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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TYKJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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

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

6. DATE OF SURVEY **12/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds **175** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 12/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245105

December 23, 2014

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

Dear Ms. Willette:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 16, 2014 the above facility is certified for:

175 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 23, 2014

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

RE: Project Number S5105026

Dear Ms. Willette:

On November 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 23, 2014, 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 November 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2014, effective December 16, 2014 and therefore remedies outlined in our letter to you dated November 17, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245105	A. Building B. Wing	12/23/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(l** LSC	Correction Completed **12/16/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/16/2014**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/16/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/16/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	12/23/2014	16022	12/23/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/6/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TYKJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00497

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(L1) **245105**
2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LAKE RIDGE**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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

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

6. DATE OF SURVEY **11/06/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds **175** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Heim, HFE NE II 12/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5230

November 17, 2014

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

RE: Project Number S5105026 and Complaint Number H5105116

Dear Ms. Willette:

On November 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 6, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5105116. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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 November 6, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5105116 that was found to be unsubstantiated.

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: <u>susanne.reuss@state.mn.us</u>
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 February 6, 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 May 6, 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint # H5105115 was investigated and not substantiated.	F 000	**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 applicable state and federal regulatory requirements.**	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156 12/2/14 SER	RECEIVED DEC 1 - 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	con't

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Willett — TITLE: Executive Director — (X6) DATE: 11-26-14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156	**F156 The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility did not provide 48-hour notice for end of Medicare coverage for 1 or 3 residents (R14) reviewed for liability notice.** *Resident 14 discharged from facility on last covered Medicare stay day as planned.* *Policy for providing advanced notice for the end of Medicare coverage has been reviewed and revised as needed.* *Re-education and review of facility policy and procedure process has been conducted for Medicare nurse and business office manager* con't	12/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide documentation of a 2 day notice of denial of Medicare benefits for 1 of 3 Medicare beneficiaries (R14) in the sample. Findings include: The facility did not have documentation that a 2 day notice for end of medicare coverage was provided to R14 before discharge. Review of the entry and discharge Minimum Data Sets revealed R14 was admitted to the facility on 7/20/14 and discharged 8/14/14. During survey, the facility was unable to provide documentation that a 2 day notice prior to denial of Medicare benefits was provided to R14.	F 156	*A weekly audit of Medicare covered residents will be conducted by the Medicare Nurse. Findings will be reported to business office manager for weekly review with executive director. Executive director will determine ongoing frequency and continuation of audits.* *Executive Director is responsible* *Date of completion: 12/16/14*	

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F 156	Continued From page 3 During an interview on 11/06/14 on 8:32 a.m., the business manager verified she was not able to find any documentation of the signed Medicare Provider Non Coverage form used by the facility for R14. The business manager indicated she had looked every where and was unable to locate any documentation. The facility's policy, Chapter 7, Denial Notices and Non-Covered Claims indicated steps for issuing the SNF Determination on Continued Stay Letter. Steps 1-4 direct staff to fill out the date, the beneficiary's name and the date of the first non-covered day in the 2 spaces provided. The administrative officer should sign the letter. Step 6 directed the patient or the patient's representative to complete the form and indicate if a expedited review process is waranted. Step 7 instructed staff how to issue by telephone and if unable to reach representative by telephone. Step 8 instructed staff to "place letter (and Generic Notice) with the mail receipts attached, if applicable, in the patient's financial folder."	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that medications left at bedside were properly	F 176		

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F 176	Continued From page 4 assessed for 1 of 1 resident (R131), reviewed for medications stored at the bedside and self administration of medications. Findings include: R131's Admission Record dated 11/05/14, identified diagnosis included Alzheimer's disease. R131's quarterly Minimum Data Set (MDS) dated 8/12/14, indicated R131 was severely cognitively impaired and required extensive assistance of one for hygiene. R131's physician order dated 2/03/14, directed staff to apply Nystatin powder to scrotal and groin topically every day and evening shift for fungal yeast infection. No order to self administer medications. No order to store medications at bedside. Review of the record revealed R131 had no care plan for medication storage or self administration of medications. During observation on 11/03/14 at 5:29 p.m. two bottles of Nystatin topical powder were sitting on the beside table in R131's room. On 11/03/14, at 7:01 p.m. the registered nurse (RN)-C was interviewed and verified that the medication should not have been on the beside table. RN-C verified that an assessment would need to be completed to have medications at beside and no assessment was completed for R131. On 11/06/14, at 11:09 a.m. the director of nursing (DON) was interviewed and verified that an	F 176	**F176 Self Administration of Drugs** **IDT must determine if it is safe for a resident to self administer medications.** **This must be periodically reviewed** **Medications must be stored in a manner that does not pose risk to room mate** **The decision must be in the plan of care** **The facility did not ensure that medications left at the bed side had been properly assessed for 1of 1 resident R131.** *Resident 131 has been assessed for self administration and storage of bedside medications.* *Residents that self administer or store medications at bedside have had care plan reviewed and revised as needed..* con't	12/16/14

