated he would like his ind not over done. The eggs 		comment cards are available room tables. 4. Monitoring to ensure com completed by the ED/Design random weekly audits of the review of Food Council and Council Minutes, and comment The results of these audits a will be reviewed at the Month Assurance Meeting.	pliance will be lee through dining room, Resident ent cards. nd reviews	

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 364 Continued From page 42 F 364 toast was very tough and there was no taste of garlic on it. R38 stated the green beans were tasteless. R38 stated they have brought up the food concerns in resident council for months. R38 stated everybody's biggest complaint was the food, and instead of it getting better it was getting worse. The Dining Experience policy dated 2011, indicated food would be flavorful and attractive. The Food Service Distribution policy dated 2011, indicated food would be served in an attractive and appetizing manner. In addition, milk would be tested for correct temperature of 41 degrees Fahrenheit (F) or below. On 5/30/14, at 11:16 p.m. the director of nursing services (DNS) confirmed her expectations regarding dining experience was for the meals to be served hot, on time, and appealing to look at as we "eat first with our eyes". 483.35(i) FOOD PROCURE, F 371 F 371 7/9/14 STORE/PREPARE/SERVE - SANITARY SS=F The facility must -(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 1. Residents are receiving food in a

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		E & MEDICAID SERVICES	.				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245323	B. WING			05/	30/2014	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	ALKER			BIRCHWOOD AVENUE WEST PO BO LKER, MN 56484	BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 371	Continued From pa	age 43	F 3	571				
	sanitary manner. T all 28 residents res from the facility. Findings include: On 5/29/14, at 11:5 service observation wash her hands ar bucket containing a liquid solution was With the same glow to lift the green clo the food thermom the cloth back into area and insert the Once the casserold C-A returned to the process of wiping t putting the cloth bac C-A repeated this p temperature of the the liquid was a sa sanitize the probe that was how she w - At 12:07 p.m. the entered the kitcher sanitizing liquid wit appropriate for use and would have to observed to contin with probe with the same gloved hand			f c r a b	sanitary manner. 2. Staff have been educated on pood in a sanitary manner. 3. Monitoring to ensure complian completed by the ED/Designee to and service. The results of food provide the service of the above reviewed at the Monthly Qual Assurance Meeting.	ice will be hrough eparation udits will		
	was observed to have	RD returned to the kitchen and and C-A a box of alcohol wipes o use the prepackaged,						

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 44 F 371 individual wipes to clean the probe with in between each food item. With the same gloved hands, C-A was observed to remove a wipe from the box, tear a corner off, and insert the probe into and through the package, withdrew it and obtained the temperature of the picante sauce. C-A was observed to repeat this process prior to obtaining the macaroni salad temperature. -At 12:15 the RD was observed sorting through individual resident menu sheets that were laying on the service counter in the kitchen, the RD was not observed to wash her hands upon entering the kitchen or prior to handling the resident menu sheets. The RD was observed writing notes on the resident menu sheets. With the same gloved hands, C-A was observed to sort through the same individual resident menu sheets. The RD exited the kitchen. -At 12:26 p.m. The RD returned to the kitchen with a policy titled, Food Thermometer Guidelines. The policy directed staff to wash, rinse, sanitize and air-dry the thermometer before each use. The policy also indicated a sanitizing mixture or a alcohol fabric wipe could be used for food-contact surfaces. However, the policy also indicated if a sanitizing solution was used, the thermometer must soak in the solution for one minute and allowed to air dry in between each use. -At 12:28 p.m. C-A was observed to remove the gloves, wash her hands and donned a clean pair of gloves. C-A was observed to pick up the same individual resident menu sheets and sorted them into piles. With the same gloved hands, C-A was observed to dish up the taco casserole from the pan using a spatula. Once the casserole was on

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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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 46 F 371 facility policies were not followed. The facility's undated Dining Services Hand Washing policy directed staff to wash their hands upon entering the dining service department, before food handling, preparation or service and after handling any soiled or contaminated equipment or cleaning cloths. -At 2:05 p.m. The director of nursing (DON) confirmed the facility's policy was not followed and stated food items should not be handled using unclean gloved hands. F 441 483.65 INFECTION CONTROL, PREVENT F 441 7/9/14 SS=F SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a

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FORM APPROVED

		AND HUMAN SERVICES				FORM	07/02/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			05/3	30/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W/	ALKER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must har transport linens so a infection. This REQUIREMEN by: Based on interview facility failed to anal resident and emplo potential to affect al the facility. Findings include: Review of the facilit revealed a system of program with ongoi of infections and inf of Resident Infectio and 05/14, revealed prescribed antibiotics. for employee infect surveillance betwee illnesses had not be	A sea or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted be. ndle, store, process and as to prevent the spread of NT is not met as evidenced w and document review, the lyze patterns and trends of yee infections. This had the II 28 residents who resided in ty's infection control program which lacked a surveillance ing analysis and interpretation fection risks. The Line Listing ons for 02/14, 03/14, 04/14, d only infections with cs were tracked. The facility's eked trending of infections In addition, a tracking system ions and comparison en resident and employee	F 4	.41	 The facility has reviewed and reviewed system for tracking, trending an analyzing infections for residents ar employees. Residents and employees have t potential of being affected. Staff ahve been educated on the system for tracking, trending and analyzing infections of residents an employees. Monitoring to ensure compliance completed by the DNS/Designee th audits of resident and staff infection at clinical start up. The results of the audits will be reviewed Monthly at the Quality Assurance Meeting. 	nd he he will be iough hs daily e	

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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 245323 **B** WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 48 F 441 control program was reviewed with the director of nursing services (DNS). The DNS stated she ran a daily report of residents who were prescribed antibiotics and entered the information onto the Line Listing of Resident Infections form. Information included on the Line Listing of Resident Infections included: resident name, room number, date of birth, admission date, type of infection, symptoms/date, cultures, treatment, other actions if needed and whether the infection was healthcare associated or community acquired. She also stated that, at times, floor nursing staff would notify her of residents prescribed antibiotics to be added to the list. The DNS indicated she then followed those residents on the list and coordinated with physicians and staff to ensure progress was made toward resolution of the infection. The DNS verified she had not been monitoring infections without a prescribed antibiotic and confirmed there was no analysis for trends in resident infections. The DNS indicated she did not gather data for tracking and trending of employee infections and confirmed there was no analysis or comparison of resident and employee infections completed. The Surveillance for Healthcare-Associated Infections policy dated 2001, indicated the infection control coordinator or designated infection control personnel was responsible for gathering and interpreting surveillance data and analyzing the data to identify trends. A policy regarding the tracking of employee infections was requested but none was provided. F 465 483.70(h) F 465 7/9/14 SAFE/FUNCTIONAL/SANITARY/COMFORTABL SS=F E ENVIRON

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/02/2014 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	0938-0391 SURVEY PLETED
		245323	B. WING		05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - W/	ALKER		09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	sanitary, and comforresidents, staff and This REQUIREMEN by: Based on observatifailed to maintain the wall, flooring and pl maintained manner affect all 28 residen Findings include: During the kitchen the with dietary aide (D dishwashing counter crumbling material the wall. Rust was a floor within the same the wall connecting attached to the dish observed rusty and leaking from the pip two feet by 3 feet we stated the area sme odor was "so strong also stated the area after maintenance for DA-A verified the we uncleanable. At 2:20 p.m. the add	ovide a safe, functional, ortable environment for	F 465	 The facility has reviewed and re the kitchen cleaning systems. Bids being obtained to repair or replace wall behind the dishwasher. Staff a being inserviced on proper disposa food left on plates and the proper u the garbage disposal. The kitchen is functioning in a cle environment. Staff have been educated on the kitchen cleaning systems/processe Monitoring to ensure compliance completed by the ED/Designee thro weekly random audits of the kitchel cleanliness. The results of these au will be reviewed at the Monthly Qua Assurance Meeting. 	are the re l of se of ean s. e will be ough n for udits	
	At 2:33 p.m. during	an interview maintenance ed the findings and stated the				

If continuation sheet Page 50 of 54

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		<u>VO. 0938-039</u> DATE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		245323	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	·	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ALKER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	700	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 465	disposal properly a	f not rinsing the garbage fter use. In addition, M-A and floor areas were problems	F 465			
F 492 SS=F	483.75(b) COMPLY		F 492		7/9/14	
	compliance with all local laws, regulation accepted profession	perate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles ssionals providing services in				
	by: Based on interview facility failed to ens service agency (SN properly registered commissioner as re to affect all 28 resid facility. Findings include: During the entrance 1:50 p.m. the admin nursing services (D utilized the 360 Hea provide nursing cov On 5/28/14, at 10:0 verified by the curre Health's Directory of	NT is not met as evidenced v and document review, the ure the supplemental nursing ISA) utilized by the facility was with the Minnesota equired. This had the potential dents who resided in the e conference on 5/27/14, at nistrator and director of DNS) confirmed the facility althcare Staffing agency to verage. D5 a.m. the administrator ent Minnesota Department of of Registered Supplemental gencies (SNSA's) that the 360		 The nurse in question is an employe of the facility. The facility ensured that the supplemental nursing agency is proper registered with the Minnesota Commissioner. Staff educated on the requirement of ensuring that Supplemental Nursing Agencys used in the facility must be registered with the Commissioner. Monitoring to ensure compliance will completed by the (FSCD) (Field Servic Clinical Director) by checking the DHS website to ensure that any Supplement Nursing Agencies are registered with th Commissioner. 	be es	

If continuation sheet Page 51 of 54

PRINTED: 07/02/2014

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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 492 Continued From page 51 F 492 approved agencies listed. The administrator confirmed registered nurse (RN)-C was currently working full time at the facility. On 5/28/14, at 2:55 p.m. the administrator verified RN-C's hire date at the facility was 5/8/14. 483.75(o)(1) QAA F 520 F 520 7/9/14 COMMITTEE-MEMBERS/MEET SS=F QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the

FORM CMS-2567(02-99) Previous Versions Obsolete

by:

compliance of such committee with the

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as

This REQUIREMENT is not met as evidenced

Based on interview and document review, the

requirements of this section.

a basis for sanctions.

