DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICAT PART I - TO BE COMPLETED BY THE								
1. MEDICARE/MEDICAID PROVIDER N (L1) 245313 2.STATE VENDOR OR MEDICAID NO. (L2) 306920600 (L2)		 NAME AND ADI (L3) GOLDEN LI (L4) 2209 UTAH A (L5) BENSON, MI 	VINGCENTER - WENUE		(L6) 56215	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	 <u>(L8)</u> Recertification CHOW Complaint Other 		
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006	NERSHIP	 PROVIDER/SUP 01 Hospital 	PLIER CATEGORY 05 HHA	Y 09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co	omplaint		
6. DATE OF SURVEY 04/05 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	62 (L18) 62 (L17) 19 SNF	B. Not in Comp	ce With quirements		And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servi 7. Medical Direc	tor		
43 (L37) (L38)	19 (L39)	(L42)	(L43)						
an investigation of complain	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Post Ce an investigation of complaint number H5313021, verified correction, effective 17. SURVEYOR SIGNATURE Date : Lyla Burkman, Unit Supervisor 04/08/2015 (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL				18. STATE SURVEY AGENCY APPROVAL Date: 19. STATE SURVEY AGENCY APPROVAL Date: 10. March March 10. STATE SURVEY AGENCY APPROVAL Date: 10. March 04/30/2015 (L20) (L20)				
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			PLIANCE WITH C ITS ACT:	IVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
22. ORIGINAL DATE OF PARTICIPATION 05/01/1986	23. LTC AGREEMI BEGINNING I		4. LTC AGREEME ENDING DATI		26. TERMINATION ACTION: <u>VOLUNTARY</u> 0 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	0 INVOLUNT 05-Fail to M	L30) <u>CARY</u> eet Health/Safety eet Agreement		
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	Status Change		
28. TERMINATION DATE:	29	INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS				
	(L28)	00454		(L31)					
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 03/25/2015	OF APPROVAL DAT	ГЕ (L33)	Posted 05/06/2015 Co				



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245313

April 30, 2015

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

Dear Ms. Dillon:

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

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

Effective March 25, 2015 the above facility is certified for:

- 43 Skilled Nursing Facility/Nursing Facility Beds
- 19 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

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

Sincerely, mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

> Minnesota Department of Health - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2015

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, MN 56215

RE: Project Number S5313025, H5313021

Dear Ms. Dillon:

On February 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on February 13, 2015 that included an investigation of complaint number H5313021. 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 April 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2015, effective March 25, 2015 and therefore remedies outlined in our letter to you dated February 26, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

-Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

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

Enclosure

5313r15

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 245313	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/5/2015
Name of Facility		Street Address, City, State, Zip Code		
GOLDEN LIVINGCENTER - MEADOW LANE			2209 UTAH AVENUE BENSON, MN 56215	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 03/25/2015	ID Prefix		Correction Completed 03/25/2015	ID Prefix	F0242		Correction Completed 03/25/2015
Reg. # LSC	483.13(c)		Reg. # LSC	483.15(a)		Reg. # LSC	483.15(b)		_
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 03/25/2015	ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 03/25/2015	ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 03/25/2015
	F0353 483.30(a)	Correction Completed 03/25/2015	Reg. #			Reg. #			
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			
Reviewed I		viewed By B/mm	Date: 04/08/20	-	of Surveyor: 280	25		Date:	05/2015
State Agen Reviewed I CMS RO		<i>iewed By</i>	Date:		of Surveyor:			Date:	03/2013
Followup t	o Survey Comple 2/13/201				Uncorrected Defic			YES	NO

DEPARTMENT O	OF HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
						AND TRANSMITTAL	ID: TTVI
			TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00930
1. MEDICARE/MEDICA (L1) 245313	AID PROVIDER N	Ю.	3. NAME AND AI (L3) GOLDEN L			DOW LANE	4. TYPE OF ACTION: $\underline{2}(L8)$
2.STATE VENDOR OR	MEDICAID NO.		(L4) 2209 UTAH				1. Initial 2. Recertification
(L2) 306920600	MEDICI IID 110.		(L5) BENSON, N			(L6) 56215	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE C	CHANGE OF OWN	NERSHIP	7. PROVIDER/SU	JPPLIER CATEC	GORY	<u>03</u> (L7)	7. On-Site Visit 9. Other
(L9) 04/01/2006			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	02/13/201	15 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION S	TATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/II	D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CE	ERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS		I
From (a):			A. In Complia		110.	And/Or Approved Waivers Of	The Following Requirements:
To (b) :			-	equirements		2. Technical Personnel	
			1	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds		62 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds		62 (L17)	X B. Not in Cor				
			Requirem	ents and/or Appl	ied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BE	D BREAKDOWN					15. FACILITY MEETS	
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	43	19					
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AC	GENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNA	ATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Christina Ma	artinson, H	FE NEII	(03/18/2015	(L19)	Mark Meath	, Enforcement Specialist 03/25/2015 (L20)
	PART	II - TO BE	COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	
19. DETERMINATION				IPLIANCE WIT			ncial Solvency (HCFA-2572)
1 Engility	is Eligible to Partic	inata		HTS ACT:		2. Ownership/Contro	ol Interest Disclosure Stmt (HCFA-1513)
-	is not Eligible	ipac				3. Both of the Above	
2. Tacinty	is not Englote	(L21)					
22. ORIGINAL DATE	23	3. LTC AGREE	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATIO		BEGINNING		ENDING DA		VOLUNTARY _0	
05/01/1986						01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION 1	DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
		A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	(L27)			(L44)			00-Active
	(127)	B. Rescind Si	uspension Date:	(1.45)			
				(L45)			
28. TERMINATION DA	ATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
			00454				
		(L28)			(L31)		
31. RO RECEIPT OF CM	MS-1539	32	. DETERMINATION	N OF APPROVAI	DATE		
		(1.22)			(1.22)	DETERMINATION	DOVAL
		(L32)			(L33)	DETERMINATION APP	KUVAL

CCN: 24-5313

On February 13, 2015 a standard survey was completed at this facility. Deficiencies were found with the most serioud deficiency cited at a scope and severity level of F. The facility has been given an opportunity to correct before remedies would be imposed.

In addition at the time of the standard survey an investigation was conducted of complaint number H5313021. The complaint was substantiated at F353. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0808

February 26, 2015

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

RE: Project Number S5313025 and H5313021

Dear Ms. Dillon:

On February 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 13, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313021.

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. In addition, at the time of the February 13, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313021 that was found to be substantiated at F353.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 25, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 25, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 13, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

5313s15

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FORM APPROVE OMB NO. 0938-039 LTIPLE CONSTRUCTION (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING COMPLETED	
		245313	B. WING	MAR 1 3 2015 02/13/2015	
NAME OF I	PROVIDER OR SUPPLIER			MSTREEPADORESS, CITY, STATE, ZIP CODE	7
GOLDEN	I LIVINGCENTER - ME	EADOW LANE	總是奉礼子	2209 UTAH AVENUE BENSON, MN 56215	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG)N
F 000	The facility's plan c as your allegation o Department's accep	f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will	FC	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements.	
	on-site revisit of you validate that substa	acceptable electronic POC an ur facility may be conducted to ntial compliance with the n attained in accordance with			
	complaint investigat time of the standard	-			
F 226 SS=D	completed. The cor Deficiency issued a 483.13(c) DEVELO	P/IMPLMENT	F 2		
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ect, and abuse of residents n of resident property.		 Immediately pulled files of new hires and identified employees that did not have reference checks. Re-trained hiring managers immediately on the understanding and importance of attempting to check references prior to hire. BOM will photocopy listed references and date mailed to previous employers. 	5
	by: Based on interview failed to complete e	IT is not met as evidenced and record review, the facility mployee reference checks for mployees (NE-A, NE-B, abuse prohibition.		4. Random audits will be done by BOM/designee to ensure references have been mailed. Results reviewed at QAPI.) V

Brooke Dillon

Executive Director

3-10-2015

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

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

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	02/26/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION			E SURVEY PLETED
		245313	B. WING	i			· 02/	13/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE		
GOLDEN	LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 226	Continued From pa Findings include:	ge 1	F 2	226	6			
	Vulnerable Adult Ma March 2012, indica employment in the have the following s 1. Reference check employer 2. Appropriate licer 3. Drug testing per 4. Fingerprint as re 5. Criminal backgro policy or state law Review of the facilit forms revealed the -NE-A's work refere employee's name p direct the facility wh reference from. NE release of informatii -NE-B's work refere employees name, s information and loc -NE-C's work refere employees name, s information and loc During interview on administrator stated	equired by state law bound check pursuant to facility ty's work reference request following: ence request form only had the printed on the form and did not here to obtain the work -A's signature to authorize any on was also missing. ence request form had the signature for release of ation to send reference check. ence request form had the signature for release of ation to send reference check.						
	to mail the reference answer, then would administrator had v	e requests out and wait for an call if no response. The isited with the director of reported the DON was not expectation. The						

Event ID: TTVI11

Facility ID: 00930

If continuation sheet Page 2 of 30

TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY IPLETED
	·	245313	B. WING	· · · · · · · · · · · · · · · · · · ·	02/	13/2015
	PROVIDER OR SUPPLIER	EADOW LANE	2	BTREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215		``````````````````````````````````````
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 F 241 SS=D	aforementioned em attempt to check re 483.15(a) DIGNITY INDIVIDUALITY The facility must pr manner and in an e enhances each res full recognition of h This REQUIREMEI by: Based on interview facility failed to prov timely toileting assis reviewed for dignity Findings include: R7's quarterly Minir 12/5/14, indicated F had the following di neuromuscular disc osteoarthrosis, glau (inflamed colon). T extensive assistant dressing. Further, always continent of R7's care plan revis had a functioning d impairments cause potential vision limit identified R7 require	aployee records lacked an ferences as required. AND RESPECT OF omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced and document review, the vide dignified care related to stance for 1 of 1 resident (R7) c num Data Set (MDS) dated agnoses: body myositis (a order), depression, acoma and ulcerative colitis the MDS indicated R7 required and the MDS identified R7 was	F 226 F 241		ed	3.25.15

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		AND HUMAN SERVICES				FORM	02/26/2015 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245313	B. WING	i		02	/13/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CC		/ 10/2010
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IL	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	Continued From pa	ge 3	F	241			
	stated the facility net the floor to meet the stated approximate the call light on at 1 assistance to use th assistant came in ri off, told R7 she wou know he needed he stated he waited 10 the call light again a minutes for staff res after waiting for and toilet, the same nur room that came in a beginning. R7 state entered his room he to wait for a "God d nurse then entered should not talk to th R7 stated he inform not have to wait for bathroom because stated he told the ni movement in bed w him. R7 stated it ag accident in the bed an hour waiting for reason for it.	2/11/15, at 11:54 a.m. R7 beded to have more staff on a needs of the residents. R7 ly seven months ago he put 0:00 a.m. to request the bathroom and a nursing ght away, shut the call light uld let another staff member elp and left the room. R7 minutes before he pushed and then waited another 45 sponse after that. R7 stated other 55 minutes to use the sing assistant came into his and shut off his light in the very ed when the nursing assistant to told her he should not have amn hour." R7 stated the his room and informed R7 he to nursing assistant like that. Need the nurse that he should a whole hour to go the staff take their break. R7 urse he had a bowel shile waiting for staff to help ggravated him that he had an and then had to lay in bed for help. R7 stated there was no					

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Facility ID: 00930

If continuation sheet Page 4 of 30

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	02/26/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY PLETED
		245313	B. WING				02/	13/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE	E, ZIP CODE		
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPF	BE	(X5) COMPLETION DATE
F 241	and R7 stated he has the nurse he was go because no one wo help him to the bath phone call staff fina assist him, but it wa gone to the bathroo made him feel bad. In addition, R7 state had put the call light a.m. and at that poin nurse that he had to stated by the time s already gone in the they cannot get in to the nurses helped th as they could, but th some staff worked f call it "being frozen. pee or shit in your p would bother you to and you just get use me feel like a God o make me fester on On 2/12/15, at 1:49 stated R7 was usua bowel and never wo NA-A stated R7 was and making needs F required staff assist standing lift for trans R7 needed to have stated R7 was able	ad identified himself and told bing to "shit" his pants uld answer his call light and proom. R7 stated after the Ily made it to his room to is too late, he had already m in his pants. R7 stated it ed on 2/7/15, at 4:45 a.m. he t on to use the bathroom. R7 was not answered until 5:10 in the had yelled out to the o go to the bathroom. R7 taff got in to help him he had bed. R7 stated staff are sorry o help him in time and stated he nursing assistants as much hey didn't like it. R7 stated for 16 hours at a time, they "R7 also stated, "Anytime you ants it bothers you and it o. You know they are short ed to it. At the time it makes lamn invalid, but it does not it daily." p.m. nursing assistant (NA)-A Ily continent of bladder and ore incontinent products. a capable of using the call light (nown. NA-A reported R7 of one and a mechanical sferring onto the toilet when a bowel movement. NA-A	F 2	241				