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F 176	Continued From page 5 assessment performed by the interdisciplinary team was to be completed to determine if R131 was safe to have medications at bedside. The DON verified a physician order would be obtained. The DON further stated she was not aware of a policy for medication storage at bedside. The facility policy and procedure Self Administration Of Medications dated 11/11, directed the interdisciplinary team to assess R131's skill regarding bedside storage of medications and to document the results in the medical record and the care plan. No policy and procedure for medication storage was obtained.	F 176	*Education will be provided to licensed staff on self administration of medications and storage of medications.* *Audits will be conducted monthly on residents that are self administering medications or storing medications at bedside. Findings will be reported to QA committee. The committee will determine ongoing frequency and continuation of audits.* *DON/ADON and Program managers will be responsible.* *Date of completion: 12/16/14*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F279 The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.** **The facility did not develop and implement care planning interventions for 1 of 5 residents (R240) reviewed for unnecessary medications.** con't	

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive plan of care for insomnia for 1 of 5 residents (R240) reviewed for unnecessary medications. Findings Include: The facility failed to develop non pharmacological interventions for sleep to complement the use of a medication prescribed for insomnia for R240. The current physician orders, dated 10/6/14 indicated trazodone HCl (an anti-depressant) tablet at 25 milligrams [mg] by mouth at bedtime for insomnia and was increased to 50 mg at bedtime for insomnia on 10/21/14. The current care plan, initiated 8/27/14, lacked any focus that identified insomnia or any direction for staff to follow for using non pharmacological interventions to aid R240 with sleep, since the start of using a sleep aid medication. On 11/6/14 at 2:02 p.m. the registered nurse (RN)-E confirmed the care plan lacked documentation identifying insomnia as a focus or of any interventions specific to aid R240 with sleep.	F 279	*A care plan has been developed for R240 regarding use of non pharmacological interventions prior to using a sleep aid medication for insomnia.* *Residents utilizing sleep aid medications for insomnia will have their care plans reviewed and revised as needed.* *Program managers and MDS coordinators will be educated on establishing an insomnia care plan, including non-pharmacological interventions, for residents utilizing a sleep aid medication.* *Weekly audits will be performed and findings reported to QA committee. The committee will determine ongoing frequency of audits and continuation of them.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	12/16/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		

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F 281	Continued From page 7 by: Based on interview and documentation review the facility failed to follow physician instructions and communicate resident condition effectively to R101's clinic in regards to preparation for a medical procedure for 1 of 1 residents (R101) reviewed for medical procedure preparation. Findings include: R101's care plan, print date of 9/21/14, indicated R101's diagnosis included atrial fibrillation, unspecified anemia, chronic kidney disease, and transient cerebral ischemia. R101's admission Minimum Data Set (MDS), dated 9/15/14, indicated R101 was moderately cognitively impaired and required extensive assistance from staff to toilet. On 11/15/14 at 2:46 p.m., a family member of R101, (F)-A, reported she was frustrated the facility had failed to follow instructions for preparation prior to a colonoscopy, which resulted in a canceled colonoscopy after R101 arrived at the clinic. The facility also administered amedication, Rivaroxaban (treats and prevents blood clots), to R101, which the physician ordered to be held prior to a colonoscopy. F-A reported she felt this reflected poor communication between the facility and the physician's office and poor oversight of R101's care. R101's physician orders dated 9/18/14 directed staff to hold R101's Rivaroxaban for three days prior to a medical procedure. R101's medication administration record (MAR) dated November 2014 indicated R101 received Rivaroxaban the three days prior to the medical procedure. The directions from the gastroenterology clinic also	F 281	**F281 The services provided or arranged by the facility must-- meet professional standards of quality care** **The facility did not hold a medication instructed by a physician for 1 of 1 resident reviewed for medical procedure.** *The colonoscopy appointment for R101 was re-scheduled and a different bowel prep was ordered. The primary MD was contacted to further discuss the pursuit of this procedure.* *Residents scheduled for medical procedures have prep orders reviewed and completed as ordered.* *Education conducted for licensed staff and unit coordinators on communicating procedure preparations and follow through with providers if there are complications.*	12/16/14 con't