1. The facility has Quality Assurance

If continuation sheet Page 52 of 54

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 245323 B. WING 05/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 520 Continued From page 52 F 520 facility failed to ensure the quality assessment Committee meets Monthly to develop and and assurance (QAA) committee met as required implement Quality Improvement and developed and implemented a quality Programs. improvement program for the facility. This had 2. Staff have been educated on the the potential to affect all 28 residents who resided requirement of conducting Quality Assurance Meetings Monthly, who is to be in the facility. in attendance, and of Quality Assurance Programs that have been indentified. Findings include: 3. Monitoring to ensure compliance will be On 5/29/14, at 10:50 a.m. the director of nursing completed by the FSCD (Field Services services (DNS) provided a list of dates and the Clinical Director) by reviewing Quality attendance list for the facility's quality assurance Assurance Meetings are being held, and committee meetings. The only meeting date that Quality Assurance Programs are listed over the past year was 4/3/14. being implemented. On 5/30/14, at 11:06 a.m. the DNS verified the facility's quality assurance committee had only met once over this past year on 4/3/14. The DNS confirmed she was unaware of the facility's quality assurance programs past processes for identifying areas for improvement and developing action plans as she was new to this role. On 5/30/14, at 11:42 a.m. nursing assistant (NA)-A confirmed she was unaware of any guality improvement or quality assurance initiatives the facility was working on. On 5/30/14, at 11:49 a.m. cook (C)-A confirmed she was unaware of any quality improvement or quality initiatives the facility was working on. On 5/30/14, at 11:58 a.m. NA-D confirmed she was unaware of any quality improvement or guality assurance initiatives the facility was working on. On 5/30/14, at 12:02 p.m. licensed practical nurse (LPN)-A confirmed she was unaware of any

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 53 of 54

		AND HUMAN SERVICES				FORM	07/02/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245323		B. WING			05/30/2014			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOLDEN	LIVINGCENTER - W	ALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 520	A policy related to the improvement program	t or quality assurance y was working on. he facility's quality am outlining the frequency of a charter for the program was	F	520				

Facility ID: 00995

DEPART	MENT OF HEALTH	AND HUMAN SERV	ICES	Ŧ	10		06/02/2014 APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERV	ICES		5323023		. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIED IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
24532				B. WING		05/28/2014	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	I I I I I I I I I I I I I I I I I I I			
GOLDEN	LIVINGCENTER -	WALKER		RCHWOOI ER, MN 56	D AVENUE WEST PO BOX 700 3484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS			K 000			
	FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Living Center of Walker was found 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. This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones.						
	fire sprinkler system NFPA 13 Standard f Systems (1999 editi heads. The facility h smoke detection in the corridor system installed in accordar National Fire Alarm	ected by a complete installed in accordator for the Installation of ion) with quick responses a fire alarm system the corridors, spaces and in common area ance with NFPA 72 "T Code" (1999 edition natic fire department	nce with Sprinkler nse em with s open to as that is he), which is				
	The facility has a ca	pacity of 42 beds an	d had a				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG				NATURE	TITLE		(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.

	MENT OF HEALTH					*	FORM	06/02/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED			
245323			B. WING			05/28/2014		
			DRESS, CITY, STATE, ZIP CODE					
GOLDEI	N LIVINGCENTER -	WALKER		ER, MN 56		BOX 700		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
K 000	Continued From pa census of 28 at the			K 000				
	The requirement at MET.	42 CFR, Subpart 48	3.70(a) is		£			
×								
								2
		reione Obselate			522721			heet Page 2 of 2



Protecting, Maintaining and Improving the Health of Minnesotans Electronically Delivered: June 17, 2014

Mr. Dan Stockdale, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5323023

Dear Mr. Stockdale:

The above facility was surveyed on May 27, 2014 through May 30, 2014 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 - Walker June 17, 2014 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Are Klegge

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

Minnesc	ota Department of He	ealth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	60/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA		HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of fithe Minnesota Depu- Determination of with corrected requires of requirements of the number and MN Rec When a rule contait comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic onsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 06/30/14

Electronically Signed

STATE FORM

If continuation sheet 1 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - W		SIRCHWOOD AVE	NUE WEST PO BOX 700			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000		age 1 alth orders being submitted t	2 000				
	you electronically. is necessary for Sta enter the word "cor text. You must ther State licensure pro completion date, th	Although no plan of correct ate Statutes/Rules, please rected" in the box available n indicate in the electronic cess, under the heading he date your orders will be electronically submitting to th	ion for				
	this Department's s and the following c Please indicate in y correction that you	, 29th, 30th, 2014, surveyor staff, visited the above provi orrection orders are issued. your electronic plan of have reviewed these orders te when they will be completed	der S,				
	the State Licensing federal software. Ta	nent of Health is documenti g Correction Orders using ag numbers have been sota state statutes/rules for	ng				
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far le D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statu t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.	e ite				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF TH N WHICH STATES, AN OF CORRECTION." TH ERAL DEFICIENCIES ONL' AR ON EACH PAGE.	IIS				

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/		HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 005	MN Rule 4658.001 REGULATIONS AN	5 COMPLIANCE WITH ID STANDARDS	2 005			7/9/14
	services in complia state, and local law and with accepted p	st operate and provide ance with all applicable federal, s, regulations, and codes, professional standards and v to professionals providing ng home.				
	by: Based on interview facility failed to ensiservice agency (SN properly registered commissioner as re	ent is not met as evidenced and document review, the ure the supplemental nursing SA) utilized by the facility was with the Minnesota equired. This had the potential lents who resided in the		Corrected.		
	Findings include:					
	1:50 p.m. the admir nursing services (D	e conference on 5/27/14, at histrator and director of NS) confirmed the facility althcare Staffing agency to rerage.				
	verified by the curre	5 a.m. the administrator ent Minnesota Department of f Registered Supplemental				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/	05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	AIKFR	HWOOD AVEI MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 005	Continued From pa	ge 3	2 005				
	Healthcare Staffing approved agencies confirmed registere working full time at On 5/28/14, at 2:55	gencies (SNSA's) that the 360 LLC was not one of the listed. The administrator d nurse (RN)-C was currently the facility. p.m. the administrator verified the facility was 5/8/14.					
	SUGGESTED MET	HOD OF CORRECTION:					
	could develop a sys state regulations ar supplemental nursi Quality Assessmen	sing (DON) and/or designee stem to assure appropriate e in compliance with ng service agency. The t and Assurance (QAA) o random audits to ensure					
	TIME PERIOD FOR	R CORRECTION:					
	Twenty-one (21) da	ys.					
2 255	MN Rule 4658.0070 Assurance Commit) Quality Assessment and tee	2 255			7/9/14	
	assessment and as of the administrator services, the medic designated by the n three other membe representing discipl resident care. The assurance committ respect to which qu necessary and deve appropriate plans o	ist maintain a quality surance committee consisting the director of nursing al director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement f action to correct identified The committee must					

Minnesc	ta Department of He	alth			-	-
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		HWOOD AV	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From pa	ige 4	2 255			
		num, incident and accident control, and medications and				
	by: Based on interview facility failed to ens and assurance (QA and developed and improvement progr	ent is not met as evidenced and document review, the ure the quality assessment A) committee met as required implemented a quality am for the facility. This had ct all 28 residents who resided		Correction in progress.		
	Findings include:					
	services (DNS) pro attendance list for t	0 a.m. the director of nursing vided a list of dates and the he facility's quality assurance s. The only meeting date year was 4/3/14.				
	facility's quality ass met once over this confirmed she was quality assurance p identifying areas for	6 a.m. the DNS verified the urance committee had only past year on 4/3/14. The DNS unaware of the facility's programs past processes for r improvement and developing was new to this role.				
	(NA)-A confirmed s	2 a.m. nursing assistant he was unaware of any quality ality assurance initiatives the on.				
	she was unaware o quality initiatives the	9 a.m. cook (C)-A confirmed of any quality improvement or e facility was working on.				
		8 a.m. NA-D confirmed she				
Minnesota D STATE FOR	epartment of Health M		6899	S33Z11	lf continuati	on sheet 5 of 62

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		05/	05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
GOLDEN	LIVINGCENTER - W		R, MN 56484	NUE WEST PO BOX 700			
(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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 255	Continued From pa	age 5	2 255				
		y quality improvement or nitiatives the facility was					
	(LPN)-A confirmed	D2 p.m. licensed practical nurse she was unaware of any nt or quality assurance by was working on.	e				
		ram outlining the frequency of a charter for the program was					
	SUGGESTED ME	THOD OF CORRECTION:					
	could develop and quality improvement improvement educ Assessment and A	sing (DON) and/or designee implement a facility wide nt program, including quality ation to staff. The Quality ssurance (QAA) committee udits to ensure compliance.					
	TIME PERIOD FO	R CORRECTION:					
	Twenty-one (21) da	ays.					
2 505	MN Rule 4658.030 Restraints	0 Subp. 1 A-E Use of	2 505			7/9/14	
		ons. For purposes of this part s have the meanings given.	,				
	method or physica material, or equipn the resident's body	straints" means any manual l or mechanical device, nent attached or adjacent to that the individual cannot ch restricts freedom of					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		05/30/2014	
	ROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	50/2014
		209 BIR		NUE WEST PO BOX 700		
OLDEN	LIVINGCENTER - W		R, MN 56484			
X4) ID REFIX 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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 505	Continued From pa	age 6	2 505			
	Physical restraints leg restraints, arm or vests, and whee restraints also inclu definition of a restra so tightly that a res move; bed rails; ch placing a resident i wall that the wall pr rising. Bed rails ar restrict freedom of used solely to assis help the resident gu is not used as a res on clothing that trig staff that a resident not, in and of them movement and sho restraints. B. "Chemical r psychopharmacolo discipline or conver- treat medical symp C. "Discipline" nursing home for th penalizing a reside D. "Convenien solely to control res- resident with a less in the resident's be E. "Emergency immediate action r unexpected situation serious and urgent	means any action taken by the ne purpose of punishing or nt. ce" means any action taken sident behavior or maintain a ser amount of effort that is not st interest. / measures" means the necessary to alleviate an on or sudden occurrence of a	t			
	by:	ion, interview and document		Corrected.		
	epartment of Health					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00995	B. WING	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 505	Continued From pa	age 7	2 505				
	restrictive restraint amount of time as	failed to ensure the least device was used for the least necessary for 1 of 1 resident e who utilized a physical p buddy).					
	Findings include:						
	identified R31's dia	ary report dated 4/24/14, agnosis as Parkinson's disease inations, anxiety, and e weakness.	Э,				
	4/14/14, indicated impairment and re-	nimum Data Set (MDS) dated R31 had severe cognitive quired extensive assist with ing, eating and toileting.					
	SCREENING FOR type of restraint/de buddy (a thick cusl lap and is secured wheelchair, which to remove themsel was also identified	RESTRAINT/DEVICE M dated 4/9/14, indicated the vice recommended was a lap hion that fits over a resident's to the armrests of the can restrict the residents' abilit ves from the wheelchair). R3 as not being able to ove the restraint on command	Í				
	check on R31 ever buddy (restraint) w	ted 4/9/14, directed staff to ry 30 minutes when the lap ras in place, release the hours and at meal time when vision of staff.					
	wheeled into the di secured to her whe observation from 1 R31 was continuou	46 p.m. R31 was observed ining room with the lap buddy eelchair. During the noon mea 2:46 p.m. through 1:30 p.m. usly observed and the lap cured to R31's wheelchair. At					