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			. I		02/26/2015
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(MAPPROVED 0. 0938-0391
STATEMENT AND PLAN (FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		245313	B. WING			02	2/13/2015
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	/13/2015
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	L		BENSON, MN 56215		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	Continued From page	ne 5	 				
	e e i i i a e a i i e i i pa	es of bowel incontinence	F 24	41			
	while waiting for the	call light to be answered.					
	NA-A also confirmed	d R7 had on multiple personal cell phone to call the					
	nurses station to rec	quest help and then the nurse					
	would go find a nurs	sing assistant to assist R7					
	alert and knew what	ger. NA-A stated R7 was t was going on and wrote					
	everything down. N	A-A stated R7 used his call					
	hour or longer witho	nd when on would go a half ut being answered. NA-A					
	stated she felt bad v	when R7 was incontinent of					
	bowel because of th	e long wait and was always embarrassed. NA-A also					
	stated it was frustrat	ting to come to the facility					
	because staff felt the	ey could not do their jobs					
	we were neglecting	not enough staff and it felt like the needs of the residents.					
	NA-A added, as care	egivers they form bonds with					
	the residents.						
	During interview						
	stated R7 independe	2/12/15, at 2:13 p.m. NA-B ently used the urinal, required					
	assist of one staff ar	nd the mechanical standing					
	lift to get onto the toi	let for bowel movements and					
	NA-B confirmed R7	inent of bladder and bowel. had an incontinent bowel					
	episode due to staff	not responding to the call					
	work and had to be	ated she had just come to R7 get cleaned up, NA-B					
	stated she could tell	in R7's voice he was upset.					
	then stated R7 was a	able to do a lot of his cares by					
		rer incontinent and having to not dignified. NA-B stated R7					
	was very easy going	, always had jokes to tell and					
	was normally a pretty	y happy guy.					

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PRINTED:	02/26/2015
FORM A	PPROVED
OMP NO C	000 0004

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

OTATEMEN!			[1	0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245313	B. WING			02	/13/2015
GOLDEN	PROVIDER OR SUPPLIER	EADOW LANE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215	<u> </u>	
(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 241	During interview on practical nurse (LPI of bladder and bow recall R7 reporting having an incontine having to wait for st	ge 6 2/13/15, at 9:34 a.m. licensed N)-A stated R7 was continent el. LPN-A stated she did to her he was upset about nt bowel movement while aff to help him to the d R7 talked about it for a long	F2	241			
	director of nursing (aware of R7's episor related to staff not a The DON confirmed bladder and bowel a for toileting. The D0 expected to care fo	2/13/15, at 9:43 a.m. the DON) stated she was not odes of bowel incontinence answering the call light timely. d R7 was usually continent of and required staff assistance ON stated, "clearly" staff are r residents in a dignified mely toileting to avoid s.					
F 242 SS=D	dated July 2006, rev staff would treat res that maintained and self-worth and impro well-being and quali 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and hea her interests, asses interact with member inside and outside the	ent's Rights Dignity policy, vised October 2009, indicated idents with dignity and respect enhanced each resident's byed his or her psychosocial ty of life. TERMINATION - RIGHT TO e right to choose activities, th care consistent with his or sments, and plans of care; ers of the community both he facility; and make choices or her life in the facility that	F 2	42	 F242 1. Resident #7 is receiving a bath/shower per choice. 2. Immediately re -assessed each resident's bathing preference. 3. Re-train staff on resident rights and choices 4. Random audits of resident satisfaction per LSW/RNAC/Department Heads/Designee. Review at QAPI if problem identified. 		3.25.15

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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 02/26/2015 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		245313	B. WING _			0	2/13/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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)	D BE	(X5) COMPLETION DATE
F 242	Continued From pa are significant to the	-	F 24	42			
	by: Based on interview facility failed to prov to choose the type of	NT is not met as evidenced and document review, the ride residents the opportunity of bath they preferred for 1 of ewed with concerns regarding					
	Findings include:						
	12/5/14, indicated F had the following dia neuromuscular diso osteoarthrosis. The	num Data Set (MDS) dated 7 was cognitively intact and agnoses: body myositis (a rder), depression and MDS indicated R7 required ne staff with transfers, nd bathing.					
	reported he was new bathing options. R7 showers for the pas reported the facility stated it would have to sit and relax in the R7 stated he had m that it would be reall sometime and was the whirlpool tub. R requested a bath ag	2/11/15, at 11:34 a.m. R7 ver given a choice regarding ' stated he had only received t year and a half. R7 did have a whirlpool bath and felt so good on his muscles e warm water and bubbles. entioned to a staff member ly nice to have a bath told by staff they do not use 7 stated he had never pain after that as he assumed as not working, or an option use.					

Event ID: TTVI11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES					P		: 02/26/2015 APPROVED
1	CENTERS FOR MEDICARE & MEDICAID SERVICES				0		. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245313	B. WING			02	/13/2015
NAME OF I	PROVIDER OR SUPPLIER		T	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	13/2013
GOLDEN	I LIVINGCENTER - ME				209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 8	F 2	42			
	stated staff came in asked him if he war time they ever did th he would like a bath	02/13/15, at 9:06 a.m. R7 to his room last night and hted a bath or shower, "first hat." R7 stated he told them once in a while and then they e stated he had heard them hts too.					
	assistant (NA)-A sta per week, on Monda residents would pre- stated staff were un- bathing to the reside time to give a reside shower. NA-A state capable of giving sh	2/12/15, at 1:49 p.m. nursing ted R7 received one shower ays. NA-A confirmed many fer to have whirlpool baths but able to provide that choice of ents because it took extra ent a tub bath compared to a d currently staff were only owers or bed baths to ed, sometimes there isn't even showers.					
	assistant (NA)-B sta one staff to get into thad never received of the whirlpool jetted b resident a bath. NA	2/12/15, at 2:13 p.m. nursing ted R7 required assistance of the shower. NA-B stated she education on how to operate pathtub and had never given a -B was not sure why the g residents the choice of the					
	have a working whirl few residents that us RN-C stated staff wo	2/12/15, at 3:07 p.m. N)-C stated the facility did pool bath tub and did have a sed it, but not every time. buld offer a bath to residents re if a resident had a flare up					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCT A. BUILDING	COMPLETED
	COMPLETED
245313 B. WING	02/13/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRES	S, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE 2209 UTAH AVE BENSON, MN	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 242 Continued From page 9 F 242 of arthritis or something like that. RN-C stated there was quite a few years that the facility did not have a working tub, so now the facility was encouraging the nursing assistants to offer that choice to the residents again. RN-C stated the NAs had received training on the use of the whirtpool tub and stated a few of the nurses knew how to use it. F 242 During interview on 2/12/15, at 4:08 p.m. the director of nursing (DON) and the administrator both confirmed the facility did not specifically address the education regarding the use of the whirlpool tub in new employee orientation. The DON and the administrator stated bathing was offered to all residents on all three shifts, and could not ensure that all staff had been trained on the use of bathing residents using the whirlpool jetted tub. The administrator stated they could line up education and have that completed right away. During interview on 2/12/15, at 4:20 p.m. licensed social worker (LSW)-A stated with each admission the facility identified each resident's preference regarding bathing and documented on a "tidbit" sheet. LSW-A confirmed the facility did not complete a tidbit sheet to identify the individual preferences for R7 upon admission. On 2/13/15, at 8:55 a.m. LSW-A was observed reviewing R7's completed admission file. LSW-A confirmed the facility had not documented R7 preferences regarding bathing.	

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		AND HUMAN SERVICES				FORM	: 02/26/2015 1 APPROVED . 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245313	B. WING	i		02	/13/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	EADOW LANE			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242 F 282	The facility's Reside October 2009, wou preferences regard whenever possible.	ige 10 ent's Rights policy, dated Id give residents options and ing care and treatment RVICES BY QUALIFIED		242			
SS=D	PERSONS/PER CA The services provide must be provided b		F2	282	 F282 Resident #1 and # 34 are being reposition timely. Other residents identified as needing assis with repositioning are receiving care per caplan. Re-educate all staff on importance of tim repositioning and following care plans. Random weekly audits that residents are 	stance re nely	3:25.15
	by: Based on observat review, the facility d interventions for rep	NT is not met as evidenced ion, interview and document lid not ensure care planned positioning were implemented (R1, R34) reviewed for			receiving repositioning per care plan to be completed by charge nurses/clinical manager/designee. Review at QAPI if prob identified.		
	Findings include:						
	R1 was not reposition plan.	oned as directed by the care					
	1/9/15, revealed R1 communicate), requ for bed mobility and for transfers. The M risk for pressure uld repositioning progra	num Data set (MDS) dated had aphasia (loss of ability to uired total two staff assistance extensive assist of two staff IDS also indicated R1 was at ters, was on a turning and um and had a pressure he bed and wheelchair.					
		ed 1/22/15, indicated R1 had rel and bladder related to					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: TTVI11	L	Faci	ility ID: 00930 If continua	ion sheet	Page 11 of 30

PRINTED:	02/26/2015
FORM /	APPROVED
OMB NO	0038-0301

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	1	E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED	
		245313	B. WING			02/	13/2015
	PROVIDER OR SUPPLIER	EADOW LANE		22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	brain injury and was The care plan direc R1 on a schedule a assessment to ensu R1's comprehensiv 4/10/14 identified R pressure ulcers rela paralysis, incontine sitting and lying for indicated R1 require repositioning sched On 2/12/15, at 8:09 seated in a high-ba -At 9:36 a.m. R1 wa position. -At 9:44 a.m. nursir was last repositioned hours and 45 minute repositioning and st repositioned every to skin breakdown. N/ not get repositioned was unable to comm On 2/12/15, at 11:24 (RN)-C confirmed F plan identified R1's pressure ulcers. RN	nitive deficits from traumatic s at risk for pressure ulcers. ted staff to turn and reposition is determined by R1's skin ure skin would remain intact. e skin assessment, dated 11 was at "High risk" for ated to factors which included nce of bowel and bladder and extended periods of time and ed an every two hour lule when lying or sitting. a.m., R1 was observed cked wheel chair. as observed in the same ing assistant (NA)-A stated R1 ne wheelchair at 5:00 a.m. and ed at 7:45 a.m., a total of two res. NA-A confirmed the two is time span between tated R1 was to be two hours to reduce risk of A-A stated "sometimes" R1 did d every two hours, because R1	F 2	282			
	every two hours as	directed.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	D: 02/26/2015 MAPPROVED	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		245313	B. WING	ì)/12/2015	
NAME OF	PROVIDER OR SUPPLIER	· · ·	- -		STREET ADDRESS, CITY, STATE, ZIP CODE	0	2/13/2015	
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			BENSON, MN 56215		······	
PRÉFIX TAG	EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Continued From page	no 12						
	e en la eur rom pa	p.m. the director of nursing	F 2	282	12			
	(DON) confirmed R	1 was at risk for pressure						
	have been repositio	was expected that R1 would ned every two hours						
	according to the car	e plan.						
						a		
	R34 was not reposit the care plan.	ioned timely as directed by						
	R34's quarterly MDS	S dated 12/19/14, indicated						
	R34 was severely co extensive assistance (ADL) and had the for failure, dementia, ce and hemiparesis.	ognitively impaired, required e for all activities of daily living ollowing diagnoses: heart erebrovascular accident (CVA) he MDS also indicated R34 aff assistance for bed mobility of two staff and a						
	incontinence of bowe immobility and deme	ed 1/1/15, indicated R34 had el and bladder related to entia. The care plan directed osition R34 as determined by assessment.						
	3/21/14, indicated R3 pressure ulcers and tolerance at two hour required every two ho or sitting. The typed s assessment indicated interventions such as	e skin assessment dated 34 was at high risk for identified R34's tissue rs which indicated R34 our repositioning when lying summary portion of the d R34's skin was intact and s repositioning every two in the wheelchair was						