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F 281	Continued From page 8 directed the facility in how to prepare R101 for her procedure, to ensure R101's stool was yellow or clear and to call the clinic prior to leaving for the appointment if there were questions as to whether the colon was cleaned. On 11/6/14 at 12:16 p.m., R101 expressed disappointment over the canceled colonoscopy as she thought she would be done with preparing for and undergoing that procedure. An interview on 11/6/14, at 12:25 p.m. with registered nurse (RN)-C verified the Rivaroxaban was to be held for three days prior to R101's medical procedure. RN-C verified the Rivaroxaban was given the three days prior to the medical procedure. RN-C also reported R101 had not been properly prepared prior to the colonoscopy as R101 reported to the clinic she had brown stool the previous evening and blood in her urine the previous evening and the morning of the scheduled test. RN-C reported the facility should have communicated the status of R101's last stool to the clinic prior to the exam. On 11/7/14 the facility sent a fax with telephone message log for 11/5/14 to 11/7/14 from the gastroenterology clinic. On 11/5/14 it was noted, "Patient presented to endo [endoscopy] center for colonoscopy. Pt [patient] has a family member with her, but lives at a care center. Reportedly she had a stool yesterday and the last stool was brown. She had hematuria [blood in urine] last pm [afternoon/evening] and here. She is also on Xarelto [Rivaroxaban] and took it today. Colonoscopy canceled because of poor prep." Upon request from the facility on 11/7/14 to learn more about the cancellation of the colonoscopy, the clinic also noted "The procedure was	F 281	*Weekly audits will be performed and findings reported to QA committee. The committee will determine ongoing frequency of audits and continuation of them.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	

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

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F 281	Continued From page 9 canceled because of poor prep. Xarelto would prevent us from taking off polyps, but we could still do the colonoscopy otherwise." A review of the telephone message log did not reveal a phone call from the facility in regards to appearance of R101's stool, as had been directed by the gastroenterology clinic instructions, or of blood in urine prior to the appointment.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide repositioning according to the care plan for 1 of 3 residents. (230) reviewed for repositioning. Findings Include: The pressure ulcer care plan dated 10/23/14, indicated R230 had an unstageable pressure ulcer present on coccyx and directed staff to turn and reposition R230 every one hour in bed and wheelchair. R230's nursing assistant care sheet, undated, directed care staff to reposition/offload every hour. During continuous observation on 11/5/14, from 7:07 a.m. until 8:36 a.m. R230 was in bed,	F 282	**F282 Be provided by qualified person's in accordance with each residents written plan of care.** **The facility did not provide repositioning according to the care pan of 1 of 3 residents R230 reviewed for pressure ulcers.** *Plan of care reviewed and updated for resident R230.* *Care plans for residents with pressure ulcers reviewed and updated as needed.* *Staff education conducted on repositioning and following care instructions on assignment sheets.*	12/16/14 con't

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F 282	Continued From page 10 sleeping on back. At 8:36 a.m. registered nurse (RN)-B and nursing assistant (NA)-A entered R230's room. NA-A stated R230 was to be repositioned every two hours. RN-B stated R230 should be repositioned every one hour and was last repositioned at 6:30 a.m. At 8:50 a.m. NA-A repositioned R230 onto right side, one hour and 43 minutes after observation had begun and 2 hours and 20 minutes after the last time R230 had been reportedly repositioned. On 11/06/14, at 11:17 a.m. the director of nursing (DON) was interviewed and verified the nursing assistant care sheet and care plan directed R230 to be repositioned every one hour. The DON further stated she would expect staff to follow the nursing assistant care sheet and the care plan.	F 282	*Positioning audits conducted weekly on residents with pressure ulcers with findings reported to QA committee. QA will determine ongoing frequency of audits and continuation.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely repositioning for 1 of 3 residents (R230) reviewed for pressure ulcers.	F 314	**F314 Pressure Sores** **Based on a comprehensive assessment of a resident the facility must ensure that-** **1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable and-** **2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**	con't