Minneso	ta Department of He	alth			-	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 505	Continued From pa	ge 8	2 505			
	nursing assistant (N observed to be sea assisted residents v	d practical nurse (LPN)-A, NA)-A and NA-B were ted at R31's table as they with their meals.				
	lap buddy had rema meal. LPN-A state have removed the l although she had o	ined secured during the noon d if it was up to her she would ap buddy during meal times, nly seen it on R31.				
	nursing (ADON) co considered a restra expectation was for	p.m. the assistant director of nfirmed R31's lap buddy was int. The ADON verified her R31's lap buddy to be al time as the facility should estrictive restraint.				
	services (DNS) con be off at meal times	3 a.m. the director of nursing firmed R31's lap buddy should s and the facility should be rictive type of restraint for the e.				
	[undated] specified	aint Devices, Physical policy the goal should be for raint or use of the less				
	SUGGESTED MET	HOD OF CORRECTION:				
	could review or revi for staff regarding p Quality Assessmen	sing (DON) and/or designee ise policies, provide education ohysical restraint use. The t and Assurance (QAA) o random audits to ensure				
Minnocata D		R CORRECTION:				
viinnesota D	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
2 505	Continued From pa	age 9	2 505			
	Twenty-one (21) da	ays.				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		7/9/14	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The must include the in	of plan of care. The n of care must list measurabl stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention pla sota Statutes, section 626.557 agraph (b).	n			
	by: Based on interview facility failed to dev measurable goals a the care and treatm	ent is not met as evidenced and document review, the relop a care plan with and interventions to address ment of Clostridium Difficile 1 of 1 resident (R22) with the	9	Initiated/in progress/ongoing.		
	Findings include:					
	extensive assist of toileting. The MDS	4/18/14, indicated R22 require one for bed mobility and included diagnoses of multipl infections due to c-diff, atrial ertension.				
	following medicatio treat range of bacte	dated 5/1/14, indicated the ons: Vancomycin (antibiotic to erial infections) 125 milligrams hours and Loperamide two	5			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING	B. WING		05/30/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
BOLDEN	I LIVINGCENTER - W		RCHWOOD AVE ER, MN 56484	NUE WEST PO BOX 700			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 560	Continued From pa	age 10	2 560				
	related to intestinal orders included to night shift and follo continues, and infe	mouth in evening for diarrhea infections due to c-diff. The monitor stools every day and w up as needed if diarrhea ections disease consult in urinary tract infections and					
	"infectious disease getting better, cont milligrams by every 5/26/14, continue to need or if diarrhea	notes dated 5/21/14, indicated follow up for c-diff pt [patient inue Vancomycin 125 / six hours by mouth until o monitor stool. Follow up as recurs. Patient should be abl go outside as long as]				
	of 5/29/14, lacked a	ated plan of care with print dat a problem statement, goal or lated to the treatment and risl					
	nursing (ADON) sta definitely be on the interventions. The	40 a.m. the assistant director ated the c-diff infection should resident's care plan with ADON verified that the ection was not on the plan of a.					
	(DON) verified that	15 p.m. the director of nursing R22's care plan should reflect and appropriate interventions					
	SUGGESTED MET	THOD OF CORRECTION:					
	could review or rev	sing (DON) and/or designee rise policies, provide educatio comprehensive care plan Quality Assessment and	n				

	ta Department of He	alth	-		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00995	B. WING		05/30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - W	AIKER	CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
2 560	Continued From pa	ge 11	2 560		
	Assurance (QAA) c audits to ensure co	ommittee could do random mpliance.			
	TIME PERIOD FOR	R CORRECTION:			
	Twenty-one (21) da	ys.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		7/9/14
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility facare plan for 2 of 2 timely repositioning of 1 resident (R26) with eating, for 1 of dialysis with a fluid	ent is not met as evidenced on, interview and document ailed to follow the resident's residents (R45, R26) for and incontinence care, for 1 resident requiring assistance 1 resident (R39) reviewed for restriction, and for 1 of 1 required assistance with		Correction in progress and ongoing.	
	Findings include:				
	to be repositioned h addition, R45's brie	SITIONING: ed 3/31/14, indicated R45 was nourly and as needed. In f was to be checked and purs and as needed.	5		
	On 5/29/14 R45 w	as observed continuously from			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
OLDEN	I LIVINGCENTER - W			NUE WEST PO BOX 700		
		WALKE	R, MN 56484			
(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 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	assistant (NA)-B at belt and walker. At was placed in the v according to her N written on. The sur in the wheelchair a minutes without rep were "short" and th on the floor as the restorative/rehab for normally they track NA-C stated she m incorrectly for R45.					
	with the gait belt to R45 was placed in brief was changed of urine. At 11:25 a and R45 had been 35 minutes since th stated they were "s NA which was their stated when they a	A and NA-B transferred R45 bed. NA-A stated right before the wheelchair at 6:50 a.m. hi as R45 had been incontinent incontinent of urine (4 hours & he last brief change). NA-A short" a 6:00 a.m. to 10:00 a.m. r busiest time of the day. NA-B ure "short" then each NA does group of residents and it g.	S : &			
	nursing (ADON) st checked every 2 h	5 p.m. the assistant director of ated R45's brief was to be ours. The ADON verified the followed for incontinence care.				
	reposition R26 eve addition, R26's inconcerned and change	ted 12/4/13, directed staff to ry 2 hours and as needed. In ontinence brief was to be ged and R26 was to be offered hours and as needed.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00995	B. WING	B. WING		05/30/2014	
IAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - W		RCHWOOD AVE	NUE WEST PO BOX 700			
(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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
2 565	Continued From pa	age 13	2 565				
	On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility.						
	not been toileted o	5 a.m. NA-C stated R26 had r repositioned, to her approximately 7:00 a.m. when ing cares.					
	her room by nursin	03 p.m. R26 was returned to g assistant NA-A and license N)-A for toileting and ces.	d				
	was up in her chair until 10:00 a.m. wit	3 a.m. NA-A confirmed R26 from approximately 7:00 a.m hout repositioning or toileting 26 should have been checked very 2 hours.					
	expect R26 would	2 a.m. DON stated she woul have been toileted and 2 hours as the care plan	d				
	EATING: R26's care plan da provide R26 eating	ted 12/4/13, directed staff to assistance of 1.					
	7:00 a.m. until 10:0 -At 7:00 a.m. R26 seated on the edge	was observed in her own roor					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W		HWOOD AVE	NUE WEST PO BOX 700		
(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 TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 14	2 565			
	her wheelchair via and dining room. -At 7:45 a.m. R26 v of the dining room eating breakfast. S not offer R26 any f to have a place set table. -At 8:45 a.m. R26 propel herself up a not been offered for -At 8:50 a.m. LPN- when staff try to fer so, " we just give f -At 9:12 a.m. R26 v activity area watch -At 9:20 a.m. R26 v throughout the acti offered food or bev -At 9:30 a.m. the c been served break service was comple offered any food or -At 9:46 a.m. socia brought R26 to her No food or drink wa On 5/29/14, at 12:5 (RD) stated she ha however, R26 refut had not "physically if R26 had been of stated she did not should have offere breakfast meal.	B stated R26 was resistive ed her and usually did not eat her supplements. " was observed to be in the ing the birds with a visitor was observed to propel herself vity room. R26 had not been verage. ook verified all residents had fast and stated the meal ete. At no time was R26 beverage. Il service designee (SSD) room and visited with her 1:1. as offered to R26. 56 p.m. consulting dietician ad offered R26 to eat, sed. The RD confirmed she " assisted R26. When asked fered finger foods, the RD know. The RD stated staff d R26 food and drink for the 1 p.m. LPN-C confirmed R26 however, stated staff should				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 15	2 565			
	served the breakfa She further stated " and would not sta LPN-B verified she or drink for breakfa want any", R26 sa when asked, LPN-I attempted to offer I breakfast time. LPI should have been of FLUID RESTRICTI R39 was admitted included end stage diabetes, hypertens Current physician of fluid restriction of 1 to provide 780 ml of 720 ml from meals		9			
	sheet and fluids giv fluids ingested eac Dietary to send 240	review intake and output ven to resident. Total volume of h shift must be recorded. D ml/meal. Nursing no more shift. Restriction is 1500/day.	f			
	problem of altered renal disease, on a be without signs ar Intervention listed v restriction. Dietary	dated 2/2/14, indicated a nutrition related to end stage therapeutic diet, with goal to ad symptoms of fluid overload. were: 1500 ml/day fluid gives 720 ml, 780cc from				
	stage renal disease	in kidney function due to end e. Encourage patient to follow ration program interventions.				
		o p.m. NA-E was observed to R39 in a water mug. NA-E				

Minnesc	ta Department of H	ealth			FORMAPPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00995	B. WING		05/30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - W		HWOOD AV	ENUE WEST PO BOX 700	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 565	stated she was not holds. At 2:29 p.m. mug holds 720 ml. provided two of the evening shift and t not sure how much gets water or some also." Review of th R39 indicated: dial restriction/day-no v meal-dietary gives on clipboard,-NA 1 NA-E was aware o and that 1440 ml o at the bedside, NA that, it might be ev will go fill his jug hi amount. I will go ta On 5/30/14, at 10:' should not be rece bedside, and adde was happening." T was not followed for On 5/30/14, at 12:0 (DON) stated they R39's excess fluid restriction. The DC was not being follo AMBULATION: R39's plan of care has a physical fund impairment related improve current lev Interventions listed as ordered. R39's Therapy Con	sure how much water the mug NA-E stated that R39's water NA-E added, "[R39] is ese for sure, once on the hen on the overnight shift. I am he gets on the day shift. He ething to drink with his meals he NA assignment sheet for ysis T-Th-SA, 1500 ml fluid water at bedside-8 ox fluid per 720 ml/day-document intake glass per shift. When asked if f R39's 1500 ml fluid restriction f water was being provided just A-E stated, "I was not aware of en more than that because he mself, he is over his fluid			
Minnesota D STATE FOR	epartment of Health M		6899	S33Z11	If continuation sheet 17 of 62