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Facility ID: 00930

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DEPARTMENT OF HEALTH AND HUMAN SERVICES				F		D: 02/26/201 M APPROVE	5	
CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 09				
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		3) DATE SURVEY COMPLETED		
		245313	B. WING)/10/0015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04	2/13/2015	\neg	
GOLDE	N LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO			\neg	
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 282	Continued From page	ge 13	F 28	32				
	and NA-G assisted via total mechanical observation, R34 w wheelchair until 9:53	on 2/11/5, at 7:15 a.m. NA-A R34 from bed to wheelchair lift. During continuous as observed to remain in the 3 a.m. (2 hours and 38 e observation, R34 was independently.						
	confirmed R34 was a.m. until 9:53 a.m., not able to reposition bed. NA-G stated R had open areas in th should be reposition pulled out the nursin	2/13/15, at 10:01 a.m. NA-G not repositioned from 7:15 and further stated R34 was n self in the wheelchair or in 34's skin was very fragile and he past. NA-G confirmed R34 ed every two hours, then g assistant assignment sheet ed staff cannot get to all the on everyone on time.						
i	During interview on 2 confirmed R34 had a six months ago and a repositioned every tw	2/13/15, at 10:23 a.m. RN-C an open area on the buttock should be turned and vo hours.						
F 309 SS=D	DON confirmed R34 ulcers and it was exp been repositioned ev of future skin breakd 483.25 PROVIDE CA HIGHEST WELL BEI	RE/SERVICES FOR	F 30	 F309 1. Updated code status on resident #14. 2. Code status of all residents have been review 3. Review code status quarterly at care conferences and with change of condition. 4. Random chart audits for proper documentat by clinical manager/RNAC/DNS/Designee. Review at QAPI if problem identified. 		325.15		

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Facility ID: 00930

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DEPARTMENT OF HEALTH AND HUMAN SERVICES					(: 02/26/2015
		& MEDICAID SERVICES						APPROVED 0938-0391
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(>	(3) DATE SURVEY COMPLETED	
		245313	B. WING				02	/13/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP COD	E	02,	13/2013
GOLDEN	I LIVINGCENTER - ME				2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRE			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	E NTE	(X5) COMPLETION DATE
F 309	Continued From page	ne 14						
		ary care and services to attain	ГС	309				
	or maintain the high	est practicable physical,						
	mental, and psychol accordance with the	social well-being, in comprehensive assessment						
	and plan of care.							
	This REQUIREMEN	IT is not met as evidenced						
	Based on interview	and document review, the						
	facility failed to coor for advanced directive who received hospic	dinate hospice interventions ves for 1 of 1 resident (R14) ce care.						
	Findings include:							
	identified a diagnosi order dated 11/11/14 The consult identifie	inimum Data Set (MDS) s of cancer. R14's physician 4, directed a hospice consult. d liver cancer with metastasis er parts of the body), and						
	directed no further o comfort as the only o	ncology treatment with						
	order dated 11/13/14	ders further included a signed 4, which directed no cardiac pation to assist breathing was						
	DNR/DNI (do not res request form, dated signed by R14's prim	revealed a form titled, suscitate, do not intubate) 11/13/14. The form was hary health care agent and to the order for DNR/DNI.						
	the front of R14's rec	ed a form in a plastic cover in cord titled, Resuscitation ective Review. The form had						

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Facility ID: 00930

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	: 02/26/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING	à		02	/13/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		10/2013
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		0(7)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ae 15	F	309			
	-	ns labeled, date of review;		508			
	code status: circle o	one, if changed, new form					
		ignature. The date of review as 11/12/14. In the code status					
	column, DNR was c	circled, then crossed out, and					
	full code (CPR and/ performed) was circ	or intubation was to be					
		p.m. LPN-A and RN-A					
		scitation form in the plastic R14's record would be the					
		ould consult for direction					
	should R14 become	e unresponsive without					
	heartbeat or breathi	ing.					
		p.m. RN-C confirmed the					
		form directed staff to perform R14 become unresponsive					
		r breathing. DON also					
		and verified there was a					
		monary resuscitation could ed on R14 even though the					
	directive in the orde	r was for DNR/DNI. RN-C and					
		d the form should have been 14's advanced directive					
	status.						
		I, Advance Directive Review,			F314		
		ed a procedure to ensure the ecords reflected health care					
	decisions as to adva	anced directives. The policy			1. Residents #1 and #34 are receiving repositioning per care plan. Residents #56 and	l	3.25.15
	included guidelines	which included the			#57 are no longer at facility.2. Other residents identified needing assistance	e	
	to quickly identify a	e facility had a system in place resident's code status and			with repositioning are receiving care per care plan.	-	
	that staff would know	w how to access the			3. Educate staff on updating care plans and		
F 314	information. 483.25(c) TREATM		F 3	N 1	nursing assistant care sheets. 4. Random audits to be completed by clinical		
	PREVENT/HEAL PR		гз	14	manager/charge nurses/designee. Review issuat QAPI if problem identified.	es	

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OMB NO	0938-0391

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

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	245313	B. WING		02/	13/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOW LANE			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215		
PREFIX (EACH DEFICIENCY MUS	INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
 who enters the facility we does not develop pressurindividual's clinical conditively were unavoidable; a pressure sores receives services to promote heat prevent new sores from This REQUIREMENT is by: Based on observation, is review, the facility failed repositioning to reduce the formation for 2 of 3 resident risk for pressure ulcer Findings include: R1's quarterly Minimum 1/9/15, revealed R1 with communicate), required for bed mobility and extent for transfers. The MDS arisk for pressure ulcers, repositioning program and reducing device in the beside the pressure ulcers. R1's Cognitive Loss/Der Communication Care Arboth dated 4/25/14, revealed 	ensive assessment of a st ensure that a resident vithout pressure sores ure sores unless the lition demonstrates that and a resident having a necessary treatment and aling, prevent infection and developing. s not met as evidenced interview and document to provide timely the risk of pressure ulcer dents (R1, R34) identified rs. Data set (MDS) dated a phasia (loss of ability to total two staff assistance ensive assist of two staff also indicated R1 was at was on a turning and nd had a pressure ed and wheelchair. mentia and ea Assessment (CAA), ealed R1 had sustained a d spinal cord injury which	F 3			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES					P		: 02/26/2015 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA							. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		245313	B. WING	i		02/	13/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2010
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 17	F٥	314	1	,	
	R1 had limited mob and bladder. The C, little independent m with a standing lift, r with bed mobility an ambulate. The CAA and staff repositioned	r CAA dated 4/25/14, indicated ility and incontinence of bowel AA also indicated R1 had very ovements, was able to stand requited extensive staff assist d transfers and did not indicated R1's skin was intact ed him every two hours with completed by the nurse.					
	incontinence of bow immobility, cognitive injury and was at ris	sment to determine					
	4/10/14, indicated R pressure ulcers and tolerance at two hour required every two h or sitting. The typed assessment indicate interventions such a	e skin assessment, dated 1 was at high risk for identified R1's tissue urs which indicated R1 nour repositioning when lying summary portion of the ed R1's skin was intact and is repositioning every two ir in the wheelchair was					
	dated 10/8/14, revea pressure ulcers, how risk for pressure ulc	lisciplinary Resident Review aled R1 had no current vever, indicated R1 was at ers and staff were to two hours while in bed and					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM	: 02/26/2015 APPROVED . 0938-0391
				PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245313	B. WING	ì			02	/13/2015
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, Z	IP CODE		10/2010
GOLDEN LIVINGCENTER - MEADOW LANE					2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF	0000000000		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ne 18	- -	.				
	wheel chair.	ge to	F3	314	+			
	On 2/12/15 at 8:00	a.m. R1 was observed seated						
	in a high-backed wh	neel chair.						
	-At 9:36 a.m. R1 wa position.	as observed in the same						
		g assistant (NA)-A stated R1						
		e wheelchair at 5:00 a.m. and						
		ed at 7:45 a.m., a total of two es. NA-A confirmed the two						
	hour and 45 minute	time span between						
	repositioning and very	erified R1 was to be wo hours in order to reduce						
	risk of skin breakdo	wn. NA-A stated "sometimes"						
	R1 did not get repos	sitioned every two hours, able to communicate needs.						
	because n'i was un	able to communicate needs.						
	On 2/12/15, at 11:20	0 a.m. registered nurse						
		1's skin assessment and						
	pressure ulcers. RN	sk for the development of I-A stated it was expected that						
	R1 be turned and re	positioned every two hours as						
	directed in order to i	reduce skin breakdown.						
	0							
	On 2/12/15, at 1:42	p.m. the director of nursing 1 was at risk for pressure						
	ulcers and it was ex	pected that R1 would have						
	been repositioned e	very two hours to reduce risk						
	of skin breakdown.							
							:	

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P		
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		APPROVED
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245313	B. WING	i		02/	/13/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R34's quarterly Min 12/19/14, indicated impaired, required e activities of daily livi following diagnoses cerebrovascular acc The MDS also indic staff assistance for assist of two staff at transfers. The MDS risk for pressure ulc repositioning progra reducing device in t R34's Pressure Ulca indicated R34 had li incontinence of bow indicated R34 need two with bed mobilit transfers and toiletir CAA indicated R1's repositioned him evic checks completed b R34's care plan data incontinence of bow immobility and demos staff to turn and repo the tissue tolerance R34's comprehensiv 3/21/14, indicated R pressure ulcers and tolerance at two hou required every two hou	imum Data set (MDS) dated R34 was severely cognitively extensive assistance for all ng (ADL) and had the : heart failure, dementia, cident (CVA) and hemiparesis. ated R34 required total two bed mobility and extensive nd a mechanical lift for also indicated R34 was at ers, was on a turning and um and had a pressure he bed and wheelchair. er CAA dated 3/21/14, mited mobility and rel and bladder. The CAA also ed extensive assistance of y, and was dependent for ng, and did not ambulate. The skin was intact and staff ery two hours with weekly skin by the nurse. ed 1/1/15, identified R34 had el and bladder related to entia. The care plan directed position R34 as determined by	F3	314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/26/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY IPLETED
		245313	B. WING			02/	13/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	<u> </u>	10/2010
GOLDEN	LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE
	interventions such a hours while in bed of currently in place. During observation and NA-G assisted via total mechanical observation, R34 w wheelchair until 9:53 minutes). During th unable to reposition During interview on confirmed R34 was a.m. until 9:53 a.m. and further stated R self in wheelchair or was very fragile and NA-G confirmed R3 every two hours, the assistant assignmen stated staff could no order to reposition e During interview on registered nurse (RI history of open area be turned and repose During interview on DON confirmed R34	ed R34's skin was intact and as repositioning every two or in the wheelchair was on 2/11/5, at 7:15 a.m. NA-A R34 from bed to wheelchair lift. During continuous vas observed to remain in the 3 a.m. (2 hours and 38 e observation, R34 was independently. 2/13/15, at 10:01 a.m. NA-G not repositioned from 7:15 for 2 hours and 38 minutes, 34 was not able to reposition bed. NA-G stated R34's skin had open areas in the past. 4 should be repositioned in pulled out the nursing nt sheet to verify. NA-G ot get to all the residents in everyone on time. 2/13/15, at 10:23 a.m. N)-C confirmed R34 had a on the buttocks and should itioned every two hours. 2/13/15, at 10:24 a.m. the was at risk for pressure	F 3				
	been repositioned e of future skin break						