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F 314	Continued From page 11 Findings include: R230's admission record, 11/05/14, identified diagnosis included dementia and hypertension. R230's significant change Minimum Data Set (MDS) dated 9/12/14, indicated R230 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfer, toileting, and grooming, and was incontinent of bowel and bladder. The MDS further identified R230 was at risk for the development of pressure ulcers, and had a pressure relieving mattress and pressure relieving device in the wheelchair. R230's Care Area Assessment (CAA) dated 9/12/14, indicated R230 was at moderate risk for tissue breakdown. A progress note dated 10/21/14, at 9:42 p.m. indicated R230 had developed a Stage III pressure ulcer on the coccyx measuring 2 centimeters (cm) x 2 cm and continue to turn and reposition every two hours and as needed. A progress note dated 10/30/14, indicated left buttock wound near coccyx measured 2 cm x 1 cm and R230 was now scheduled for turning and reposition every hour. (Pressure Ulcer Staging: Stage III Full thickness skin loss : Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Bone/tendon is not visible or directly palpable. Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan,	F 314	**The facility did not provide repositioning according to the plan of care for 1 of 3 residents (230) reviewed for** pressure ulcers. *Repositioning plan reviewed for resident R230.* *Repositioning plans reviewed for residents with pressure sores.* *Education provided to nurse managers and nursing staff on repositioning plans for residents with pressure sores.* *Positioning plan audits will be conducted weekly on residents with pressure sores. Findings will be reported to QA committee. The QA committee will determine ongoing frequency and continuation of audits.* *WCC and program managers responsible* *Date of completion: 12/16/14*	12/16/14

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F 314	Continued From page 12 brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined.) R230's tissue tolerance observation, dated 10/23/14, indicated R230 had a current ulcer/history of pressure ulcers, cognitive impairment, was receiving hospice services, and was at medium risk for pressure ulcer. The tissue tolerance observation was updated 10/24/14, to turn and reposition every one hour in bed and wheelchair. The pressure ulcer care plan dated 10/23/14, indicated R230 had an unstageable pressure ulcer present on coccyx. Interventions included turn and reposition every one hour in bed and wheelchair. The Wound Evaluation Flow Sheets dated 10/23/14, and 10/30/14, directed turning and repositioning every hour. R230's nursing assistant care sheet directed care staff to reposition/offload every hour. During continuous observation on 11/5/14, from 7:07 a.m. until 8:36 a.m. R230 was in bed, sleeping on his back. At 8:36 a.m. registered nurse (RN)-B and nursing assistant (NA)-A entered R230's room. NA-A stated R230 was to be repositioned every two hours. RN-B stated R230 should be repositioned every one hour and was last repositioned at 6:30 a.m. At 8:50 a.m., NA-A repositioned R230 onto his right side, one hour and 43 minutes after observation had begun and 2 hours and 20 minutes after the time R230	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LAKE RIDGE	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 was reportedly last repositioned. At 8:59 a.m. RN-A and RN-B completed the dressing change on R230. RN-A described the pressure ulcer as a Stage III pressure ulcer, and measured 1 cm x 1 cm. RN-A stated the pressure ulcer had been previously unstageable because of slough. On 11/06/14, at 11:17 a.m. the director of nursing (DON) was interviewed and verified the nursing assistant care sheet and care plan directed R230 to be repositioned every one hour. The DON further stated she would expect staff to follow the nursing assistant care sheet and the care plan. The facility policy and procedure Skin Integrity Guideline dated January 2011, directed staff to initiate positioning schedule to meet individual needs and minimize concentrated pressure to skin.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	**F329 Each resident's drug regimen must be free from unnecessary drugs.** **The facility did not ensure that 2 of 5 residents were free of unnecessary drugs. R 145 and R240.** *R145 has had Acetaminophen orders clarified to limit daily intake of Acetaminophen to no greater than 3 grams/24 hours. R240 has had care plan reviewed and revised to include non-pharmacological interventions for sleep disturbance.*	12/16/14 Con't

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F 329	Continued From page 14 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure that scheduled and " as needed " medication would not potentially exceed the safe dosage amount for 1 of 5 residents (R145) in the sample and did not develop a care plan for the risk of insomnia including non-drug interventions for 1 of 5 residents (R240) who were reviewed for unnecessary medications. Finding include: Physician Order Sheets " revealed that R145 was admitted to the facility on 11/25/13 with diagnoses that included paranoid state, spinal stenosis, personal history of fall, and generalized pain. Review of the November Medication Administration Records (MAR) specified the following Tylenol orders: 1. acetaminophen 650 milligrams [mg] by mouth three times a day for back pain related to spinal stenosis. 2. acetaminophen 650 mg by mouth every 24 hours as needed for back pain related to spinal stenosis. 3. Okay for standing house orders as need. The Standing House Order form indicated to administer acetaminophen 650 mg every 4 hours	F 329	*Residents receiving Acetaminophen therapy will have orders clarified to ensure maximum recommended dose of Acetaminophen is not exceeded. Residents utilizing sleep aid medications for insomnia will have their care plans reviewed and revised as needed.* *Education will be provided to program managers and nurses on sleep hygiene, non-pharmacological interventions and maximum dose recommendations for acetaminophen use.* *Weekly audits will be performed and findings reported to QA committee. The committee will determine ongoing frequency of audits and continuation of them.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 11/06/2014