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00995	B. WING		05/	05/30/2014	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
I LIVINGCENTER - W			NUE WEST PO BOX 700			
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa dated 2/21/14, india ambulate 100-150 Goal: Maintain curra ambulate with gait wheel chair to follo R39's Restorative March 5, 2014 to N staff to ambulate R and follow with forv 125-150 feet as res maintain current le sheets indicated th - March 5-31, 2014 ambulate, 21 oppo 27 opportunities R3 70, and 70 feet. - April 1-30, 2014, ambulate, 25 oppo 30 opportunities R3 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R3 feet. On 5/30/14, at 10:0 restorative nursing "Sometimes he ref what days those ar blanks indicated R services. NA-B was	age 17 cated current functional status, feet with wheeled walker. rent level of mobility. Approach belt and assist of one and w. Records were reviewed from May 30, 2014, and instructed 39 with gait belt, assist of one, ward wheeled walker. Ambulate sident allows one time a day to vel of mobility. The flow us following: 4, out of 27 opportunities to rtunities were blank. For 6 of 39 was ambulated 70, 125, 80, out of 30 opportunities to rtunities were blank. For 5 of 39 was ambulated 140, 100, out of 30 opportunities to rtunities were blank. For 2 of 39 was ambulated 76 and 60 00 a.m. NA-B who provides services to R39 stated, uses but I could not tell you re." NA-B verified that any 39 did not receive ambulation s observed to apply a gait belt	2 565	DEFICIENC	Υ)		
	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER LIVINGCENTER - W SUMMARY ST, (EACH DEFICIENC REGULATORY OR I Continued From pa dated 2/21/14, indi ambulate 100-150 Goal: Maintain curr ambulate with gait wheel chair to follo R39'S Restorative March 5, 2014 to N staff to ambulate R and follow with forv 125-150 feet as reamintain current le sheets indicated th - March 5-31, 2014 ambulate, 21 oppo 27 opportunities R 70, and 70 feet. - April 1-30, 2014, ambulate, 25 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, and 70 feet - May 1-30, 2014, ambulate, 28 oppo 30 opportunities R 70, 50, 50, 50, 50, 50, 50, 50, 50, 50, 5	OF CORRECTION IDENTIFICATION NUMBER: 00995 00995 PROVIDER OR SUPPLIER STREET AL 209 BIRG WALKER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker. Goal: Maintain current level of mobility. Approach ambulate with gait belt and assist of one and wheel chair to follow. R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: O0995 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 17 2 565 dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker. 2 565 Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow. 2 565 R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. On 5/30/14, at 10:00 a.m. NA-B whop provides restorative nursing services to R	TO F DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	TO F DEFICIENCIES (M) PROVIDER/SUPPLIERCLA A22 MULTPLIE CONSTRUCTION (A) BUILDING: (A) BUILDING:	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(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 DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 18	2 565			
		came here. But maybe they ne when I am not here."				
	"[R39] should be re and if he is refusing he is not ambulatin	A a.m. the ADON stated, eceiving ambulation services, g staff should be reporting that g." The ADON verified the followed for ambulation.				
	should be following and providing resto The NA should be not ambulating. Th	00 p.m. the DON stated, "Staff g the resident's plan of care prative ambulation at ordered. reporting to me if a resident is e DON verified R39's plan of followed for ambulation.				
	A care plan policy v provided.	was requested but not				
	SUGGESTED ME	THOD OF CORRECTION:				
	could review or rev for staff regarding o Quality Assessmer	sing (DON) and/or designee rise policies, provide education care plan implementation. The tt and Assurance (QAA) o random audits to ensure				
	TIME PERIOD FO	R CORRECTION:				
	Twenty-one (21) da	ays.				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			7/9/14
	care must be revie interdisciplinary tea	 A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility 				

6899

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		05/30/2014	ļ
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W/		HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ETE
2 570	Continued From pa	ge 19	2 570			
2 570	for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requireme by: Based on observati review, the facility fa to include removal meal times for 1 of with a physical rest Findings include: R31's order summa identified R31's diag depression, hallucir generalized muscle R31's quarterly Min	d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B. ent is not met as evidenced on, interview, and document ailed to update the care plan of a physical restraint during 1 resident (R31) in the sample raint (lap buddy).	2 570	Corrected.		
	4/14/14, indicated F impairment and req	R31 had severe cognitive uired extensive assist with ng, eating and toileting.				
	SCREENING FORI type of restraint/dev buddy (a thick cush lap and is secured to wheelchair, which of to remove themselv was also identified a	ESTRAINT/DEVICE M dated 4/9/14, indicated the vice recommended was a lap ion that fits over a resident's to the armrests of the can restrict the residents' ability ves from the wheelchair). R31 as not being able to ove the restraint on command.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY PLETED
		00995	B. WING		05/30/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(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 T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 20	2 570			
	check on R31 ever buddy (restraint) w reposition every tw under direct super R31's care plan da area for utilization buddy). However, interventions which monitor R31 when when to release th On 5/29/14, at 12:4 the dining room wi wheelchair. During p.m. through 1:30 observed and the I R31's wheelchair. On 5/29/14, at 1:30	ted 5/29/14, identified a focus of a physical restraint (lap the care plan lacked n directed the staff when to the restraint was in place and				
	On 5/29/14, at 2:00 nursing (ADON) co considered a restra expectation was fo removed during m be using the least confirmed the inter 30 minutes when t release the restrain meal time had not	D p.m. the assistant director of onfirmed R31's lap buddy was aint. ADON verified her or R31's lap buddy to be eal time as the facility should restrictive restraint. ADON eventions to monitor R31 every he restraint was in place and to not every two hours and during been carried over from to the current care plan dated				
		aint Devices, Physical policy staff to develop or review				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/	30/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOLDEN	I LIVINGCENTER - W		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	ige 21	2 570			
	reason for use, mo	or type of restraint device, nitoring of resident and th of time restraint device is				
		procedure for care plan ion and review was provided.				
	SUGGESTED MET	HOD OF CORRECTION:				
	could review or rev for staff regarding a plans. The Quality	sing (DON) and/or designee ise policies, provide education appropriate revision of care Assessment and Assurance could do random audits to				
	TIME PERIOD FOR	R CORRECTION:				
	Twenty-one (21) da	iys.				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			7/9/14
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on of preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET
2 830	Continued From pa	age 22	2 830			
	by: Based on observat review, the facility and follow fluid res	tion, interview and document failed to monitor fluid intake trictions as directed by the resident (R39) receiving		Correction iniated/POA in p	progress.	
	Findings include:					
	R39 's diagnoses stage renal disease Data Set (MDS) da moderate cognitive treatments, require ambulation in his re staff assist for eating	Report dated 1/16/14, indicated included diabetes with end e. R39 's quarterly Minimum ated 4/18/14, indicated R39 had e impairment, received dialysis ed limited staff assistance for oom and supervision with one ng. The MDS indicated R39 I outside of his room.				
	fluid restriction of 1 to provide 780 ml of 720 ml from meals to check meal tray sheet and fluids giv fluids ingested eac Dietary to send 240	orders dated 4/23/14, indicated 500 milliliters (ml)/day. Nursing over 3/shifts, dietary to provide (or 240 ml per meal). Nursing , review intake and output ven to resident. Total volume of th shift must be recorded. 0 ml/meal. Nursing no more r shift. Restriction is 1500/day.	9			
	problem of altered renal disease, on a be without signs ar Intervention listed restriction. Dietary nursing. Alteration stage renal disease	dated 2/2/14, indicated a nutrition related to end stage a therapeutic diet, with goal to nd symptoms of fluid overload. were: 1500 ml/day fluid gives 720 ml, 780cc from in kidney function due to end e. Encourage patient to follow ration program interventions.				