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Facility ID: 00930

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IMENT OF HEALTH	AND HUMAN SERVICES		PI	RINTED: 02/26/201
	& MEDICAID SERVICES			FORM APPROVEL MB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	B. WING		02/13/2015
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2013
I LIVINGCENTER - ME				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION
Continued From page	ge 21	F 314	1	
revised 2/25/10, ind would be initiated to needs and minimize skin. 483.30(a) SUFFICIE PER CARE PLANS The facility must hav provide nursing and maintain the highest and psychosocial we determined by resid- individual plans of ca The facility must pro- numbers of each of personnel on a 24-h care to all residents care plans: Except when waived section, licensed nur- personnel. Except when waived section, the facility m nurse to serve as a c duty. This REQUIREMENT by: Based on observatio	icated a positioning schedule meet individual resident concentrated pressure to ENT 24-HR NURSING STAFF // e sufficient nursing staff to related services to attain or practicable physical, mental, ell-being of each resident, as ent assessments and are. vide services by sufficient the following types of our basis to provide nursing in accordance with resident under paragraph (c) of this reses and other nursing under paragraph (c) of this reses and other nursing under paragraph (c) of this pust designate a licensed charge nurse on each tour of T is not met as evidenced on, interview and document	F 353	 F353 Scheduling sufficient staff to meet resident # and # 34. Residents #56 and # 57 are no at long at facility. Addressing staffing patterns by making changes as needed based on all resident needs. Facility to re-establish a Recruitment and Retention Committee. Random direct care audits and interviews that care and services are being provided sufficiently 	ger 5.25.17
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER I LIVINGCENTER - ME SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS Continued From pay The facility policy titl revised 2/25/10, ind would be initiated to needs and minimize skin. 483.30(a) SUFFICIE PER CARE PLANS The facility must hav provide nursing and maintain the highest and psychosocial we determined by reside individual plans of ca The facility must pro numbers of each of personnel on a 24-h care to all residents care plans: Except when waived section, licensed nur personnel. Except when waived section, the facility m nurse to serve as a c duty.	DENTIFICATION NUMBER: 245313 PROVIDER OR SUPPLIER LIVINGCENTER - MEADOW LANE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 The facility policy titled, Skin Care Guidelines, revised 2/25/10, indicated a positioning schedule would be initiated to meet individual resident needs and minimize concentrated pressure to skin. 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	BS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 245313 B. WING PROVIDER OR SUPPLIER 245313 B. WING ILVINGCENTER - MEADOW LANE D PREFICENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 21 F 314 The facility policy titled, Skin Care Guidelines, revised 2/25/10, indicated a positioning schedule would be initiated to meet individual resident needs and minimize concentrated pressure to skin. F 353 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. F 353 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: F Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document F	SPOR MEDICARE & MEDICAID SERVICES O OP DEFICIENCIES (1) PROVIDERSUPPLIENCLA IDENTIFICATION NUMBER: (2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER 245313 IS THOUSER SERVICES 245313 IS PROVIDER OR SUPPLIER 245313 IS UNINGCENTER - MEADOW LANE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG PROVIDERS PLAN OF CORRECTION (200 CONSERVER ACTION SIGURE) (200 UTAH AVENUE BENSON, MN 56215 Continued From page 21 F 314 F 314 The facility policy titled, Skin Care Guidelines, revised 2/25/10, indicated a positioning schedule would be initiated to meet individual resident needs and minimize concentrated pressure to skin. F 314 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychoscolal well-being of each resident as determined by resident assessments and individual plans of care. F 353 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing eare to all residents in accordance with resident care plans: - Addresing admin all skin med. - Reident assess at OAPI if problem identified. Except when waived under paragraph (c) of this section, licensed nurses and other nurusing personnel. Scheduling m

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		AND HUMAN SERVICES			P		D: 02/26/2015 MAPPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES					0		<u>D. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245313	B. WING			02	2/13/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	02	/13/2015
GOLDEN LIVINGCENTER - MEADOW LANE				2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 353	Continued From page	ne 22	- -				
	qualified nursing sta	aff were available to meet	F3	53			
	resident needs for n	iursing care in a manner					
	and psychosocial w	ch resident's physical, mental ell-being, thus enhancing their					
	quality of life. This p	ractice had the potential to					
	affect all 49 resident	ts residing in the facility.					
	Findings include:						
	Findings include:						
	The facility failed to assistance for 1 of 1 bowel incontinence.	provide timely toileting resident (R7) resulting in Refer to F241.					
	repositioning service assessed need for 2	provide timely turning and es according to the individual 2 of 3 residents (R1, R34) as idual care plans. Refer to					
	indicated resident R 12:45 p.m. and answ time of 35 minutes. T summoned for assis in which he required	ht audits dated 10/20/14, 56's call light was put on at vered at 1:20 p.m., a wait The audit indicated R56 had tance to go to the bathroom two staff assistance and the lift for transfers. Refer to					L. L
	11/13/14, indicated F 2:59 p.m. and answe of 31 minutes. The a	v of the call light audits dated R57's call light was put on at pred at 3:30 p.m., a wait time audit further indicated R57 stance due to complaints of					

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PRINTED:	02/26/2015
FORM /	APPROVED
OMB NO.	0938-0391

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

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	245313	B. WING		02/	13/2015	
NAME OF PROVIDER OR SUPPLIER	ADOW LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	<u> </u>		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
staffing schedules fo 8/7/14 to 1/31/15, ind shifts in which no reg identified to have had day shift, evening sh Various Open Shifts nights -8/7/14 to 8/31/14: 73 -9/1/14 to 9/30/14: 6 -10/1/14 to 10/31/14: -11/1/14 to 11/30/14: -12/1/14 to 12/31/14: -1/1/15 to 1/31/15: 3 On 2/12/15, at 11:18 staffing schedules fo to 1/31/15, indicated which no regular sch to have had worked t evening shift and nig Various Open Shifts nights -8/1/14 to 8/31/14: 3 -9/1/14 to 10/31/14: -10/1/14 to 10/31/14: -12/1/14 to 12/31/14: -12/1/14 to 12/31/14: -12/1/14 to 12/31/14: -12/1/14 to 13/115: 42 During interview on 2 assistant (NA)-A stat	 a.m. during review of or nursing assistants from dicated the following open gular scheduled staff were d worked the individual open ift and night shifts. Available: days, evening and 3 shifts open 57 shifts open 33 shifts open 39 shifts open a.m. during review of or licensed nurses from 8/1/14 the following open shifts in neduled staff were identified the individual open day shift, jht shifts. Available: days, evening and 1 shifts open 32 shifts open 23 shifts open 23 shifts open 24 shifts open 25 shifts open 27 shifts open 27 shifts open 	F3	353			

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

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Facility ID: 00930

If continuation sheet Page 24 of 30
DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		: 02/26/2015 APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES			0		. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245313	B. WING	i		02/	13/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ME				209 UTAH AVENUE BENSON, MN 56215		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	NA-A also stated the hour shift she had b work longer for a to next shift being sho used to have five N the skilled level side two NAs on each er would float back and only have two NAs of and they had not ha NA-A stated they us evening shift and no NA-A stated the nig NA and one license which also included confirmed that that was no one to answ returned from break NA-A verified R7 ha due to the long wait nurses did not help helped with the Stat NA-A stated the faci everyone to come in here" [surveyors]. N had only two NAs so "we don't even have the residents and ye resident care." NA-A to management abo attitude and then we confirmed staff get " to work later) into th shortages.	at after already working a 12 been told she would have to tal of 16 plus hours due to the rt staffed. NA-A stated they As working the day shift on e of the facility which included hd and the restorative aid d forth, and now they have working on the skilled side the arestorative aid for years. Seed to have four NAs on the bw they only have two NAs. ht shift staff consisted of one d nurse for the skilled side the board/care side. NA-A when she went on break there were her call lights so when she the residents were mad. d bowel accidents in his pants time for help. NA-A stated the with call lights and only e survey agency was present. lity had been trying to call no work because "you are A-A verified this evening shift cheduled to work and added, e the people to take care of et we are told its all about A added, "when we try to talk but it, they tell us we have an e get into trouble." NA-A frozen" (meaning mandated e next shift for staff	F3	353			
	practical nurse (LPN have enough staff to	2/11/15, at 8:27 a.m. licensed I)-A verified the facility did not o cover all the open shifts and					

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/26/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
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GOLDEN	I LIVINGCENTER - ME	EADOW LANE			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	had to have other e facilities to help. LP the help." LPN-A sta work until 10:00 a.m to stay because the stated if she would as scheduled, that we the whole east and home. LPN-A stated NAs, two nurses and verified they had be each wing and a nur with cares. During interview on stated compared to the facility "is terrible not enough staff to NA-G stated she was into the next shift) to 6:00 p.m. that even not get her work do cares time such as timely. NA-G added you feel for the resid had to work overtimp period and stated "y sometimes I do feel neglected." NA-G v along time for assis and R7 has had acc waiting, but they alw NA-G added, "I use now I feel so bad fo she had gone to the	mployees come from other N-A added, "They do not have ated she was scheduled to h. today, but was told she had surveyors were here. LPN-A have went home at 10:00 a.m. would have left one nurse for west wing of the nursing d they used to have three d a restorative aid working but en working with one NA on rse would try to help them 2/11/15, at 2:54 p.m. NA-G two years ago, the staffing at el" NA-G confirmed there was cover all the open shifts. as "frozen" (mandated to work herefore, had to work until ing. NA-G verified she could ne, provide all the resident repositioning and toileting , "My mind is boggling and dents." NA-G confirmed she e four to five times a pay rou are always frozen and like they [residents] are erified R7 has had to wait tance and staff try to hurry sidents in his pants due to rays have to hurry with cares. d to feel good about work, r the residents." NA-G state e director of nursing (DON) for was due to resident census,	F 3	53			

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Facility ID: 00930

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		AND HUMAN SERVICES			PH	INTED: 02/26/2015 FORM APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES			ON	AB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245313	B. WING			02/13/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - ME	EADOW LANE		2209 UTAH AVENUE		
				BENSON, MN 56215		
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F 353	Continued From pa	age 26	F 35	3		
	not toilet the resider morning cares, som toileted again until a she could not get re and feed them, ther late, as late as 10:3 stated she was also residents timely, pro- fingernails and don' residents their baths forced to feel like w During interview on confirmed there was the open shifts and it is really stressful t don't have enough p verified she could n they had so many re increased level of co- residents toileted ar stated sometimes a residents had to wa repositioned or toile provided cares for th first and the residen wait to get toileted a "We try but we cant work 12 hours, you confirmed she was	0 a.m. NA-A stated she could nts on time and stated after ne of the residents did not get after lunch. NA-A also stated esidents to breakfast on time refore, breakfast was always 0 a.m. In addition, NA-A o unable to reposition the ovide dental hygiene, trim their 't have people to give the s. NA-A added, "We get re are neglecting people here." 2/12/15, at 10:44 a.m. NA-B s not enough staff to cover all stated "staffing is terrible and to come to work because you people to help you." NA-B not get her work done because esidents that required are that they could not get the nd repositioned on time. NA-B after morning cares, the it until after lunch to get ted again. NA-B stated staff he residents that could talk nts that could not talk had to and repositioned. NA-B stated, get it all done and when you are exhausted." NA-B frozen five to six times a pay				
	I feel like I am gettir	2/12/15, at 11:10 a.m. LPN-B				
	67(02-99) Previous Versions		LF	acility ID: 00930	If continuation	n sheet Page 27 of 30

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		AND HUMAN SERVICES				FORM	: 02/26/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
v		245313	B. WING	i		02	/13/2015
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GOLDEN	I LIVINGCENTER - ME	EADOW LANE			2209 UTAH AVENUE BENSON, MN 56215		
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F 353	confirmed there wa nursing home to co- stated, "we could us when she worked in could not get all her and answer call ligh compared to over h honestly I have relie LPN-B verified the f working a shift then and now they might working the floor. LI people repositioned always get it done." breakfast was not b the NAs could not g on time to eat. During interview on director of nursing (not enough staff to stated, "yes we do h would like to hire a the facility had one short and verified st mandated to stay la don't have a choice picked up extra shift the frozen policy mo stated someday's it getting burnt out an- verified she had rec that the repeated 12 getting to be too mu	ge 27 s not enough staff in the ver all the open shifts and se more help." LPN-B verified in the long term care unit, she work done, provide cares its and stated, "It is busy ere [board and care] and of when I work over here." facility used to have four NAs dropped down to three NAs have two or three NAs PN-B stated, "They try to get and toileted but you can't In addition, LPN-B stated being served on time because get people to the dining room 2/12/15, at 11:18 a.m. the DON) confirmed there was cover all the open shifts and have issues with staffing and I few more." The DON stated weekend that was always taff were frozen and were te. The DON added, "They ." The DON indicated staff ts but they also had to utilize one so than not. The DON felt as though staff were d some days not. The DON reived complaints from staff 2 and 16 hour shifts were ich and also a request to have rening shift. The DON stated	F	353			
	DON denied any sp	on facility census only. The ecific concerns about cares there of, and complaints from					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/26/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
		245313	B. WING _		02	/13/2015
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GOLDEN	I LIVINGCENTER - ME			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	D BE	(X5) COMPLETION DATE
F 353	the residents. The E complaints about ca which call lights aud call light response to During interview on DON verified the da three NAs schedule census was up they DON verified the ev and three NAs or so they would freeze th night staff come in e night shift consisted or two NAs for the v the nurse would hel duty. The DON state enforced on a daily when the census dr shifts. The DON state resident census and During interview on administrator denied resident concerns o she believed the fac nurses worked 12 h request. The administrat stayed an additional shift, and the night s cover the evening of verified she had rec- related to staffing ch	2/12/15, at 1:50 p.m. the and lights not being answered in dits were done which revealed ime problems after meals. 2/12/15, at 1:50 p.m. the and the problems after meals. 2/12/15, at 1:50 p.m. the and the two nurses and d, but when the resident would have four NAs. The rening shift had two nurses ometimes two NAs which then the day shift staff and have earlier. The DON stated the d of one nurse and either one whole facility. The DON stated p if there was only one NA on ed the freeze policy was basis. The DON also stated opped, they utilized shorter ted staffing was based on	F 35	53		

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Facility ID: 00930

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PRINTED: 02/26/2015

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		245313	B. WING			02/13/201	15
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	02/13/201	<u> </u>
GOLDEN	LIVINGCENTER - MI	EADOW LANE		2209 UTAH AVENUE BENSON, MN 56215			
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F 353	schedule and state census and the acu administrator confir complaints in the pa being answered and done and they had addition, the admini served a little late a been offering reside well.	d made changes to the d they based staffing off the uity of resident care. The med she had also received ast about the call lights not d verified call light audits were tried to "fix it in QAA." In istrator verified breakfast was t times and staff should have ents the whirlpool baths as	F3	······································			
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F241-D

1. Resident #7 is receiving care in a dignified manner Dignity means interactions with residents will maintain and enhance self-esteem and self-worth.