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F 329	Continued From page 15 as needed for pain,-not fever - call NP/MD [nurse practitioner or physician] for all new fever episodes and -Note-acetaminophen not to exceed 3 grams [gm] per 24 hours. The scheduled acetaminophen amount equaled 2600 mg. One standing house order dose of acetaminophen would equal 650 mg, putting the daily total dose at 3250 mg. The MAR lacked further direction to the nursing staff regarding administration of any additional Tylenol and did not direct staff to limit any daily total of acetaminophen including 3 gm. On 11/6/14 at 3:00 p.m. registered nurse (RN)-F verified R145 had not had received any acetaminophen using the standing house order for the month of October 2014 or during November 2014. RN-F verified understanding the potential of exceeding the total amount of acetaminophen. On 11/7/14 at 2:50 p.m. the pharmacist verified the findings and agreed the current standing house order for acetaminophen placed R145 at risk of exceeding the recommended daily dose. R240 was receiving medication for sleep and did not have any interventions including nonpharmacological interventions for sleep and the effectiveness of these interventions included in the care plan. R240 was admitted to the facility on 8/17/14 with diagnoses of dementia with delusional features and insomnia. The current physician orders, dated 10/6/14 indicated trazodone HCl (an anti-depressant) tablet at 25 mg by mouth at bedtime for insomnia and was increased to 50 mg at bedtime for insomnia on 10/21/14. Progress notes were as follows: 10/30/14 12:40 a.m. "Weekly Review: Res [resident] receives Trazodone for insomnia, but	F 329		

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F 329	Continued From page 16 continues to be awake most nights yelling out for wife [name of wife]. Res. has had 3 episodes of target behaviors this week. Resident sleep only 2-3 hours a night on an average". 10/23/14 at 10:49 read: "Weekly Review--Resident receives resiperal [sic] tid [three times daily] and trazodone q (every) HS (hours sleep). Trazodone was increased to 50 mg on 10/21." The current care plan, initiated 8/27/14, lacked any focus that identified insomnia or any direction to staff when intervening with difficulty with sleep since the start of using a medication for sleep. On 11/6/14 at 2:02 p.m. the registered nurse (RN)-E verified the care plan lacked documentation of and focus topic or any sleep interventions for R240.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the pharmacist failed to identify and report to the physician drug irregularities for 1 of 5 (R145) residents in the sample reviewed for the use of	F 428	**F428 Drug Regimen Review** **The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.** **The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.** **The facility did not ensure the pharmacist identified irregularities in the medication regime for 1 of 5 residents R145 who was reviewed for unnecessary medications.**	con't

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F 428	Continued From page 17 unnecessary medications. Finding include: Physician Order Sheets revealed that R145 was admitted to the facility on 11/25/13 with diagnoses that included paranoid state, spinal stenosis, personal history of fall, and generalized pain. Review of the November Medication Administration Records (MAR) specified the following acetaminophen orders: 1. acetaminophen 650 milligrams [mg] by mouth three times a day for back pain related to spinal stenosis. 2. acetaminophen 650 mg by mouth every 24 hours as needed for back pain related to spinal stenosis. 3. Okay for standing house orders as need Per the Standing House Order form the as needed order reads: acetaminophen 650 mg every 4 hours as needed for pain,-not fever - call NP/MD [nurse practitioner or physician] for all new fever episodes and -Note-acetaminophen not to exceed 3 grams [gm] per 24 hours. The scheduled acetaminophen amount equaled 2600 mg. One standing house order dose of acetaminophen would equal 650 mg, putting the daily total dose at 3250 mg. The MAR lacked further direction to the nursing staff regarding administration of any additional acetaminophen and did not direct staff to limit any daily total of acetaminophen including the 3 gm. On 11/6/14 at 3:00 p.m. registered nurse (RN)-F verified R145 had not had received any acetaminophen using the standing house order for the month of October 2014 or during November 2014. RN-F verified understanding the potential of exceeding the total amount of acetaminophen. On 11/7/14 at 2:50 p.m. the pharmacist verified	F 428	*R145 has had pharmacist review repeated.* *Residents receiving Acetaminophen will be reviewed by pharmacist and maximum recommended acetaminophen dose will be added to orders.* *Education will be provided to consulting pharmacist on the review of Acetaminophen orders and ensuring the maximum recommended acetaminophen dose is not exceeded.* *Weekly audits will be performed and findings reported to QA committee. The committee will determine ongoing frequency of audits and continuation of them.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	12/16/14