wiinineso	ta Department of He	ealth				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		-	
		00995	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	-	
	LIVINGCENTER - W	ALKER 209 BI	RCHWOOD AVE	NUE WEST PO BOX 700		
OOLDLIN		WALKI	ER, MN 56484			
(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 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	be passing water to stated she was not holds. At 2:29 p.m. mug holds 720 ml. provided two of the evening shift and th not sure how much gets water or some also." Review of th R39 indicated: dialy restriction/day-no v meal-dietary gives on clipboard,-NA 1 NA-E was aware o and that 1440 ml o at the bedside, NA that, it might be even will go fill his jug his amount. I will go ta On 5/30/14, at 10:1 nursing (ADON) star receiving that much "I was not aware the added, "We should water containers at what he should be	5 p.m. NA-E was observed to o R39 in a water mug. NA-E is sure how much water the m NA-E stated that R39's wate NA-E added, "[R39] is ease for sure, once on the hen on the overnight shift. I a in he gets on the day shift. He ething to drink with his meals ne NA assignment sheet for ysis T-Th-SA, 1500 ml fluid vater at bedside-8 ox fluid pe 720 ml/day-document intake glass per shift. When asked f R39's 1500 ml fluid restriction f water was being provided ju A-E stated, "I was not aware of en more than that because ho mself, he is over his fluid lk to my nurse."	ug r m if on ist of e of			
	(DON) stated they R39's excess fluid restriction. The DO	00 p.m. the director of nursing should not be contributing to problem with his fluid NN verified R39's plan of care wed for fluid restriction.	3			
	A fluid restriction perovided.	olicy was requested but not				
	-DAUMENT OF HEAITS					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00995	B. WING		05/30/2014		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		// 30/2014	
GOLDEN	LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700			
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE	
2 830	Continued From pa	age 24	2 830				
	SUGGESTED METHOD OF CORRECTION:						
	could review or rev for staff regarding The Quality Assess	sing (DON) and/or designee vise policies, provide education care of the dialysis resident. sment and Assurance (QAA) o random audits to ensure					
	TIME PERIOD FO	R CORRECTION:					
	Twenty-one (21) da	ays.					
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			7/9/14	
	positioned in good of residents unable must be changed a including periods o been put to bed for has documented th hours during this tim	ng. Residents must be body alignment. The position a to change their own position at least every two hours, of time after the resident has r the night, unless the physician nat repositioning every two me period is unnecessary or ordered a different interval.	n				
	by: Based on observat review, the facility f were identified at ri received timely rep	tion, interview, and document failed to ensure residents who isk for skin breakdown positioning according to their or 2 of 2 residents (R45, R26) poning.		Correction initiated/ongoing mo	nitoring.		
	Findings include:						
		tes dated 3/12/14, indicated					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2014
	I LIVINGCENTER - W	AI KER 209 BIR		NUE WEST PO BOX 700		
(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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 25	2 905			
	actual depth of the by slough and/or ex- right and left heel. (partial thickness loss shallow open ulcer without slough), an thickness tissue loss visible but bone, te exposed. Slough m obscure the depth coccyx/sacral area	kness tissue loss in which ulcer is completely obscured schar in the wound bed) to the R45 also had three stage II oss of dermis presenting as a with a red pink wound bed, id an "almost" stage III (full ss. Subcutaneous fat may be ndon or muscle are not hay be present but does not of tissue loss), PUs on the . On 5/20/14, the progress 5's coccyx area remained				
	(MDS) dated 4/25/ cognitive impairme R45 was diagnose diabetes. The Activ Assessment (CAA) required extensive and transfers. Staff during cares for sig The Tissue Tolerar pressure) Observa indicated R45 was and required every	nce (ability of skin to withstand tion form dated 3/11/14, at high risk for skin breakdowr two hour repositioning.	n			
	to be repositioned The nursing assista	ted 3/31/14, indicated R45 was hourly and as needed. ant (NA) group care sheets to be repositioned every 2 ed.	5			
		as observed continuously from 02 a.m. At 6:50 a.m. R45 was	1			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(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)	I SHOULD BE	(X5) COMPLET DATE
2 905	Continued From pa	age 26	2 905			
	6:58 a.m. R45 was At 7:40 a.m. R45 w room down the hal a.m. the director of brought R45 into h From 8:08 a.m. un his wheelchair in hi wheelchair alarm s room and opened t provide any cares of remained up in the stated his bottom v 9:36 a.m. NA-B an- belt and walker for pressure from botto observed to have a a.m. NA-C stated F every 2 hours. At 9:55 a.m. NA-C wheelchair at 7:55 group sheet that sh told NA-C that R45 a.m. (2 hours & 46 NA-C stated norma of residents. NA-C the time done incom	til 9:12 a.m. R45 remained in is room. At 9:12 a.m. R45's clip ounded and NA-A entered the the drapes. NA-A did not for R45. At 9:20 a.m. R45 wheelchair. At 9:25 a.m. R45 vas sore from sitting up. At d NA-C stood R45 with a gait few minutes to relieve om. The wheelchair was a cushion on the seat. At 9:39 R45 was to be repositioned stated R45 was placed in the a.m. according to her NA he had written on. The surveyo was in the wheelchair at 6:50 minutes since repositioning). vere "short" and there were g on the floor as the third NA prative/rehab for the residents. ally they track their own group stated she must have written rrectly for R45.	r			
	removed R45's brie noted behind R45's redness would be f wheelchair. R45's	bed. At 11:25 a.m. NA-A ef and a slight redness was s right thigh. NA-B stated the from being seated in the skin on the buttocks/coccyx be intact with no PU. NA-A				
		short" a 6:00 a.m. to 10:00 a.m.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/	30/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
OLDEN	LIVINGCENTER - W		HWOOD AVE	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
	Continued From pa	ige 27	2 905				
	NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing.						
	At 1:15 p.m. the assistant director of nursing (ADON) stated she was not aware the NAs were working "short" today. The ADON stated there would normally be three NAs working the floor, and in addition, there would be a restorative/rehab NA. The ADON stated the last she knew R45 was to be repositioned every hour and as needed. The ADON stated the previous interim DNS wanted R45 to be on an every hour repositioning schedule, even though there was not a Tissue Tolerance Assessment which reflected hourly.						
	was at risk for PU of been admitted with verified the care pla repositioning. The A an hourly reposition admitted, and she of sheet read every 2 stated R45 should	3 a.m. the ADON stated R45 development since he had multiple PUs. The ADON an was not followed for ADON added R45 had been or hing schedule since he was did not know why the NA group hours. In addition, the ADON have been reassessed for PU his significant change MDS 4/25/14.					
	Care dated 4/24/06	Guideline for Preventative Skin , indicated residents should be f skin breakdown when there eir condition.					
	R26 had severe co	S dated 2/24/14, indicated gnitive impairment and assistance of one for bed er.					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00995	B. WING	B. WING		05/30/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
OLDEN	I LIVINGCENTER - W		RCHWOOD AVE ER, MN 56484	NUE WEST PO BOX 700			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 905	Continued From pa	age 28	2 905				
	R26 had diagnoses behavioral disturba of closed femur fra R26's care plan da monitor R26 for po assist of 1-2 with tu	eport dated 2/20/14 indicated s that included dementia with ince, heart failure and a histo icture. ted 12/4/13, directed staff to sitional changes with staff urning and repositioning every eded for the prevention of	ry				
	R26 required assis	Group 3 sheet directed staff tance of one for turning and 2 hours and as needed.					
	up and dressed, se propelling herself, v and into the hallwa observed until 10:0 was observed to pr facility. At 9:55 a.m been repositioned, approximately 7:00 morning cares. At to her room by NA- (LPN)-A for reposit	7 a.m. R26 was observed to be eated in a wheelchair and via her feet, out of her room y. R26 was continuously 03 a.m. during which time she ropel herself throughout the a. NA-C stated R26 had not to her knowledge, since a.m. when she provided 10:03 p.m. R26 was returned A and licensed practical nurs ioning. R26's brief was was observed to be intact.					
	was up in her chair until 10:00 a.m. wit	33 a.m. NA-A confirmed R26 from approximately 7:00 a.n hout repositioning. NA-A buld have been checked and 2 hours.	η.				
	service (DNS) state	I 2 a.m. director of nursing ed she would expect R26 pileted and repositioned ever e plan directed.	y				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00995	B. WING		05/3	60/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA		HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 29	2 905			
		and repositioning for the ure ulcers was requested but				
	SUGGESTED MET	HOD OF CORRECTION:				
	could review or revi for staff regarding of for risk for skin brea Assessment and As	sing (DON) and/or designee ise policies, provide education care of the resident identified akdown. The Quality ssurance (QAA) committee udits to ensure compliance.				
	TIME PERIOD FOR	R CORRECTION:				
	Twenty-one (21) da	ys.				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			7/9/14
	have a continuous management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home og catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to at infections and to restore as er function as possible.				
<i>l</i> innesota D	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/3	05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE			
OLDEN	I LIVINGCENTER - W		BIRCHWOOD AV KER, MN 56484	ENUE WEST PO BOX 700			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 910	Continued From pa	age 30	2 910				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that timely incontinence care was completed for 2 of 2 residents (R45, R26) reviewed for incontinence care.		ent	Plan to be initiated and t	racking ongoing.		
	Findings include:						
	(MDS) dated 4/25/ cognitive impairme	nange Minimum Data Set 14, indicated R45 had seve ent. The MDS also indicated d with Alzheimer's disease	d				
	(CAA) dated 5/5/14 incontinent of blade	inence Care Area Assessm 4, indicated R45 was alway der, and staff would check very 2 hours and as needed	rs and				
	•	d 3/31/14, indicated R45 w changed every 2 hours an					
		ant (NA) group care sheets to be assisted with toileting as needed.					
	6:50 a.m. until 10:0 observed up in his 6:58 a.m. R45 was At 7:40 a.m. R45 w room down the hal a.m. the director of brought R45 into h	as observed continuously f 02 a.m At 6:50 a.m. R45 v wheelchair in the hallway. observed in the dining roo vheeled himself from the di lway towards his room. At a f nursing services (DNS) is room. til 9:12 a.m. R45 remained	was At om. ining 8:03				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		05/30/2014	
					05/	30/2014
VAIVIE OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	NUE WEST PO BOX 700		
GOLDEN	I LIVINGCENTER - W		R, MN 56484			
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 31	2 910			
	clip wheelchair alar the room and open provide any cares. in the wheelchair. A stood R45 with a g pressure to R45's I checked. At 9:39 a placed in the whee surveyor told NA-C wheelchair at 6:50 since toileting or re NA-C stated R45 k	is room. At 9:12 a.m. R45's rm sounded and NA-A entered red the drapes. NA-A did not At 9:20 a.m. R45 remained up At 9:36 a.m. NA-B and NA-C ait belt and walker to relieve bottom. R45's brief was not .m. NA-C stated R45 was Ichair at 7:45 a.m. The that R45 was in the a.m. (2 hours & 46 minutes positioning). At 9:55 a.m. new when he needed the ief was not checked when he				
	sounded, she went he needed the toile NA-A stated her gr assist with toileting NA-A stated R45 k bowel movement. R45's answer when bathroom. RN-A st	A stated when R45's clip alarm t in the room, and asked R45 if et. NA-A stated R45 said no. oup sheet directed staff to every 2 hours and as needed. new when he needed to have a NA-A stated they do accept n he stated he did not need the ated R45's brief had not been was placed in the wheelchair	a			
	with the gait belt to R45 was placed in brief was changed of urine. At 11:25 a and R45 had been 35 minutes since th stated they were "s NA which was their stated when they a	A and NA-B transferred R45 bed. NA-A stated right before the wheelchair at 6:50 a.m. his as R45 had been incontinent i.m. NA-A removed R45's brief incontinent of urine (4 hours & he last brief change). NA-A short" a 6:00 a.m. to 10:00 a.m busiest time of the day. NA-B re "short" then each NA does group of residents and it a.				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 32	2 910			
	On 5/29/14, at 1:15 p.m. the assistant director of nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care.					
		are policy was requested and a staff how to do incontinence	a			
	R26 had severe co	S dated 2/24/14, indicated gnitive impairment and assistance of one for bed assistance.				
	R26 had diagnoses	eport dated 2/20/14 indicated s that included dementia with ince, heart failure and a history cture.	/			
	check and change needed, as well as	ted 12/4/13, directed staff to R26 every two hours and as offer to toilet R26 every two ed for urge incontinence.				
		Group 3 sheet directed staff ng every 2 hours and as ience.				
	up and dressed, se	a.m. R26 was observed to be eated in a wheelchair and out of her room and into the	•			
	not been toileted, to	5 a.m. NA-C stated R26 had o her knowledge, since a.m. when she provided				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/30/2014		
AME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
OLDEN	I LIVINGCENTER - W			NUE WEST PO BOX 700			
(X4) ID	SUMMARY ST		R, MN 56484	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLE DATE	
2 910	Continued From pa	age 33	2 910				
	during which time s observed to propel At 10:03 a.m. R26 NA-A and licensed toileting and reposi reported R26's inco stated R26 was to and as needed. N/ toileted at approxim her care sheet. On 5/29/14 at 11:33 was up in her whee a.m. until 10:00 a.m toileting. On 5/30/14, at 10:1 service (DNS) state would have been to 2 hours as the care An Incontinence Ca procedure directing care was provided. SUGGESTED MET The director of nurs could review or rev for staff regarding r The Quality Assess	herself throughout the facility. was returned to her room by practical nurse (LPN)-A for tioning services. NA-A ontinence brief was wet and be toileted every two hours A-A indicated R26 was last nately 7:10 a.m. according to 3 a.m. NA-A confirmed R26 elchair from approximately 7:00 n. without repositioning or 12 a.m. director of nursing ed she would expect R26 bileted and repositioned every e plan directed. are policy was requested and a g staff how to do incontinence THOD OF CORRECTION: sing (DON) and/or designee ise policies, provide education nutritional care of residents. sment and Assurance (QAA) o random audits to ensure R CORRECTION:	a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED 05/30/2014	
		00995	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 915	Continued From pa	age 34	2 915			
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915		7/9/14	
	home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speec	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; ad ambulate;				
	by: Based on observati review, the facility f appropriate ambulation (R39) who required Findings include: R39's plan of care	ent is not met as evidenced ion, interview and document ailed to provide the ation services to maintain or n ability for 1 of 1 resident assistance with ambulation.		POA initiated. Ongoing review.		
	impairment related improve current lev	tioning deficit related mobility to weakness, with a goal to rel of physical functioning. were rehab therapy services				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		05/	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TI		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 35	2 915			
	dated 2/21/14, india ambulate 100-150 Goal: Maintain curr ambulate with gait wheel chair to follo R39's Restorative I March 5, 2014 to M staff to ambulate R and follow with forv 125-150 feet as res maintain current le sheets indicated th - March 5-31, 2014 ambulate, 21 oppo 27 opportunities R3 70, and 70 feet.	Records were reviewed from lay 30, 2014, and instructed 39 with gait belt, assist of one, vard wheeled walker. Ambulate sident allows one time a day to vel of mobility. The flow	: e			
	ambulate, 25 oppo	rtunities were blank. For 5 of 39 was ambulated 140, 100,				
	ambulate, 28 oppo	out of 30 opportunities to rtunities were blank. For 2 of 39 was ambulated 76 and 60				
	(NA)-B who provide to R39 stated, "Sor not tell you what da that any blanks ind ambulation service a gait belt to R39 a	00 a.m. nursing assistant es restorative nursing services netimes he refuses but I could ays those are." NA-B verified icated R39 did not receive s. NA-B was observed to apply nd ambulate from room and ut 100 feet. R39 stated, "That				