2. All residents are receiving care in a dignified manner. Dignity means interactions with residents will maintain and enhance self-esteem and self-worth.

3. Random call light, care observation and resident interview audits three times a week for six weeks. This will include an audit of timely toileting. Audits to be completed by DNS/Clinical Manager/Designee.

4. Review at QAPI if problem identified

F242 -D

1. Resident #7 is receiving a bath/shower per choice.

2. Immediately re -assessed each resident's bathing preference.

3. Re-train staff on resident rights and choices per policy. Assess resident choices upon admission and quarterly at care conferences.

4. Random audits of resident satisfaction per

LSW/RNAC/Department Heads/Designee. Review at QAPI if problem identified.

F282-E

1. Resident #1 and # 34 are being repositioned timely.

2. Other residents identified as needing assistance with repositioning are receiving care per care plan.

3. Re-educate all staff on importance of timely repositioning per skin integrity guidelines and following care plans.

4. Three audits per week on alternating shifts for six weeks that residents are being repositioning per care plan to be

completed by charge nurses/clinical manager/designee. Review at QAPI if problem identified.

F309-E

1. Updated code status on resident #14.

2. Code status of all residents have been reviewed and updated if needed.

3. Educate staff to review code status on admission, at quarterly care conferences and with change of condition.

4. Random chart audits three times a week for six weeks for proper documentation by clinical

manager/RNAC/DNS/Designee. Review at QAPI if problem identified.

F314-D

1. Residents #1 and #34 are receiving repositioning per care plan. Residents #56 and #57 are no longer at facility.

2. Other residents identified needing assistance with repositioning are receiving care per care plan.

3. Educate staff on repositioning residents every two hours (per skin integrity guideline) who are unable to independently, update care plans and nursing assistant care sheets.

4. Random audits three times a week for six weeks on alternating shifts to be completed by clinical manager/charge nurses/designee. Audits will include observation of resident, care plans and nursing assistant care sheets. Review issues at QAPI if problem identified.

F353-F

1. Scheduling sufficient staff to meet resident #1 and # 34. Residents #56 and # 57 are no at longer at facility.

2. Continually address staffing patterns by making changes as needed based on all resident acuity and discussing with staff based on resident acuity.

3. Facility to re-establish a Recruitment and Retention Committee to maintain a stable staffing pattern.

4. Random observational care audits and interview with resident/staff three times a week for six weeks that cares and services are being provided sufficiently by clinical manager/charge nurse/DNS/Designee. Review issues at QAPI if problem identified.

		AND HUMAN SERVI & MEDICAID SERVI	CES F	53130	023		MAPPROVED 0. 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			LE CONSTRUCTION 6 01 - Main Building 01	(X3) DATE S COMPL	
		245313		B. WING		02/*	11/2015
	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER -	MEADOW LANE		TAH AVENU DN, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL R NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY			*			
	Minnesota Departm time of this survey, Meadow Lane was compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	e requirements for pa hid at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc 01, Life Safety Code	At the r - rticipation rt 2000 iation				2
	building with a partia constructed at 3 diff building was constru- facility and was deter construction. In 197 built that was deterr construction. In 197 connect the SNF/NI which was determin construction. Becau the 2 additions mee	er - Meadow Lane is al basement. The bui ferent times. The orig ucted in 1958, it is an ermined to be of Type 70, the SNF/NF facilit mined to be of Type I 76 an addition was ac F building to the NF2 hed to be of Type II(0) use the original building the construction typ buildings, the facility uilding.	ilding was ginal n NF2 e V(000) y was I(222) Ided to building 00) ng and pes				
	facility has a fire all detection in the corr corridors that is mo department notification	sprinklered throughd arm system with smol ridors and spaces op nitored for automatic tion. The facility has a f 62 and had a censu ey.	ke en to the fire a				, m
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	NTATIVE'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.

Printed: 02/24/2015

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 245313 B. WING 02/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/11/2015 GOLDEN LIVINGCENTER - MEADOW LANE STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE PREFIX (EACH DEFICIENCY MUST BE PREOEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLET K 000 Continued From page 1 K 000 K 000 K 000 K 000 K 000 SUMMARY STATEMENT 483.70(a) is K 000 K 00		TMENT OF HEALTH RS FOR MEDICARE						MAPPROVED D. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - MEADOW LANE 2209 UTAH AVENUE BENSON, MN 56215 (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) COMPLET COMPLET DATE K 000 Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is K 000								
GOLDEN LIVINGCENTER - MEADOW LANE 2209 UTAH AVENUE BENSON, MN 56215 (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) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is K 000			245313		B. WING		02/ [,]	11/2015
FREFIX LEAGN DEFICIENCE (LAGN DEFICIENCE) TAG OR LSC IDENTIFYING INFORMATION) K 000 Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is			MEADOW LANE	2209 U [.]	TAH AVENU	JE		9
The requirement at 42 CFR, Subpart 483.70(a) is	PRÉFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
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Printed: 02/24/2015



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6357 0808

February 26, 2015

Ms. Brooke Dillon, Administrator Golden LivingCenter - Meadow Lane 2209 Utah Avenue Benson, Minnesota 56215

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5313025 and H5313021

Dear Ms. Dillon:

The above facility was surveyed on February 9, 2015 through February 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5313021. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Golden LivingCenter - Meadow Lane February 26, 2015 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

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 Lyla Burkman at the number of email listed above.

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

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

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

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		00930	B. WING	dinnestoa Denatiment or Health	02/	13/2015
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OLDEN	LIVINGCENTER - MI		HAVENUE MN 56215			
(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 AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all rule provided at the tag ile number indicated below. Its several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item tring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	Department's staff, the following licensin corrections are com make a copy of thes original to the Minne Division of Compliar	S: 2/13/15, surveyors of this visited the above provider and ng orders were issued. When pleted, please sign and date, se orders and return the esota Department of Health, nce Monitoring, Licensing and		Minnesota Department of documenting the State Li Correction Orders using Tag numbers have been Minnesota state statutes/ Homes.	censing federal software. assigned to	200 d 3/23 8
esota De RATORY	partment of Health DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE
	Mar nillow				3-19-2015	(NO) DAIE

IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00930	B. WING		02/1	3/2015
PROVIDER OR SUPPLIER			STATE, ZIP CODE		
I LIVINGCENTER - ME		-			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Initial Comments		2 000			
*****ATTE	NTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag alle number indicated below. The several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
You may request a that may result from orders provided tha the Department with notice of assessme INITIAL COMMENT On 2/9/15, through Department's staff, the following licensi corrections are com make a copy of the original to the Minne	n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance. S: 2/13/15, surveyors of this visited the above provider and ng orders were issued. When npleted, please sign and date, se orders and return the esota Department of Health,		documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned	oftware. to	
	I LIVINGCENTER - ME SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Initial Comments *****ATTEN NH LICENSING In accordance with 144A.10, this correc pursuant to a surve found that the defici herein are not correc not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess that was violated du corrected. You may request a that may result from orders provided that the Department with notice of assessme INITIAL COMMENT On 2/9/15, through Department's staff, the following licensi corrections are com make a copy of the original to the Minne	STREET ADD PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/9/15, through 2/13/15, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	D0930 B. WING	O0930 E. WING PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTIONS NON 56215 PROVIDER'S PLAN OF CORRECTIVE REQUATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SINCE) Initial Comments 2 000 D CERCIENCY MUST BEEN USED (EACH CORRECTIVE ACTION SINCE) D D DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SINCE) Initial Comments 2 000 2 000 D DEFICIENCY (EACH CORRECTION ORDER D D DEFICIENCY In accordance with Minnesota Statute, section 144A 10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. Minnesota Department of Health, the any result from non-compliance. INITIAL COMMENTS: On 28/15, through 2/13/15, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When correction as ac completed, please sign and date, make a copy of these orders and return the oringinal to the Minnesota Department of Health, Division of Compli	B. WING STREET ADDRESS, GITY, STATE. ZIP CODE PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE. ZIP CODE LIVINGCENTER - MEADOW LANE 2209 UTAH AVEINUE BENSON, MIN 56215 PROVIDERS PLAN OF CORPECTION (EACH CORRECTIVE ACTION PROLID BE (EACH CORRECTION ORDER) PROVIDERS PLAN OF CORPECTION (EACH CORRECTION ORDER) Initial Comments 2 000 ···································

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

TITLE

TTVI11

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP		
		00930	B. WING		02/1	02/13/2015	
	PROVIDER OR SUPPLIER	FADOW LANE 2209 UTA	H AVENUE	STATE, ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, MN 56215 ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From page 1 Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537. In addition, a complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5313021 was completed. The complaint was substantiated. Deficiency issued at 0800.		2 000	 The assigned tag number appears in t far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings whi are in violation of the state statute afte statement, "This Rule is not met as evidenced by." Following the surveyo findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THI WILL APPEAR ON EACH PAGE. 			
2 565	Plan of Care; Use Subp. 3. Use. A co must be used by al care of the resident	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the t. ent is not met as evidenced	2 565	THERE IS NO REQUIREM SUBMIT A PLAN OF CORF VIOLATIONS OF MINNES STATUTES/RULES.	RECTION FOR		

STATEMEN	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or oormeonion	BENNI IOMIONINOIMBEN.	A. BUILDING: _			
		00930	B. WING		02/	13/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M		AH AVENUE N, MN 56215			
(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
2 565	Continued From pa	age 2	2 565			
	review, the facility interventions for re	tion, interview and document did not ensure care planned positioning were implemented s (R1, R34) reviewed for				
Findings include: R1 was not repositioned as directed by the care plan.						
	1/9/15, revealed R communicate), rec for bed mobility an for transfers. The I risk for pressure u repositioning progr	mum Data set (MDS) dated 1 had aphasia (loss of ability to juired total two staff assistance d extensive assist of two staff MDS also indicated R1 was at cers, was on a turning and ram and had a pressure the bed and wheelchair.				
	incontinence of bo immobility and cog brain injury and wa The care plan dire R1 on a schedule	ted 1/22/15, indicated R1 had wel and bladder related to initive deficits from traumatic as at risk for pressure ulcers. cted staff to turn and reposition as determined by R1's skin sure skin would remain intact.	1			
	4/10/14 identified F pressure ulcers rel paralysis, incontine sitting and lying for indicated R1 requir	ve skin assessment, dated R1 was at "High risk" for ated to factors which included ence of bowel and bladder and restended periods of time and red an every two hour dule when lying or sitting.				
		9 a.m., R1 was observed				
nesota De ATE FORM	epartment of Health M		6899 T	TVI11	If continue	tion sheet 3 d