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F 428	Continued From page 18 the findings and agreed the current standing house order for acetaminophen placed R145 at risk of exceeding the recommended daily dose.	F 428		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 2 of 5 mechanical stands reviewed at the facility were clean, which had the potential to impact 11 of 11 residents who required transfer assistance with mechanical standing lifts; including R263, R198 and R184. Findings include: R263's most recent MDS [Minimum Data Set], dated 10/17/14 indicated he was unable to complete a brief cognitive status assessment due to inability to be understood most of the time, and required extensive assistance to transfer. On 11/3/14 at 6:00 p.m. a family member of R263, (F)-B complained the facility was not washing the mechanical standing lifts and slings frequently enough and they were sometimes dirty. R198's most recent MDS indicated he was unable to complete a brief cognitive status assessment due to inability to be understood	F 465	**F465 Other Environmental Conditions** **The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.** **The facility did not provide housekeeping and maintenance services necessary to maintain sanitary mechanical standing lifts for 2 of 3 lifts / stands observed. (The foot plate of the stands were soiled)** *Facility stand lifts have been cleaned.* *An on going cleaning schedule for stand lifts was developed and presented at time of survey.*	12/16/14 con't

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F 465	Continued From page 19 most of the time, had both short and long term memory problems and required extensive assistance to transfer. On 11/4/14 at 9:00 a.m. two nursing assistants, (NA)-B and (NA)-C used a mechanical lift stand to transfer R198 from his bed to his wheelchair. The leg cushions had dried multicolor matter on them and crumbs on the stand. R184's most recent MDS, dated 9/9/14, revealed R184 was unable to complete a brief cognitive status assessment due to inability to be understood most of the time and required extensive assistance to transfer. On 11/4/14 at 1:20 p.m. a mechanical lift stand was noted in the bathroom of R184 with dried multicolor matter on the legs and crumbs on the stand. No resident or staff was in the room at the time of observation. During environmental tour on 11/6/14 at 10:30 a.m., two mechanical standing lifts (#14 and #15) used for all 11 residents had dried multicolored particles, crumbs, and dried multicolored stains visible. During a tour of the environment on 11/6/14, at 10:30 a.m. the executive director (ED) confirmed the mechanical standing lift #15 had dried matter and debris on it. Interview with the ED indicated the housekeeping service or maintenance staff should clean the mechanical lifts. The facility lift cleaning schedule, undated, was provided with no dates when the mechanical standing lifts were cleaned. The form directed staff: the lifts are to be cleaned weekly on	F 465	*Education will be provided to housekeeping staff on the cleaning plan and to the nursing staff on wiping down spills and soil between times of cleaning.* *Weekly audits will be conducted and findings reported to QA committee. The QA committee will determine ongoing frequency and continuation of audits.* *DON/ADON and Program managers will be responsible* *Date of completion: 12/16/14*	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 20 Tuesdays. The facility policy cleaning and disinfection of resident care items and equipment,revised October 2009, directed staff: reusable items are cleaned and disinfected or sterilized between residents (e.g. durable medical equipment).	F 465		

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	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2014**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Lake Ridge was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Living Center Lake Ridge was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The entire building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detectors at all smoke barrier doors that are held open and with detection in areas open to the corridor. The facility has 30-foot on center corridor smoke detection in the 1983 addition (Woodhill) that is on the fire alarm system. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code. The building is divided into 9 smoke zones with 1/2 hour fire rated barriers. Because the original building and its additions	K 000		

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

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K 000	Continued From page 1 meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 175 beds and had a census of 150 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5230

November 17, 2014

Ms. Diane Willette, Administrator
Golden LivingCenter - Lake Ridge
2727 North Victoria
Roseville, Minnesota 55113

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5105026 and Complaint Number H5105116

Dear Ms. Willette:

The above facility was surveyed on November 3, 2014 through November 6, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5105116 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

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

Enclosures

cc: Original - Facility
Licensing and Certification File