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	Minneso	ta Department of He	ealth				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - WALKER 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX 2 915 Continued From page 36 stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." 2 915 On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to m if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. On s/aould be reporting to m if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not							
OD BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC: IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) IX ON DEFICIENCY 2 915 Continued From page 36 stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." 2 915 On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. Stated, "Staff should be feolowing the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. No 5/30/14, at 12:00 p.m. the DON verified R39's plan of care was not being followed for ambulation. He is not ambulation. A care plan policy was requested but not A care plan policy was requested but not He is not ambulation.			00995	B. WING		05/3	0/2014
GOLDEN LIVINGCENTER - WALKER WALKER, MN 56484 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Common DATE 2 915 Continued From page 36 2 915 2 915 Stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." 2 915 On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not A care plan policy was requested but not ID	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, 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) COMP DATE 2 915 Continued From page 36 stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." 2 915 2 915 On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. Statef On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. Staff A care plan policy was requested but not	GOLDEN	I LIVINGCENTER - W			ENUE WEST PO BOX 700		
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 "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not 		ambulate since he	came here. But maybe they				
should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not		"[R39] should be re and if he is refusing he is not ambulatin	ceiving ambulation services, g staff should be reporting that g." The ADON verified the				
		should be following and providing resto The NA should be r not ambulating. The	the resident's plan of care prative ambulation at ordered. reporting to me if a resident is e DON verified R39's plan of				
			was requested but not				
SUGGESTED METHOD OF CORRECTION:		SUGGESTED MET	THOD OF CORRECTION:				
The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding resident ambulation services. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.		could review or rev for staff regarding r The Quality Assess committee could do	ise policies, provide education resident ambulation services. sment and Assurance (QAA)				
TIME PERIOD FOR CORRECTION:		TIME PERIOD FOR	R CORRECTION:				
Twenty-one (21) days.		Twenty-one (21) da	ays.				
2 920 MN Rule 4658.0525 Subp. 6 B Rehab - ADLs 2 920 7/9/14	2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			7/9/14
Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing		comprehensive res					

6899

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY PLETED
		00995	B. WING		05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER					
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	age 37	2 920			
	activities of daily liv	b is unable to carry out ving receives the necessary n good nutrition, grooming,				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with eating for 1 of 1 resident (R26) who required assistance with eating for 1 of 2 dining observations.			Corrective action initiated with review.	n ongoing	
	Findings include:					
	2/24/14, indicated	nimum Data Set (MDS) dated R26 had severe cognitive quired extensive assistance of				
	R26 had diagnoses	eport dated 2/20/14, indicated s that included dementia with ince, heart failure and a histor cture.				
	R26's care plan da required eating ass	ted 12/4/13, directed staff R26 sistance of 1.	3			
	dated 5/20/14, ider	ndition Nutrition Assessment ntified nutritional interventions assist and encourage resident				
	7:00 a.m. until 10:0 -At 7:00 a.m. R26 seated on the edge	was observed in her own room				
nesota D ATE FORI	epartment of Health		6899	S33Z11	lf oortiges t	on sheet 38 c

VEFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY THE DEFICIENCY COUNT DEFICIENCY	Minneso	ta Department of H	ealth			FORI	IAPPROVE
D0995 B. WING D05/30/2014 WE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 5644 CALL DEN LUNKGCENTER • WALKER 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 5644 CROSS-REFERENT OF DEFICIENCY (EACH DEPICIENCY MIST BE PRECEDED BY FULL (EACH DEPICIENC) (EACH DEPICIENC BY AND							
Continued From page 38 2 920 2 2 20 Continued From page 38 2 920 2 3 20 Continued From page 38 2 920 3 47.745 a.m. R26 was observed going in and out of ther wheelchair via her feet throughout the facility and dining from. 2 920 - At 8:45 a.m. R26 continued to independently propelling herself in her wheelchair via her feet throughout the facility and dining from. 2 920 - At 8:45 a.m. R26 continued to independently propelling herself in her wheelchair via her feet throughout the facility and dining from. - At 8:45 a.m. R26 was observed going in and out of ther R26 any food or dinik. R26 was noted to have of page 88. 2 920 - At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not beer signers. - At 8:45 a.m. R26 was observed to be in the activity zera watching the birds with a visitor of the ray food or dinik. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. - At 8:46 a.m. social service doignee (SSD) brought R26 to her on and visited with her 11. No food or dinik was offered to R26 to eat, however, R26 refused. The RD confirmed she had offered R26 to eat, however, R26 refused. The RD confirmed she had not fered food in brevarage. - At 9:40 a.m. social service do R26 to eat, however, R26 refused. The RD confirmed she had not fered R26 to be an observed to take and stated the meal service was complete. At R0 confirmed she had not fered R26 to be an observed breverage. - At 9:40 a.m. social service dasignee (SSD) brought R26 to her				A. BUILDING:			
Desk LivingCentre - Walker 299 BIRCHWOOD AVENUE WEST PO BOX 00 Walker, MN 5642 OUT SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL) (EACH DEFICIENCY MUST BE INFORMATION) (A 18 45 a.m. R26 was observed to infage and the fold in to the a place set up for her at at a fining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered fold or beverage. -At 8:50 a.m. licensed practical nurse (LPN)-B stated R26 was resistive when staff try to feed her and usually did not eat so, "we just give her supplements." -At 9:30 a.m. R26 was observed to be in the activity area watching the birds with a visitor -At 9:30 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered fold or beverage. -At 9:30 a.m. the cook vertified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited staff should have offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked			00995	B. WING		05/30/2014	
Dependence WALKER, MN 56484 410 The ESUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) ID (EACH DEFICIENCY) ID (EACH DEFICIENCY) ID (EACH DEFICIENCY) (D) (EACH DEFICIENCY) (D) (D) (D) (D) (D) (D) (D) (D) (D) (D)	NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
Building Tool SUMMARY STATEMENT OF DEFICIENCIES provider PROVIDERS FLAN OF CORRECTION provider <	GOLDEN	LIVINGCENTER - W	AI KFR		NUE WEST PO BOX 700		
VEFLX IEACH DEFICIENCY MUST BE PRECEDE BY FULL TAG PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CACORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DT IT HEAPROPRIATE OWHER DEFICIENCY 2 920 Continued From page 38 dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. 2 920 2 920 -AT 745 a.m. R26 was observed going in and out of the dining room. -AT 745 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -AT 8.45 a.m. R26 was observed to independently propel herself up and down the halls. R26 had not been offered food or beverage. -AT 8.20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -AT 9.20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered any food or beverage. -AT 9.20 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -AT 9.436 a.m. social service designee (SSD) brought at 12.56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R20 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD batted staff should have offered R26 food and drink for the breakfast meal. Dn 5/29/14, at 1.01 p.m. LPN-C confirmed R26 <th>(X4) ID</th> <th>SUMMARY ST</th> <th></th> <th></th> <th>PROVIDER'S PLAN OF C</th> <th>ORRECTION</th> <th>(X5)</th>	(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF C	ORRECTION	(X5)
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esota Department of Health		her wheelchair via and dining room. -At 7:45 a.m. R26 of the dining room eating breakfast. S not offer R26 any f to have a place se table. -At 8:45 a.m. R26 propel herself up a not been offered for -At 8:50 a.m. licens stated R26 was reacher her and usually dir supplements." -At 9:12 a.m. R26 activity area watch -At 9:20 a.m. R26 throughout the act offered food or bey -At 9:30 a.m. the of been served break service was comple offered any food of -At 9:46 a.m. social brought R26 to her No food or drink w On 5/29/14, at 12:3 (RD) stated she has however, R26 refut had not "physically if R26 had been of stated she did not should have offere breakfast meal.	her feet throughout the facility was observed going in and ou while other residents were Staff was present, however, die food or drink. R26 was noted t up for her at a dining room continued to independently and down the halls. R26 had bod or beverage. sed practical nurse (LPN)-B sistive when staff try to feed d not eat so, "we just give her was observed to be in the ing the birds with a visitor was observed to propel herse ivity room. R26 had not been verage. sook verified all residents had dfast and stated the meal lete. At no time was R26 r beverage. al service designee (SSD) r room and visited with her 1: as offered to R26.	/ It If 1.			
	nnesota De						
	ATE FORM			⁶⁸⁹⁹ S	33Z11	If continuati	on sheet 39 d

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ALKER	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 920	did not eat much, h have provided her a On 5/29/14, at 1:11 served the breakfas She further stated I and would not stay LPN-B verified she or drink for breakfa want any," R26 sai when asked, LPN-E attempted to offer F breakfast time. LPN should have been of On 5/29/14 at 1:16 not find any docum attempts of providir consume while roat During an interview hospice director (H of hospice is to "go patient and family of They encourage the do without force fee would be her expect would be her expect would be her expect attempts of providir consume the same co other residents in the expectation would be assistance to eat of props if necessary.	owever, stated staff should a breakfast meal. p.m. LPN-B verified she had st meal in the dining room. R26 "absolutely would not eat" still for long enough to eat. had not offered R26 any food st and stated R26 "did not d no when offered. However, 8 confirmed she had not R26 any food or drink at N-B stated food probably				
	R26. A policy regarding p	ne hospice nurse caring for provision of assistance at ed but none was provided.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2014	
		00995	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
OLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
2 920	Continued From pa	age 40	2 920			
	SUGGESTED MET	THOD OF CORRECTION:				
	could review or rev for staff regarding a dining. The Quality	sing (DON) and/or designee ise policies, provide education assistance of residents during Assessment and Assurance could do random audits to				
	TIME PERIOD FOI	R CORRECTION:				
	Twenty-one (21) da	ays.				
2 960	MN Rule 4658.060 Food Quality	0 Subp. 1 Dietary Service -	2 960			7/9/14
		uality. Food must have taste, ance that encourages residen d.	t			
	by: Based on observat review, the facility f palatable and at the (R38, R18) residen interviewable, and R16, R11, R14, R3 R29, R26, R22) wh interviewable, and main dining room. serve eggs prepare	ent is not met as evidenced ion, interview and document failed to serve food that was e right temperature for 2 of 2 its in the dining room who were for 14 of 14 residents (R9, R6, 3, R45, R10, R8, R15, R61, to were identified as not who received their meals in the In addition, the facility failed to ed to a resident's request for 1 who ate breakfast in their room	9	POA initiated with ongoing review.		
	Findings include:					
	On 5/27/14, at at 5	:24 p.m. the evening meal was	;			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		BIRCHWOOD AVE	NUE WEST PO BOX 700		
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	Continued From pa	age 41	2 960			
	residents that were dining room, and 1 on the other half of On 5/27/14, at 5:29 The menu was tun bread, and green b "And that was supp R38 stated, "I had cafeteria." R38 state made from "scratch	hing room. There were five e seated on one half of the 1 residents that were seate the dining room. 9 p.m. the meal was served a casserole, a slice of garl beans. At 5:37 p.m. R18 st bosed to be garlic toast?" better food in the high sch ted the tuna casserole was h." Both R18 and R38 state what the alternative meal w	ed d. ic ated, ool s not ed			
	tray to eat the mea casserole, the garli	rveyor requested a sample I. There was no tuna in the ic toast was tough, and the asserole were tasteless.	9			
	to put the alternate was ham/potatoes. for tuna and she ha casserole. At 5:55	ook (C)-A stated she had for meal on the board, however . C-A stated the recipe call ad forgot to put the tuna in p.m. C-A offered the reside since she had forgot to put oble.	ver, it ed the ents			
	wheelchair eating t served two fried eg "hII" out of the eg	7 a.m. R9 was up in his preakfast in his room. R9 v ggs. R9 stated, they fried th gs. R9 stated he would like nd not over done. The eggs be fried hard.	ne e his			
	casserole that was bland with no flavo toast was very toug	41 a.m. R38 stated the tun served on 5/27/14, was ver r at all. In addition, the gar gh and there was no taste ated the green beans were	ery lic of			