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING	B. WING		13/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	LIVINGCENTER - M	FADOWIANE	AH AVENUE N, MN 56215			
(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 AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	position. -At 9:44 a.m. nursin was assisted into th was last repositioned hours and 45 minute repositioning and s repositioned every skin breakdown. Na	as observed in the same ng assistant (NA)-A stated R1 ne wheelchair at 5:00 a.m. and ed at 7:45 a.m., a total of two tes. NA-A confirmed the two es time span between tated R1 was to be two hours to reduce risk of A-A stated "sometimes" R1 did d every two hours, because R ²	1			
	(RN)-C confirmed I plan identified R1's pressure ulcers. RI	0 a.m. registered nurse R1's skin assessment and care risk for the development of N-A verified it would be rould have been repositioned directed.	9			
	(DON) confirmed F ulcers and stated it	P.m. the director of nursing 1 was at risk for pressure was expected that R1 would oned every two hours re plan.				
	R34 was not repos the care plan.	itioned timely as directed by				
	R34 was severely of extensive assistant (ADL) and had the failure, dementia, of and hemiparesis.	S dated 12/19/14, indicated cognitively impaired, required ce for all activities of daily living following diagnoses: heart erebrovascular accident (CVA The MDS also indicated R34 taff assistance for bed mobility)			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00930	B. WING		02/13/2015		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 4	2 565				
	and extensive assist of two staff and a mechanical lift for transfers.						
	incontinence of bo immobility and den	ated 1/1/15, indicated R34 had wel and bladder related to nentia. The care plan directed position R34 as determined by e assessment.					
	3/21/14, indicated pressure ulcers an tolerance at two ho required every two or sitting. The type assessment indica interventions such	sive skin assessment dated R34 was at high risk for id identified R34's tissue burs which indicated R34 hour repositioning when lying id summary portion of the ated R34's skin was intact and as repositioning every two or in the wheelchair was					
	and NA-G assisted via total mechanica observation, R34 wheelchair until 9:5	n on 2/11/5, at 7:15 a.m. NA-A d R34 from bed to wheelchair al lift. During continuous was observed to remain in the 53 a.m. (2 hours and 38 the observation, R34 was n independently.					
	confirmed R34 was a.m. until 9:53 a.m not able to repositi bed. NA-G stated had open areas in should be reposition	n 2/13/15, at 10:01 a.m. NA-G s not repositioned from 7:15 , and further stated R34 was on self in the wheelchair or in R34's skin was very fragile and the past. NA-G confirmed R34 oned every two hours, then ing assistant assignment shee	1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA CO	
		00930	B. WING		02/	13/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST AH AVENUE I, MN 56215	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	to verify. NA-G sta residents to reposi During interview or confirmed R34 had six months ago and	ated staff cannot get to all the tion everyone on time. an 2/13/15, at 10:23 a.m. RN-C d an open area on the buttock d should be turned and	2 565			
	DON confirmed R3 ulcers and it was e	n 2/13/15, at 10:24 a.m. the 34 was at risk for pressure xpected that R34 would have every two hours to reduce risk				
	The director of nur assure that policies necessary, staff ar assure all residents treatment, persona supervision based preferences as ide	THOD OF CORRECTION: sing and/or designee could s are reviewed, revised as e trained and monitored to s receive nursing care and and custodial care, and on individual needs and ntified in the comprehensive ent and plan of care.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One	,			
2 800	MN Rule 4658.051 Staffing requireme	0 Subp. 1 Nursing Personnel; nts	2 800			
	home must have o number of qualified registered nurses,	g requirements. A nursing n duty at all times a sufficient d nursing personnel, including licensed practical nurses, and to meet the needs of the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		02/	13/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OLDEN	LIVINGCENTER - M		AH AVENUE I, MN 56215			
(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) COMPLE DATE
2 800	Continued From pa	age 6	2 800			
	in all buildings if me	ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on observat review, the facility f qualified nursing st resident needs for which promoted ea and psychosocial w quality of life. This	ent is not met as evidenced ion, interview and document failed to ensure sufficient aff were available to meet nursing care in a manner the resident's physical, mental vell-being, thus enhancing their practice had the potential to nts residing in the facility.	r			
	Findings include:					
		o provide timely toileting 1 resident (R7) resulting in 9. Refer to 1805.				
	repositioning servic assessed need for	o provide timely turning and ces according to the individual 2 of 3 residents (R1, R34) as vidual care plans. Refer to				
	indicated resident I 12:45 p.m. and ans time of 35 minutes summoned for ass in which he require	ight audits dated 10/20/14, R56's call light was put on at swered at 1:20 p.m., a wait . The audit indicated R56 had istance to go to the bathroom d two staff assistance and the al lift for transfers. Refer to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED	
			B. WING				
		00930			02/	02/13/2015	
	PROVIDER OR SUPPLIER	2209 LIT	DDRESS, CITY, ST AH AVENUE	ATE, ZIP CODE			
OLDEN	I LIVINGCENTER - M		N, MN 56215				
(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) COMPLE DATE	
2 800	Continued From pa	age 7	2 800				
	F241.						
	11/13/14, indicated 2:59 p.m. and answ of 31 minutes. The	ew of the call light audits dated I R57's call light was put on at wered at 3:30 p.m., a wait time e audit further indicated R57 sistance due to complaints of n.					
	staffing schedules 8/7/14 to 1/31/15, i shifts in which no r identified to have h	8 a.m. during review of for nursing assistants from ndicated the following open egular scheduled staff were ad worked the individual open shift and night shifts.					
	Various Open Shift nights	s Available: days, evening and					
	-8/7/14 to 8/31/14: -9/1/14 to 9/30/14: -10/1/14 to 10/31/1 -11/1/14 to 11/30/1 -12/1/14 to 12/31/1 -1/1/15 to 1/31/15:	67 shifts open 4: 57 shifts open 4: 33 shifts open 4: 39 shifts open					
	staffing schedules to 1/31/15, indicate which no regular se	18 a.m. during review of for licensed nurses from 8/1/14 ed the following open shifts in cheduled staff were identified d the individual open day shift, night shifts.	4				
	Various Open Shift nights	ts Available: days, evening and					
	-8/1/14 to 8/31/14: -9/1/14 to 9/30/14: -10/1/14 to 10/31/1 -11/1/14 to 11/30/1	17 shifts open 4: 32 shifts open					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	B. WING			02/13/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	age 8	2 800				
	-12/1/14 to 12/31/1 -1/1/15 to 1/31/15:						
	assistant (NA)-A st the week, we are a worked 12 hour sh NA-A also stated th hour shift she had work longer for a to next shift being shu used to have five N the skilled level sic two NAs on each e would float back an only have two NAs and they had not h NA-A stated they u evening shift and r NA-A stated the nig NA and one license which also include confirmed that that was no one to ansi returned from brea NA-A verified R7 h due to the long wa nurses did not help helped with the Sta NA-A stated the fa- everyone to come here" [surveyors]. I had only two NAs s "we don't even hav the residents and y	n 2/11/15, at 7:50 a.m. nursing rated "we are short everyday of always short." NA-A stated staff ifts due to staffing shortages. nat after already working a 12 been told she would have to otal of 16 plus hours due to the ort staffed. NA-A stated they NAs working the day shift on le of the facility which included and and the restorative aid nd forth, and now they have working on the skilled side ad a restorative aid for years. Ised to have four NAs on the now they only have two NAs. ght shift staff consisted of one ed nurse for the skilled side d the board/care side. NA-A t when she went on break there wer her call lights so when she is the residents were mad. ad bowel accidents in his pants it time for help. NA-A stated the o with call lights and only ate survey agency was present. cility had been trying to call into work because "you are NA-A verified this evening shift scheduled to work and added, we the people to take care of yet we are told its all about -A added, "when we try to talk					
nesota Do	NA-A stated the far everyone to come here" [surveyors]. I had only two NAs s "we don't even hav the residents and y resident care." NA to management at attitude and then w	cility had been trying to call into work because "you are NA-A verified this evening shift scheduled to work and added, re the people to take care of					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	ane 9	2 800	DEFICIENC	,¥)		
	to work later) into the next shift for staff shortages.						
	practical nurse (LP have enough staff had to have other of facilities to help. LF the help." LPN-A st work until 10:00 a. to stay because the stated if she would as scheduled, that the whole east and home. LPN-A state NAs, two nurses and verified they had be	n 2/11/15, at 8:27 a.m. licensed N)-A verified the facility did not to cover all the open shifts and employees come from other PN-A added, "They do not have tated she was scheduled to m. today, but was told she had e surveyors were here. LPN-A have went home at 10:00 a.m would have left one nurse for twest wing of the nursing ed they used to have three nd a restorative aid working bu een working with one NA on urse would try to help them					
	stated compared to the facility "is terrib not enough staff to NA-G stated she w into the next shift) 6:00 p.m. that ever not get her work do cares time such as timely. NA-G adder you feel for the res had to work overtir period and stated " sometimes I do fee neglected." NA-G	n 2/11/15, at 2:54 p.m. NA-G o two years ago, the staffing at ble!" NA-G confirmed there was o cover all the open shifts. vas "frozen" (mandated to work therefore, had to work until ning. NA-G verified she could one, provide all the resident s repositioning and toileting d, "My mind is boggling and idents." NA-G confirmed she ne four to five times a pay 'you are always frozen and el like they [residents] are verified R7 has had to wait stance and staff try to hurry	;				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00930	B. WING		02/13/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	_	
OLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(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	(X5) COMPLE DATE
2 800	Continued From pa	age 10	2 800			
	she had gone to th	or the residents." NA-G state e director of nursing (DON) for t was due to resident census, o.				
	not toilet the reside morning cares, sor toileted again until she could not get r and feed them, the late, as late as 10:3 stated she was als residents timely, pr fingernails and dor residents their bath	40 a.m. NA-A stated she could ents on time and stated after me of the residents did not get after lunch. NA-A also stated esidents to breakfast on time erefore, breakfast was always 30 a.m. In addition, NA-A o unable to reposition the rovide dental hygiene, trim thei n't have people to give the ns. NA-A added, "We get we are neglecting people here."				
	confirmed there was the open shifts and it is really stressful don't have enough verified she could r they had so many increased level of of residents toileted a stated sometimes residents had to wa repositioned or toil provided cares for first and the reside wait to get toileted "We try but we can work 12 hours, you	n 2/12/15, at 10:44 a.m. NA-B as not enough staff to cover all d stated "staffing is terrible and to come to work because you people to help you." NA-B not get her work done because residents that required care that they could not get the and repositioned on time. NA-B after morning cares, the ait until after lunch to get eted again. NA-B stated staff the residents that could talk nts that could not talk had to and repositioned. NA-B stated t get it all done and when you a are exhausted." NA-B				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING	B. WING		02/13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	I LIVINGCENTER - M	EADOW LANE 2209 UT	AH AVENUE				
GOLDEN		BENSOI	N, MN 56215				
(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	
2 800	Continued From pa	age 11	2 800				
	I feel like I am getting burnt out."						
	confirmed there wa nursing home to co stated, "we could u when she worked i could not get all he and answer call lig compared to over h honestly I have reli LPN-B verified the working a shift then and now they migh working the floor. L people repositioned always get it done. breakfast was not h the NAs could not g on time to eat.	as not enough staff in the over all the open shifts and use more help." LPN-B verified in the long term care unit, she er work done, provide cares hts and stated, "It is busy here [board and care] and ef when I work over here." facility used to have four NAs in dropped down to three NAs t have two or three NAs .PN-B stated, "They try to get d and toileted but you can't " In addition, LPN-B stated being served on time because get people to the dining room					
	director of nursing not enough staff to stated, "yes we do would like to hire a the facility had one short and verified s mandated to stay is don't have a choice	n 2/12/15, at 11:18 a.m. the (DON) confirmed there was cover all the open shifts and have issues with staffing and I few more." The DON stated weekend that was always staff were frozen and were ate. The DON added, "They e." The DON indicated staff					
	the frozen policy m stated someday's i getting burnt out ar verified she had re that the repeated 1	ifts but they also had to utilize ore so than not. The DON t felt as though staff were nd some days not. The DON ceived complaints from staff 2 and 16 hour shifts were uch and also a request to have					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING		02/	02/13/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	age 12	2 800				
	staffing was based DON denied any s getting done or lac the residents. The complaints about of which call lights au call light response During interview or DON verified the d three NAs schedul census was up the DON verified the e and three NAs or s	evening shift. The DON stated on facility census only. The pecific concerns about cares k there of, and complaints from DON verified they had call lights not being answered in dits were done which revealed time problems after meals. n 2/12/15, at 1:50 p.m. the ay shift had two nurses and ed, but when the resident by would have four NAs. The vening shift had two nurses cometimes two NAs which then the day shift staff and have	1				
	night shift consiste or two NAs for the the nurse would he duty. The DON sta enforced on a daily when the census d	earlier. The DON stated the d of one nurse and either one whole facility. The DON stated elp if there was only one NA on ted the freeze policy was / basis. The DON also stated lropped, they utilized shorter ated staffing was based on nd resident needs.					
	administrator denie resident concerns she believed the fa nurses worked 12 request. The admini frozen policy and s mandated to stay i ins. The administra	n 2/12/15, at 2:17 p.m. the ed any specific family or of sufficient staffing and stated acility was "fully staffed" and the hours shifts per their personal nistrator verified the facility stated a staff person was f there were open shifts or call ator confirmed the day shift al 4 hours into the evening	•				
	shift, and the night	shift came in 4 hours early to open shifts. The administrato	r				

TATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
		00930	0 B. WING		02/13/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	I LIVINGCENTER - M		AH AVENUE			
		EADOW LANE BENSON	I, MN 56215			
(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
2 800	Continued From pa	age 13	2 800			
	related to staffing of down. The administ was down, they has schedule and state census and the act administrator confil complaints in the p being answered and done and they had addition, the admin served a little late a	ceived complaints from staff changes when the census was strator verified when the census d made changes to the ed they based staffing off the uity of resident care. The rmed she had also received ast about the call lights not id verified call light audits were tried to "fix it in QAA." In histrator verified breakfast was at times and staff should have ents the whirlpool baths as	5			
	On 2/13/15, a facili requested and was	ty policy related to staffing was not provided	3			
	Facility administrat could utilize employ to evaluate staffing places where those be adjusted and im order to meet all re- manner. Facility po- sufficient staffing c Pertinent employee policies/ practices. developed to obser care, meeting all re- their care plan. Th & Assurance comm findings and develo actions for any path	THOD OF CORRECTION: ion and the director of nursing yee, resident and family input patterns and identify times/ e staffing patterns could/should plement those adjustments in esident needs in a timely olicies and procedures for ould be reviewed/ revised. es could be retrained on those Audit tools could be rve for timely and complete esident needs as identified in e facility's Quality Assessment nittee could review those op/ implement corrective terns or root/cause on-going compliance.				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	B. WING		02/	02/13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - M	FADOWIANE	HAVENUE , MN 56215				
(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	
2 800	Continued From pa	age 14	2 800				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830				
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.					
	by: Based on interview facility failed to coo	ent is not met as evidenced and document review, the rdinate hospice interventions tives for 1 of 1 resident (R14) ice care.					
	Findings include:						
	identified a diagnos order dated 11/11/1 The consult identifi (spread through oth directed no further	Ainimum Data Set (MDS) sis of cancer. R14's physician 4, directed a hospice consult. ed liver cancer with metastasis her parts of the body), and oncology treatment with goal in R14's care.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00930	B. WING		02/13/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OLDEN	I LIVINGCENTER - M	FADOW LANE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 15	2 830			
	order dated 11/13/	orders further included a signed 14, which directed no cardiac ubation to assist breathing was				
	DNR/DNI (do not re request form, date signed by R14's pr	er revealed a form titled, esuscitate, do not intubate) d 11/13/14. The form was imary health care agent and nt to the order for DNR/DNI.				
	the front of R14's r Status, Advance D three printed colum code status: circle needed; and staff s was last identified a column, DNR was	aled a form in a plastic cover in ecord titled, Resuscitation irective Review. The form had ans labeled, date of review; one, if changed, new form signature. The date of review as 11/12/14. In the code status circled, then crossed out, and l/or intubation was to be cled.				
	confirmed the resu cover in the front o place facility staff v	2 p.m. LPN-A and RN-A scitation form in the plastic f R14's record would be the vould consult for direction e unresponsive without ning.				
	resuscitation status resuscitation shoul without heartbeat of confirmed the form possibility cardioput have been perform directive in the orde DON further verifie	2 p.m. RN-C confirmed the s form directed staff to perform d R14 become unresponsive or breathing. DON also and verified there was a ilmonary resuscitation could ued on R14 even though the er was for DNR/DNI. RN-C and d the form should have been R14's advanced directive				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		00930			02/	13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	I LIVINGCENTER - M	FADOWIANE	AH AVENUE I, MN 56215				
(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	
2 830	Continued From pa	age 16	2 830				
	dated 1/5/15, direc residents' medical decisions as to adv included guidelines confirmation that th to quickly identify a	d, Advance Directive Review, ted a procedure to ensure the records reflected health care vanced directives. The policy s which included the ne facility had a system in place resident's code status and bw how to access the	9				
	SUGGESTED ME	THOD OF CORRECTION:					
	assure that policies necessary, staff ar assure all residents documented and c according to the re including hospice p	sing and/or designee could s are reviewed, revised as e trained and monitored to s advance directives are ommunicated accurately sidents preference to all staff personnel. The director of e could conduct audits to e.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905				
	positioned in good of residents unable must be changed a including periods o been put to bed for has documented th hours during this ti	ng. Residents must be body alignment. The position a to change their own position at least every two hours, f time after the resident has r the night, unless the physician nat repositioning every two me period is unnecessary or ordered a different interval.	ו				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00930	B. WING			13/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - MI	FADOWIANE	H AVENUE , MN 56215			
(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
2 905	Continued From pa	age 17	2 905			
	by: Based on observat review, the facility f repositioning to red	ent is not met as evidenced ion, interview and document ailed to provide timely luce the risk of pressure ulcer residents (R1, R34) identified ulcers.				
	Findings include:					
	1/9/15, revealed R communicate), req for bed mobility and for transfers. The N risk for pressure us repositioning progra	mum Data set (MDS) dated 1 with aphasia (loss of ability to uired total two staff assistance d extensive assist of two staff ADS also indicated R1 was at cers, was on a turning and am and had a pressure the bed and wheelchair.				
	both dated 4/25/14 traumatic brain inju	s/Dementia and are Area Assessment (CAA), , revealed R1 had sustained a ry and spinal cord injury which ent inability to verbalize any				
	R1 had limited mob and bladder. The C little independent m with a standing lift, with bed mobility and ambulate. The CAA and staff reposition	er CAA dated 4/25/14, indicated bility and incontinence of bowel CAA also indicated R1 had very novements, was able to stand requited extensive staff assist and transfers and did not A indicated R1's skin was intact ed him every two hours with a completed by the nurse.				

TTVI11

If continuation sheet 18 of 36

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		02/13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	· · · ·	
OLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 905	Continued From pa	age 18	2 905			
	incontinence of boy immobility, cognitiv injury and was at ri care plan directed as determined by t	ed 1/22/15, identified R1 had wel and bladder related to ve deficits from traumatic brain isk for pressure ulcers. The staff to turn and reposition R1 he tissue tolerance ssment to determine tioning needs).				
	4/10/14, indicated pressure ulcers an tolerance at two ho required every two or sitting. The type assessment indica interventions such	ve skin assessment, dated R1 was at high risk for d identified R1's tissue burs which indicated R1 hour repositioning when lying d summary portion of the ted R1's skin was intact and as repositioning every two or in the wheelchair was				
	dated 10/8/14, reve pressure ulcers, ho risk for pressure ul	rdisciplinary Resident Review ealed R1 had no current owever, indicated R1 was at cers and staff were to y two hours while in bed and				
	in a high-backed w -At 9:36 a.m. R1 w position. -At 9:44 a.m. nursi was assisted into t was last reposition hours and 45 minute	9 a.m. R1 was observed seated wheel chair. ras observed in the same ng assistant (NA)-A stated R1 he wheelchair at 5:00 a.m. and ed at 7:45 a.m., a total of two ttes. NA-A confirmed the two e time span between verified R1 was to be				

TATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00930	B. WING		02/	13/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 905	Continued From pa	age 19	2 905			
	risk of skin breakd R1 did not get repo	two hours in order to reduce own. NA-A stated "sometimes" ositioned every two hours, nable to communicate needs.				
	(RN)-C confirmed verified R1 was at pressure ulcers. R R1 be turned and r	20 a.m. registered nurse R1's skin assessment and risk for the development of N-A stated it was expected tha repositioned every two hours a preduce skin breakdown.				
	(DON) confirmed F ulcers and it was e	2 p.m. the director of nursing R1 was at risk for pressure xpected that R1 would have every two hours to reduce risk				
	12/19/14, indicated impaired, required activities of daily liv following diagnose cerebrovascular ac The MDS also indi staff assistance for assist of two staff a transfers. The MDS risk for pressure ul repositioning progr	nimum Data set (MDS) dated d R34 was severely cognitively extensive assistance for all ving (ADL) and had the s: heart failure, dementia, ccident (CVA) and hemiparesis cated R34 required total two r bed mobility and extensive and a mechanical lift for S also indicated R34 was at leers, was on a turning and ram and had a pressure the bed and wheelchair.				
	indicated R34 had	cer CAA dated 3/21/14, limited mobility and wel and bladder. The CAA also				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		02/	13/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 905	Continued From pa	age 20	2 905			
	indicated R34 needed extensive assistance of two with bed mobility, and was dependent for transfers and toileting, and did not ambulate. The CAA indicated R1's skin was intact and staff repositioned him every two hours with weekly skin checks completed by the nurse.					
	incontinence of bo immobility and den	ted 1/1/15, identified R34 had wel and bladder related to nentia. The care plan directed position R34 as determined by e assessment.				
	3/21/14, indicated pressure ulcers an tolerance at two ho required every two or sitting. The type assessment indica interventions such	sive skin assessment dated R34 was at high risk for id identified R34's tissue burs which indicated R34 hour repositioning when lying d summary portion of the ted R34's skin was intact and as repositioning every two or in the wheelchair was				
	and NA-G assisted via total mechanica observation, R34 wheelchair until 9:5	n on 2/11/5, at 7:15 a.m. NA-A d R34 from bed to wheelchair al lift. During continuous was observed to remain in the 53 a.m. (2 hours and 38 he observation, R34 was n independently.				
	confirmed R34 was a.m. until 9:53 a.m	n 2/13/15, at 10:01 a.m. NA-G s not repositioned from 7:15 n. for 2 hours and 38 minutes, R34 was not able to reposition				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00930			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/13/2015		
		00930					
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	IATE, ZIP CODE		10/2013	
OLDEN	I LIVINGCENTER - M		, MN 56215				
(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 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 905	Continued From pa	age 21	2 905				
	was very fragile an NA-G confirmed R every two hours, th assistant assignme stated staff could n order to reposition During interview or registered nurse (F history of open are	or bed. NA-G stated R34's skin id had open areas in the past. 34 should be repositioned hen pulled out the nursing ent sheet to verify. NA-G hot get to all the residents in everyone on time. n 2/13/15, at 10:23 a.m. RN)-C confirmed R34 had a ha on the buttocks and should ositioned every two hours.					
	DON confirmed R3 ulcers and it was e	n 2/13/15, at 10:24 a.m. the 34 was at risk for pressure expected that R34 would have every two hours to reduce risk kdown.					
	revised 2/25/10, in would be initiated t	itled, Skin Care Guidelines, dicated a positioning schedule o meet individual resident ce concentrated pressure to					
	The director of nur train all staff on en- turning and reposit their assessed nee	THOD OF CORRECTION: sing (DON) or designee could suring each resident receives ioning assistance according to ed. The DON or designee could rvational audits to determine					
	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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		00930	B. WING		02/	02/13/2015	
	PROVIDER OR SUPPLIER	2209 LITA	ADDRESS, CITY, STATE, ZIP CODE TAH AVENUE				
(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	
2 905	Continued From pa	age 22	2 905				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis	21426				
	infection control pri current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provid regarding impleme	hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines. ance with this subdivision must he nursing home.					
	by: Based on interview facility failed to con (TB) symptomolog skin testing (TST) employees (NA-C addition, the facility	ent is not met as evidenced v and document review, the nplete employee tuberculosis y screening and/or tuberculin for 3 of 5 newly hired , NA-D, NA-E) as required. In v failed to complete TB eening for 1 of 5 residents					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		02/13/2015	
	PROVIDER OR SUPPLIER I LIVINGCENTER - MI		DDRESS, CITY, S AH AVENUE I, MN 56215	STATE, ZIP CODE		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ige 23	21426			
	Findings include:					
	Employee:					
	a hire date of 12/9/ Tuberculosis Scree with the first and se	NA)-C employee file indicated 14. NA-C's Employee ening form was blank along econd step TSTs section. ence these had been				
	1/13/15. NA-D's En Screening form wa second step TSTs	ile indicated a hire date of nployee Tuberculosis s blank along with the first and section. There was no I been administered.				
	12/22/14. NA-E's E Screening form wa with the first step T	le indicated a hire date of Employee Tuberculosis s completed 12/22/14, along ST. There was no evidence a ad been administered.				
	Resident:					
		rd indicated an admission date Fuberculosis Screening form	•			
		2:30 p.m. RN-C confirmed that g was blank and that it should				
		1:11 a.m. the business				
TE FOR	epartment of Health M		6899 -	TTVI11	If continuati	on sheet 24 c

STATEMEN	ta Department of He IT OF DEFICIENCIES	(X1) Provider/Supplier/Clia	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00930	B. WING		02/13/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - MI		H AVENUE MN 56215		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
21426	Continued From pa	age 24	21426		
	manager who provi TST records stated available for NA-C	ided the new employee list and I there were no records or NA-D.			
	Control Plan dated admission, new ass receive a 2-step Ma administered on ad	tled Tuberculosis Exposure 12/98, indicated all new sociates, and volunteers will antoux PPD Test. Step I to be Imission or on hire, step II to 10 days after step I.			
	The director of nurs implement policies completing employ according to CDC g assessment and as	THOD FOR CORRECTION: sing (DON) could develop and and procedures related to ee and resident TB screening guidelines. The quality ssurance committee could idits to ensure compliance.			
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21)			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a			
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide dignified care related to			
nnesota De ATE FORM	epartment of Health M		6899 -	TTVI11	f continuation sheet 25 o

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING	B. WING		02/13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21805	Continued From pa	age 25	21805				
	timely toileting ass reviewed for dignit	istance for 1 of 1 resident (R7) y.					
	Findings include:						
	12/5/14, indicated had the following d neuromuscular dis osteoarthrosis, gla (inflamed colon). extensive assistan dressing. Further,	mum Data Set (MDS) dated R7 was cognitively intact and liagnoses: body myositis (a order), depression, ucoma and ulcerative colitis The MDS indicated R7 required ce with transfers, toileting and the MDS identified R7 was f bladder and bowel.	Ł				
	had a functioning of impairments cause potential vision lim identified R7 requir	sed on 6/17/14, identified R7 deficit related to mobility ed by body myositis and itations. The care plan red assistance of one staff and ding lift to transfer to and from sted by resident.					
	stated the facility n the floor to meet th stated approximate the call light on at assistance to use t assistant came in n off, told R7 she wo know he needed h stated he waited 10 the call light again minutes for staff re after waiting for an	n 2/11/15, at 11:54 a.m. R7 eeded to have more staff on he needs of the residents. R7 ely seven months ago he put 10:00 a.m. to request the bathroom and a nursing right away, shut the call light uld let another staff member elp and left the room. R7 0 minutes before he pushed and then waited another 45 esponse after that. R7 stated other 55 minutes to use the					
Minnesota D	after waiting for an toilet, the same nu		y				

STATEMEN	<u>ta Department of Herror Department of Herror Department</u> OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00930	B. WING	B. WING		13/2015
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 26	21805			
	entered his room h to wait for a "God o nurse then entered should not talk to th R7 stated he inform not have to wait for bathroom because stated he told the r movement in bed w him. R7 stated it a accident in the bed	ed when the nursing assistant e told her he should not have lamn hour." R7 stated the his room and informed R7 he ne nursing assistant like that. ned the nurse that he should r a whole hour to go the staff take their break. R7 nurse he had a bowel while waiting for staff to help ggravated him that he had an and then had to lay in bed for help. R7 stated there was no				
	months ago his cal while he waited for bathroom so he ca personal phone in R7 stated a nurse and R7 stated he h the nurse he was g because no one wo help him to the bat phone call staff fina assist him, but it wa	terview, R7 reported that two I light was on for 30 minutes assistance to use the lled the nursing home with his order to get staff's attention. answered the phone right away had identified himself and told joing to "shit" his pants buld answer his call light and hroom. R7 stated after the ally made it to his room to as too late, he had already om in his pants. R7 stated it	/			
	had put the call light stated the call light a.m. and at that po nurse that he had t stated by the time s already gone in the	ed on 2/7/15, at 4:45 a.m. he at on to use the bathroom. R7 was not answered until 5:10 int he had yelled out to the o go to the bathroom. R7 staff got in to help him he had bed. R7 stated staff are sorry to help him in time and stated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	B. WING	B. WING		02/13/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
		2209 LIT	AH AVENUE	,			
	LIVINGCENTER - M	EADOW LANE BENSON	I, MN 56215				
(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) COMPLE DATE	
21805	Continued From pa	age 27	21805				
	as they could, but t some staff worked call it "being frozen pee or shit in your would bother you to and you just get us	the nursing assistants as much hey didn't like it. R7 stated for 16 hours at a time, they n." R7 also stated, "Anytime you pants it bothers you and it bo. You know they are short red to it. At the time it makes damn invalid, but it does not it daily."					
	stated R7 was usua bowel and never w NA-A stated R7 wa and making needs required staff assis standing lift for tran R7 needed to have stated R7 was able independently. NA experienced episod while waiting for the NA-A also confirme occasions used his nurses station to re would go find a nur which took even log alert and knew wha everything down. I light appropriately a hour or longer with stated she felt bad bowel because of t very apologetic and stated it was frustra because staff felt th because there was	 p.m. nursing assistant (NA)-A ally continent of bladder and ore incontinent products. as capable of using the call ligh known. NA-A reported R7 at of one and a mechanical asferring onto the toilet when a bowel movement. NA-A at the urinal and the urinal and the soft bowel incontinence a call light to be answered. ad R7 had on multiple approved R7 had on multiple approved R7 had on multiple approved R7 had then the nurse raing assistant to assist R7 nger. NA-A stated R7 was at was going on and wrote NA-A stated R7 used his call and when on would go a half out being answered. NA-A when R7 was incontinent of the long wait and was always d embarrassed. NA-A also ating to come to the facility hey could not do their jobs anot enough staff and it felt like the needs of the residents. 	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00930	B. WING	B. WING		13/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 28	21805			
	the residents.					
	stated R7 independ assist of one staff lift to get onto the t R7 was usually con NA-B confirmed R episode due to sta light timely. NA-B work and had to he stated she could te then stated R7 was himself and was ne be cleaned up was was very easy goir was normally a pre		Y Y			
	practical nurse (LF of bladder and bow recall R7 reporting having an incontine having to wait for s	n 2/13/15, at 9:34 a.m. licensed PN)-A stated R7 was continent vel. LPN-A stated she did to her he was upset about ent bowel movement while staff to help him to the ed R7 talked about it for a long				
mooto	director of nursing aware of R7's epis related to staff not The DON confirme bladder and bowel for toileting. The E expected to care for	n 2/13/15, at 9:43 a.m. the (DON) stated she was not odes of bowel incontinence answering the call light timely. ed R7 was usually continent of and required staff assistance DON stated, "clearly" staff are or residents in a dignified imely toileting to avoid				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		02/	13/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215			
(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
21805	Continued From pa	age 29	21805			
	incontinent episode	es.				
	dated July 2006, re staff would treat res that maintained and	ent's Rights Dignity policy, vised October 2009, indicated sidents with dignity and respec d enhanced each resident's roved his or her psychosocial lity of life.				
	The director of nurs in-service all staff or residents with resp Assessment and A develop a system t	THOD OF CORRECTION: sing or social services could on the need to treat all ect and dignity. The Quality ssurance committee could o audit employees for dignified oward residents in the facility.	I			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			
	Subd. 10. Particip notification of famil	bation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with inco opportunity to requi- care conferences, a family member or c	Il have the right to participate neir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	- B. WING	B. WING		02/13/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		02/	10/2013	
		2209 LIT	AH AVENUE				
GOLDEN	N LIVINGCENTER - M	ΕΔΟΟΨΙΔΝΕ	I, MN 56215				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
21830	Continued From pa	age 30	21830				
	chosen by the reside conferences. (b) If a resident we unconscious or corr communicate, the fi- efforts as required either a family men- writing by the reside an emergency that admitted to the fact family member to p planning, unless the to believe the reside directive to the con- specified in writing member included in notifying a family me family member to p planning, the facility efforts, consistent we practice, to determ executed an advan- esident's health can this paragraph, "rea- (1) examining the resident; (2) examining the resident in the pose (3) inquiring of a family member corr whether the resident directive and whether physician to whom care; and (4) inquiring of the resident in the resident	tember or other representative dent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify nber or a person designated in ent as the person to contact in the resident has been ility. The facility shall allow the participate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family n treatment planning. After nember but prior to allowing a participate in treatment y must make reasonable with reasonable medical ine if the resident has the directive relative to the re decisions. For purposes of asonable efforts" include: e personal effects of the session of the facility; ny emergency contact or thacted under this section in thas executed an advance her the resident has a the resident normally goes for he physician to whom the loes for care, if known, in thas executed an advance ty notifies a family member or	5				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		00930	B. WING		02/13/2015	
AME OF	PROVIDER OR SUPPLIER	I	DDRESS, CITY, S	TATE, ZIP CODE		
	I LIVINGCENTER - M	2200 117	AH AVENUE			
JOLDEN		BENSON	I, MN 56215			
(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) COMPLET DATE
21830	Continued From pa	age 31	21830			
	member to particip accordance with the liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making rea family member or of the facility shall atte members or a desi examining the pers and the medical re possession of the f to notify a family m emergency contact admission, the faci social service ager agency that the res the facility has bee member or design county social servite enforcement agend identifying and noti designated emerge	asonable efforts to notify a designated emergency contact empt to identify family ignated emergency contact by sonal effects of the resident cords of the resident in the facility. If the facility is unable member or designated t within 24 hours after the ility shall notify the county ncy or local law enforcement sident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in ifying a family member or ency contact. A county social local law enforcement agency ty in implementing this	t			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00930	B. WING		02/	02/13/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(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) COMPLET DATE	
21830	Continued From pa	age 32	21830				
		of bath they preferred for 1 of iewed with concerns regarding					
	Findings include:						
	12/5/14, indicated had the following d neuromuscular dis osteoarthrosis. The	mum Data Set (MDS) dated R7 was cognitively intact and liagnoses: body myositis (a order), depression and e MDS indicated R7 required one staff with transfers, and bathing.					
	reported he was ne bathing options. R showers for the pa reported the facility stated it would hav to sit and relax in th R7 stated he had r that it would be rea sometime and was the whirlpool tub. I requested a bath a	n 2/11/15, at 11:34 a.m. R7 ever given a choice regarding 7 stated he had only received st year and a half. R7 7 did have a whirlpool bath and re felt so good on his muscles he warm water and bubbles. nentioned to a staff member ally nice to have a bath is told by staff they do not use R7 stated he had never ugain after that as he assumed was not working, or an option o use.					
	stated staff came i asked him if he wa time they ever did he would like a bat	n 02/13/15, at 9:06 a.m. R7 nto his room last night and inted a bath or shower, "first that." R7 stated he told them h once in a while and then they ie stated he had heard them ents too.	/				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00930	B. WING		02/	02/13/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - M		AH AVENUE I, MN 56215				
(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	
21830	Continued From pa	age 33	21830				
	assistant (NA)-A st per week, on Monor residents would pre- stated staff were un bathing to the resid time to give a resid shower. NA-A stat capable of giving s	n 2/12/15, at 1:49 p.m. nursing ated R7 received one shower days. NA-A confirmed many efer to have whirlpool baths bur nable to provide that choice of dents because it took extra lent a tub bath compared to a ed currently staff were only howers or bed baths to ded, sometimes there isn't ever e showers.					
	assistant (NA)-B st one staff to get into had never received the whirlpool jetted resident a bath. No	n 2/12/15, at 2:13 p.m. nursing ated R7 required assistance of the shower. NA-B stated she d education on how to operate bathtub and had never given a A-B was not sure why the ng residents the choice of the					
	registered nurse (F have a working wh few residents that of RN-C stated staff w as a comfort meas of arthritis or some there was quite a ful have a working tub encouraging the nu choice to the reside NAs had received to	A 2/12/15, at 3:07 p.m. RN)-C stated the facility did irlpool bath tub and did have a used it, but not every time. would offer a bath to residents ure if a resident had a flare up thing like that. RN-C stated ew years that the facility did no b, so now the facility was ursing assistants to offer that ents again. RN-C stated the training on the use of the tated a few of the nurses knew	t				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/13/2015	
		00930				
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE			
OLDEN	I LIVINGCENTER - M	FADOWIANE	AH AVENUE N, MN 56215			
(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) COMPLE DATE
21830	Continued From page 34		21830			
	director of nursing both confirmed the address the educa whirlpool tub in new DON and the admi offered to all reside could not ensure th the use of bathing jetted tub. The admi	n 2/12/15, at 4:08 p.m. the (DON) and the administrator facility did not specifically tion regarding the use of the w employee orientation. The nistrator stated bathing was ents on all three shifts, and nat all staff had been trained or residents using the whirlpool ministrator stated they could and have that completed right	ı			
	social worker (LSV admission the facil preference regardi a "tidbit" sheet. LS not complete a tidb	n 2/12/15, at 4:20 p.m. licensed V)-A stated with each ity identified each resident's ng bathing and documented or W-A confirmed the facility did bit sheet to identify the ces for R7 upon admission.				
	reviewing R7's con	5 a.m. LSW-A was observed opleted admission file. LSW-A ity had not documented R7 ling bathing.				
	October 2009, wou	ent's Rights policy, dated Ild give residents options and ling care and treatment				
	The DON or design procedures regard	THOD OF CORRECTION: nee could develop policies and ing resident choices, educate audits to ensure resident likes,				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00930	B. WING		02/	13/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OLDEN	I LIVINGCENTER - M		AH AVENUE N, MN 56215			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From page 35		21830			
	dislikes and routines are followed by staff.					
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.		•			
esota De	epartment of Health					