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	60/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W	AIKFR	HWOOD AV , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 960	food concerns in re stated everybody's food, and instead o worse. The Dining Experie indicated food woul The Food Service I indicated food woul and appetizing mar tested for correct te Fahrenheit (F) or bu On 5/30/14, at 11:1 services (DNS) con regarding dining ex be served hot, on ti as we "eat first with SUGGESTED MET The director of nurs could identify and d dining experience a staff education rega Quality Assessmen	ed they have brought up the sident council for months. R38 biggest complaint was the f it getting better it was getting nce policy dated 2011, d be flavorful and attractive. Distribution policy dated 2011, d be served in an attractive oner. In addition, milk would be emperature of 41 degrees elow. 6 p.m. the director of nursing firmed her expectations perience was for the meals to me, and appealing to look at our eyes". THOD OF CORRECTION: sing (DON) and/or designee evelop a more palatable and could provide appropriate arding food preparation. The t and Assurance (QAA) o random audits to ensure	2 960	DEFICIENCY)		
21000	Twenty-one (21) da MN Rule 4658.0610 Requirements-Hygi) Subp. 4 Dietary Staff	21000			7/9/14
Minnesota De STATE FORM	epartment of Health		6899	S33711	If continuatio	n sheet 43 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2014	
		00995	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(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)	N SHOULD BE	(X5) COMPLET DATE
21000	Continued From pa	age 43	21000			
	wash their hands a their arms with soa washing facility bef as often as is nece after smoking, eati handling soiled equ	Dietary staff must thoroughly and the exposed portions of ap and warm water in a hand ore starting work, during work essary to keep them clean, and ng, drinking, using the toilet, or upment or utensils. Dietary eir fingernails clean and				
	by: Based on observat review, the facility t sanitary manner. T	ient is not met as evidenced ion, interview and document failed to serve food in a his had the potential to affect iding in and receiving meals		POA initiated. Monitoring w	ill be ongoing.	
	Findings include:	indings include:				
	service observation wash her hands an bucket containing a liquid solution was With the same glow to lift the green clow the food thermome the cloth back into area and insert the Once the casserole C-A returned to the process of wiping t putting the cloth bac C-A repeated this p temperature of the	4 a.m. during the noon meal n, Cook (C)-A was observed to a donned gloves. A red a green cloth submerged in a observed on the sink counter. ved hands, C-A was observed th from the bucket and wipe eter probe with the cloth, put the bucket, walk back to stove probe into the Taco casserole e temperature was obtained, bucket and repeated the he probe with the same cloth, ack into the bucket when done. process after checking the e corn and gravy. C-A stated nitizing solution used to	e e. e.			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
21000	Continued From pa	age 44	21000			
	- At 12:07 p.m. the registered dietician (RD) entered the kitchen. When asked if the bucket of sanitizing liquid with the cloth submerged was appropriate for use she stated she did not know and would have to "check on that." C-A was observed to continue the same process of wiping with probe with the submerged cloth, with the same gloved hands.					
	was observed to ha and directed C-A to individual wipes to between each food hands, C-A was ob the box, tear a com into and through th obtained the tempe C-A was observed	RD returned to the kitchen and and C-A a box of alcohol wipes o use the prepackaged, clean the probe with in d item. With the same gloved pserved to remove a wipe from her off, and insert the probe he package, withdrew it and erature of the picante sauce. to repeat this process prior to aroni salad temperature.				
	individual resident on the service cour not observed to wa the kitchen or prior sheets. The RD wa the resident menu hands, C-A was ob	vas observed sorting through menu sheets that were laying nter in the kitchen, the RD was ash her hands upon entering to handling the resident menu as observed writing notes on sheets. With the same gloved bserved to sort through the sident menu sheets. The RD				
	with a policy titled, Guidelines. The por rinse, sanitize and each use. The poli mixture or a alcoho	RD returned to the kitchen Food Thermometer blicy directed staff to wash, air-dry the thermometer before cy also indicated a sanitizing of fabric wipe could be used for ces. However, the policy also				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING	B. WING		30/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE	NUE WEST PO BOX 700		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21000	Continued From pa	age 45	21000			
	indicated if a sanitizing solution was used, the thermometer must soak in the solution for one minute and allowed to air dry in between each use.					
	gloves, wash her h of gloves. C-A was individual resident into piles. With the observed to dish up pan using a spatula the spatula, C-A was the top of the cass while transferring it proceeded to place up a menu sheet a cover. C-A continue papers, select one serving of casserol C-A continued this resident meal plate service cart. C-A w dish area and obta wheeled it to the fo line. C-A was obset through additional to casserole onto the the three tiered car	was observed to remove the ands and donned a clean pair observed to pick up the same menu sheets and sorted them a same gloved hands, C-A was o the taco casserole from the a. Once the casserole was on as observed to cover and hold erole with her gloved hand to a resident meal plate. C-A e a cover over the plate, picked nd placed it on top of the ed to sort through the menu at a time, dish up another e using the same technique. process for another nine is and set them on the meal as observed to enter the dirty ined a three tier rolling cart and od service counter / food tray rved to pick up and sort resident menu sheets and p 16 resident casserole dishes hnique to transfer the plates and placed them onto t. At no time was C-A e her gloves or wash her	1			
	items after contam she should have w her gloves as she food. C-A also cont	verified she touched food inating her gloves. C-A stated ashed her hands and changed was not supposed to touch the firmed she had not followed d to properly cleaning the food				

Minnesc	ta Department of He	ealth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	(X5) COMPLETE DATE
21000	Continued From pa	ige 46	21000			
	thermometer probe	in between each use.				
	washed her hands prior to handling the RD verified C-A had in a sanitary manne sanitize the thermo addition, the RD sta the alcohol wipe fro the probe with the p facility policies were The facility's undate Washing policy dire upon entering the c before food handlin after handling any s equipment or clean -At 2:05 p.m. The c	ed Dining Services Hand ected staff to wash their hands lining service department, ing, preparation or service and soiled or contaminated ing cloths. lirector of nursing (DON) ty's policy was not followed ms should not be handled				
	SUGGESTED MET	HOD OF CORRECTION:				
	could develop, revie education for staff i appropriate food pr kitchen. The Quali	sing (DON) and/or designee ew or revise policies, provide regarding regarding eparation and sanitation in the ty Assessment and Assurance could do random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
Minnesota D	epartment of Health		μ	1		I

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ALKER	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
21390	Continued From pa	ge 47	21390			
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390		7/9/14	
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service e prevention and con E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system fo products which affed disinfectants, antise incontinence produ I. methods for	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and				
	by: Based on interview facility failed to ana resident and emplo	and document review, the lyze patterns and trends of yee infections. This had the Il 28 residents who resided in		POA initiated. Review and correction v be ongoing.	vill	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/	05/30/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	I LIVINGCENTER - W	209 BIRG	CHWOOD AVE	NUE WEST PO BOX 700			
		WALKER WALKER	R, MN 56484				
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21390	Continued From pa	age 48	21390				
	Findings include:						
	revealed a system program with ongo of infections and in of Resident Infection and 05/14, reveale prescribed antibiot tracking system lace without antibiotics. for employee infection	ity's infection control program which lacked a surveillance ing analysis and interpretation ifection risks. The Line Listing ons for 02/14, 03/14, 04/14, d only infections with ics were tracked. The facility's cked trending of infections In addition, a tracking system tions and comparison en resident and employee een established.					
	control program wa nursing services (I a daily report of re- antibiotics and entre Line Listing of Res Information include Resident Infections room number, date of infection, sympto other actions if nee was healthcare as acquired. She also nursing staff would prescribed antibiot DNS indicated she on the list and coo staff to ensure pro- resolution of the in had not been moni- prescribed antibiot analysis for trends	20 a.m. the facility infection as reviewed with the director of DNS). The DNS stated she ran sidents who were prescribed ered the information onto the ident Infections form. ed on the Line Listing of s included: resident name, e of birth, admission date, type oms/date, cultures, treatment, eded and whether the infection sociated or community o stated that, at times, floor I notify her of residents ics to be added to the list. The then followed those residents rdinated with physicians and gress was made toward fection. The DNS verified she itoring infections without a ic and confirmed there was no in resident infections. The did not gather data for					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		05/	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AIKFR	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ge 49	21390			
	resident and emplo	yee infections completed.				
	Infections policy da infection control co- infection control pe gathering and inter- analyzing the data t	r Healthcare-Associated ted 2001, indicated the ordinator or designated rsonnel was responsible for oreting surveillance data and to identify trends. A policy ing of employee infections was a was provided.	;			
	SUGGESTED MET	HOD OF CORRECTION:				
	could review or revi for staff regarding a program. The Qua	sing (DON) and/or designee ise policies, provide education a facility wide infection control lity Assessment and committee could do random mpliance.				
	TIME PERIOD FOR	R CORRECTION:				
	Twenty-one (21) da	ys.				
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 4 Tuberculosis htrol	21426			7/9/14
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must	e provider must establish and nensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis on that covers all paid and				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/	05/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
21426	Continued From pa	age 50	21426				
	residents, and volu Health shall provide regarding implement	contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision mus	t				
	by:	ent is not met as evidenced					
	MN Rule 4658.081	·		Correction initiated/ongoir	ng monitoring.		
	facility failed to com assessment accord Disease Control (C the transmission of ensure screening o testing was comple residents (R14). Ac provide TB screeni	and document review, the nplete a tuberculosis (TB) risk ding to the current Centers for EDC) guidelines for preventing tuberculosis and failed to of active TB symptoms and eted upon admission for 1 of 5 dditionally, the facility failed to ng and testing for 1 of 5 newly lirector of nursing services) as					
	Findings include:						
	was admitted to the the undated Baselin Residents revealed and symptoms of a were blank. Addition section for the TB to two-step tuberculin	ta Set (MDS) indicated R14 e facility on 1/16/14. Review o ne TB Screening Tool for d R14's history and risk factors active TB disease sections onally, the administration blood test was also blank. The skin test (TST) section read e tuberculosis skin test]. No					

Minneso	ta Department of He	alth			-	-
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		HWOOD AV , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From par result was found in On 5/29/14, at 12:5 of nursing (ADON) assessment, TB sy was performed or of indicated R14 had a tuberculosis skin te facility. The ADON no documentation of tuberculosis testing baseline chest X-ra- record to indicate R active TB disease. Review of the direc personnel record w lack of documentat screening and the f completed. On 5/30/14, at 1:18 not completed a TE since date of hire a The CDC Guideline Transmission of My Health Care Setting or newly positive TS M. tuberculosis) res radiograph to exclu (or an interpretable timeframe, such as chest radiograph is documented, repea-	ge 51 R14's medical record. 1 p.m. the assistant director confirmed R14's risk mptom screening nor testing completed. The ADON a previous positive st prior to admission to the further confirmed there was of the previous positive nor documentation of a y on file in R14's medical r14 did not have evidence of tor of nursing services as reviewed and revealed the ion to indicate the required TB irst or second step TST were p.m. DNS confirmed she had a screening or a TST prior to or	21426			
	SUGGESTED MET	HOD OF CORRECTION:				
-		sing (DON) and/or designee				
/linnesota D STATE FORI	epartment of Health VI		6899	S33Z11	If continuation	n sheet 52 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2014
GOLDEN	I LIVINGCENTER - W		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ige 52	21426			
	for staff regarding r tuberculosis screer Assessment and A					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			7/9/14
	monitor each reside unnecessary drug of home's policies and pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, t review to the Qualiti (QAA) committee r	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	9 r			
	This MN Requirem by: Based on interview	ent is not met as evidenced		Correction initiated.		

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		05/	05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	TATE. ZIP CODE	00/	50/2014	
	LIVINGCENTER - W	209 BI		NUE WEST PO BOX 700			
		WALK	ER, MN 56484				
(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 ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	age 53	21540				
	interventions were administering an ar	nti-anxiety medication of 5 residents (R45) whose	al				
	Findings include:						
	(MDS) dated 4/25/ cognitive impairme R45 was diagnosed diabetes. R45 was	hange Minimum Data Set 14, indicated R45 had severe nt. The MDS also indicated d with Alzheimer's Disease a admitted to hospice services sed with failure to thrive per er.	and				
		d 3/31/14, indicated R45 had nd had a medication to use.	da				
		hly Flow Sheets dated April cated R45 was diagnosed w ety disorder.	<i>i</i> ith				
	read, Lorazepam 0 hours as needed for administration try n interventions first: (stimulation (2) Han	ian's Orders dated 5/28/14, .5 milligrams (mg) every 8 or anxiety or agitation. Prior t ion-pharmacological (1) Remove resident from d massage (3) Unmet need, ing, hunger/thirst, is resident / the Lorazepam.	,				
	records for April an received the Loraze	edication administration d May 2014, MAR, R45 epam on 4/14/14, 4/27/14, 17/14, 5/20/14, and 5/26/14.					
		p.m. the assistant director of a ten and the assistant director of the time the	of				

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		05/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W		HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 54	21540			
21340	nurses do not docu that they tried the n interventions prior t ADON stated the n on the Behavior Mo non-pharmacologic the Lorazepam adn On 5/30/14, at 11:1 was no documenta the Lorazepam on s non-pharmacologic prior. At 11:53 a.m. nursin would ask for his m change clothes to g NA-A stated she wo by showing him his The undated Behave directed staff to use interventions, prior psychoactive medic	ment in the progress notes on-pharmacological o giving the Lorazepam. The urses should be documenting onthly Flow Sheets the al interventions tried prior to ninistration. 5 a.m. the ADON stated there tion that prior to R45 receiving seven occasions that al interventions were tried ng assistant (NA)-A stated R45 other, and would be looking to go to a wedding or a funeral. build be able to re-direct R45 wedding picture.	21040			
	SUGGESTED MET	HOD OF CORRECTION:				
	could develope, rev education for staff r non-pharmacologic Assessment and As	al interventions. The Quality ssurance (QAA) committee udits to ensure compliance.				
	apartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00995	B. WING		05/30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
21695	Continued From pa	age 55	21695		
21695	MN Rule 4658.141 Housekeeping, Op	5 Subp. 4 Plant eration, & Maintenance	21695		7/9/14
	provide housekeep necessary to maint comfortable interior	eeping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,			
	by: Based on observati failed to maintain th wall, flooring and pl maintained manner	ent is not met as evidenced ion and interview, the facility he kitchen dishwashing area lumbing in a clean and well r. This had the potential to hts services by the kitchen.		Correction initiated.	
	Findings include:				
	with dietary aide (E dishwashing counte crumbling material the wall. Rust was a floor within the sam the wall connecting attached to the dish observed rusty and leaking from the pip two feet by 3 feet w stated the area smo odor was "so strong also stated the area after maintenance	tour on 5/29/14, at 10:49 a.m. DA)-A the wall below the er was observed have with duct tape securing tiles to also observed on the wall and he area. A pipe coming from to the garbage disposal and hwashing counter was I corroded with water observed be. A rust stain approximately vas observed on floor. DA-A elled like a barn yard and the g" it "made her sick." DA-A a was somewhat improved had previously worked on it. rall and floor areas were	0		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00995	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W		RCHWOOD AVE ER, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
21695	Continued From pa	ige 56	21695			
		ministrator verified the findin ve identified area was "a	gs			
	staff (M)-A confirm odor was from staff disposal properly a	an interview maintenance ed the findings and stated th f not rinsing the garbage fter use. In addition, M-A and floor areas were problen				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop, review or education for staff r of the dietary depar Assessment and As	er and/or designee could revise policies, provide regarding proper maintenanc rtment. The Quality ssurance (QAA) committee udits to ensure compliance.	e			
	TIME PERIOD FOR Twenty-one (21) da					
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870		7/9/14	
	residents shall have	nsive service. Patients and e the right to a prompt and se to their questions and				
	by: Based on interview facility failed to act	ent is not met as evidenced and document review, the upon resident grievances for ent council meetings regardi		Correction initiated and ongoing.		

11111630	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		-	
		00995	B. WING		05/	30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE		
		209 BIR		NUE WEST PO BOX 700		
GOLDEN	LIVINGCENTER - W		R, MN 56484			
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	age 57	21870			
	food palatability. This had the potential to affect all 28 residents who received meals in the facility.		<i>.</i>			
	Findings include:					
	stated the food qua (residents) have co R38 added the qua sometimes it is und over cooked and jur residents who can themselves, but yo the food. The resid anything from the co the menu is changed don't have the food they did not get the delivered. R38 add complaints about th follow up. R38 cont with no tuna, the ve at times mushy, me cannot chew it. R3 that a member of th a meal with us and the quality of food to stated he was goin designee to find ou complaints are not council minutes. The resident counce documentation incl 1/22/14, residents 1 food is cold and foo On 2/20/14, five resi that the food is cold 3/28/14, "Is there a	brought up concerns that the od is not cooked thoroughly. sidents brought up concerns d. ny diabetic desserts besides	9, 9 5 9 1			
		spring menu coming here?				
mesota De	epartment of Health ⁄I		6899 오		lf continuati	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		05/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - W	ALKER 209 BIRC		NUE WEST PO BOX 700		
OULDEI		WALKER	, MN 56484			1
(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 TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	age 58	21870			
	food. Does the Adm suggestion?" Answ residents who agre small. Please let ki more pasta. Meal in and late." 4/25/14, "Is there a fruit? Would like to with residents at lea 5/16/14, "Food iter day of menu, i.e. sa carbohydrates, Foo cooked-vegetables On 5/30/14, at 9:40 the social service of resident council cou unpalatable food the stated, " If there is regarding the food, them verbally. I ha give to the kitchen concerns. I know the complaints about the added, "The dietary monthly meeting an bring up complaints form to notify the kit residents from the asked why all the foo documented in the would just go tell di stated, "We have a departments that the concerns with. I am form for the depart The SSD verified, " out regarding the co					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00995	B. WING	B. WING		05/30/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
GOLDEN LIVINGCENTER - WALKER 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484								
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
21870	resident council me The SSD provided Resident Council F the Golden Living s RSD are to be invo- more residents hav Response form (D DRF's need to hav completed and sign department head, a council meeting the the issue has been and needs to re-ac Repetitive problem The SSD verified th followed. On 5/30/14, at 9:55 (CD) was asked if council complaint f have not, but I hav vocal residents and been because they quality of the food. with the quality of th to improve this." On 5/30/14, at 11:4 services (DNS) ver should be followed regarding the poor been addressed. SUGGESTED ME ⁻ The director of nur could review or rev for staff regarding The Quality Assess	age 59 eetings regarding food quality. documentation titled, Process which indicated, "It is standard that the SSD and olved in the council. If two or ve issues, then the Departmen RF) is to be utilized. If the e a plan to correct the situation ned by the appropriate and then signed. At the next e resident will decide whether a resolved or remains ongoing ldress using the same format. s may need further address." hat the policy had not been 5 a.m. the consulting dietician she had received any resident orms, the dietician stated, " I e talked to some of the more d I asked how the food has v have complaints about the We are aware of the problems he food and we have to work 40 a.m. the director of nursing rified the resident council polic, , and the residents' concerns quality of food should have THOD OF CORRECTION: sing (DON) and/or designee rise policies, provide education resident grievance process. sment and Assurance (QAA) o random audits to ensure	t n s					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				·		
	00995		B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - W		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(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 B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
21870	Continued From page 60		21870			
	TIME PERIOD FOR CORRECTION:					
	Twenty-one (21) da	ays.				
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils		21942		7/9/14	
	boarding care hom advisory council ar fewer than three po participating. If one function, the nursin home shall docum council or councils year. This subdivis	council. Each nursing home or e shall establish a resident ad a family council, unless ersons express an interest in e or both councils do not ag home or boarding care ent its attempts to establish the at least once each calendar ion does not alter the rights of lies provided by section on 27.				
	by: Based on interview facility failed to atter within the past cale	ent is not met as evidenced and document review, the empt to form a family council endar year as required. This affect all 28 residents who ty.		Completed.		
	Findings include:					
	recreation director/ gave the surveyor indicated the next	3 a.m. the therapeutic social service designee (SSD) a letter dated 5/22/14, which Family Council meeting would , and treats would be served.				

Minnesc	ta Department of He	ealth							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 05/30/2014				
		00995							
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
GOLDEN LIVINGCENTER - WALKER 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE				
21942	At 9:08 a.m. the SSD stated there had not been an attempt to establish a Family Council meeting in 2013. The SSD stated the previous social worker would have been responsible during that time. The SSD stated she would be taking over the responsibility for establishing the Family Council on an annual basis. The last Family Council meeting was held on 10/11/12. The Family Council policy revised 10/09, indicated the social services director would provide assistance in coordinating the Family Council meetings. The expectation was to have Family Council available on at least a quarterly basis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education		21942						
Minnosoto	for staff regarding f Council. The Quali	ormulation of a Family ity Assessment and Assurance ould do random audits to R CORRECTION:							