DEPARTMENT OF HEALTI	I AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAII	D CERTIFIC	CATION	AND TRANSMITTAL	ID: URDS		
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00937		
1. MEDICARE/MEDICAID PROVIDE           (L1)         245222           2.STATE VENDOR OR MEDICAID N           (L2)         543433500		3. NAME AND AD (L3) GOLDEN L1 (L4) 2106 SECON (L5) MINNEAPO	IVINGCENTI ND AVENUE S	ER - CHAT	ГЕАU (L6) 55404	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint		
5. EFFECTIVE DATE CHANGE OF ( (L9) 04/01/2006	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY     12/19       8. ACCREDITATION STATUS:       0 Unaccredited       1 TJC       2 AOA	/2013 (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 DATE: (L35) 12/31		
11LTC PERIOD OF CERTIFICATION	ſ	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	=		
12.Total Facility Beds	<b>69</b> (L18)		cceptable POC		$\frac{4.724}{X}$ Flour KN 4.7-Day RN (Rural SN $\overline{X}$ 5. Life Safety Code	7. Medical Director KF)8. Patient Room Size 9. Beds/Room		
13.Total Certified Beds	<b>69</b> (L17)		pliance with Prog ents and/or Appli		* Code: A,5	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 69	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
<u>Gloria Derfus, Unit Su</u>	ipervisor	0.	2/05/2014	(L19)	Anne Kleppe, Enforcement Specialist 03/12/2014 (L20)			
PAI	RT II - TO BE	COMPLETED F	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
<ol> <li>DETERMINATION OF ELIGIBIL</li> <li><u>X</u> 1. Facility is Eligible to P</li> </ol>			PLIANCE WITH ITS ACT:	H CIVIL	<ol> <li>1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ol>			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION <b>10/01/1978</b>	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY         00           01-Merger, Closure         00	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>		
	A. Suspension	n of Admissions:	<b></b>		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00454						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	02/24/2014		(L33)	DETERMINATION APP	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

#### CCN-24-5222

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 7, 2013. On December 19, 2013, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on December 12, 2013, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 7, 2013, effective December 12, 2013. Refer to the CMS-2567B for both health and life safety code.

Effective December 12, 2013, the facility is certified for 69 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5222

March 12, 2014

Mr. Ryan Onstad, Administrator Golden LivingCenter - Chateau 2106 Second Avenue South Minneapolis, Minnesota 55404

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 December 12, 2013, the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 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,

Are Klegepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



#### Protecting, Maintaining and Improving the Health of Minnesotans

February 5, 2014

Mr. Ryan Onstad, Administrator Golden Livingcenter - Chateau 2106 Second Avenue South Minneapolis, MN 55404

RE: Project Number S5520024

Dear Mr. Onstad:

On November 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 19, 2013, 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 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013 and therefore remedies outlined in our letter to you dated November 26, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K-0067 at the time of the November 7, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Gloria Derfus

Gloria Derfus, Unit Supervisor Licensing and Certification Program Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

#### **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 245222	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/19/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - CHATEAU			2106 SECOND AVENUE SOUTI MINNEAPOLIS, MN 55404	Н

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	F0155	Correction Completed 12/17/2013	ID Prefix	F0157	Correction Completed 12/17/2013	ID Prefix	F0246		Correction Completed 12/17/2013
Reg. # LSC	483.10(b)(4)		Reg. # LSC	483.10(b)(11)		Reg. # LSC	483.15(e)(1)		
ID Prefix Reg. # LSC	483.20(d)(3), 4		ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 12/17/2013	ID Prefix Reg. # LSC	483.25(a)(2)		Correction Completed 12/17/2013
	F0318 483.25(e)(2)	Correction Completed 12/17/2013		F0323 483.25(h)	Correction Completed 12/17/2013	Reg. #	_F0412 483.55(b)		Correction Completed 12/17/2013
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Б "			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			
Reviewed I State Agen	icy (	leviewed By GD/AK	Date: 02/05/20		-	18	3623		9/2013
Reviewed I CMS RO Followup 1	By F		Date:		f Surveyor: Incorrected Defic Deficiencies (CM			Date: YES	NO
Form CMS	- 2567B (9-92)			Page 1 of 1			Event ID:	URDS12	2

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES	
	MEDIC	ARE/MEDICAII	O CERTIFIC	CATION	AND TRANSMITTAL	ID: URDS	
	PART I -	TO BE COMPL	ETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00937	
1. MEDICARE/MEDICAID PROVIDER (L1) 245222	NO.	3. NAME AND AD (L3) GOLDEN LI			ГЕАU	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID NO (L2) 543433500	(L4) 2106 SECON (L5) MINNEAPO		SOUTH	(L6) <b>55404</b>	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF O' (L9) 04/01/2006	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 11/07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2013 (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 DATE: (L35) 12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS		1	
From (a):		A. In Complian			And/Or Approved Waivers Of	The Following Requirements:	
To (b):		Program Re	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director	
12.Total Facility Beds	<b>69</b> (L18)	1. Ac	cceptable POC		4. 7-Day RN (Rural SNF)     8. Patient Room Size       X 5. Life Safety Code     9. Beds/Room		
13. Total Certified Beds	<b>69</b> (L17)		pliance with Progents and/or Appli		* Code: <b>B</b> , <b>5</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	'N				15. FACILITY MEETS		
18 SNF 18/19 SNF 69	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Jonathan Hill, HFE NE	II	1:	2/12/2013	(L19)	Kamala Fiske-Downing, Enforcement Specialist 2/24/14		
PAR	Г II - ТО ВЕ (	COMPLETED B	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S		
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li>1. Facility is Eligible to Particular</li> </ol>			PLIANCE WITH ITS ACT:	H CIVIL	<ol> <li>1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ol>		
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	<b>MENT</b>	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 10/01/1978	BEGINNINC	G DATE	ENDING DA	ΓE	VOLUNTARY         00           01-Merger, Closure         00	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension	n of Admissions:	(1.44)		04-Other Reason for whitehawar	07-Provider Status Change 00-Active	
(L27)	B. Rescind St	uspension Date:	(L44)			of here	
			(L45)				
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00454					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPI	ROVAL	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: URDS PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00937

### C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5222

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7425

November 26, 2013

Mr. Ryan Onstad, Administrator Golden LivingCenter - Chateau 2106 Second Avenue South Minneapolis, Minnesota 55404

RE: Project Number S5222023

Dear Mr. Onstad:

On November 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Golden LivingCenter - Chateau November 26, 2013 Page 2

## <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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792 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 NO DATA, 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 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Golden LivingCenter - Chateau November 26, 2013 Page 5

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

ate Comston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

## Larson, Monica (MDH)

From:	Meath, Mark (MDH)
Sent:	Monday, February 24, 2014 3:55 PM
То:	Larson, Monica (MDH)
Subject:	DONE with CMS 1539 for GLC Chateau
-	

Importance:

High

ΤΗΑΝΚ ΥΟυ.

Mark Meath

MARK MEATH, ENFORCEMENT SPECIALIST PROGRAM ASSURANCE UNIT LICENSING AND CERTIFICATION PROGRAM DIVISION OF COMPLIANCE MONITORING 85 EAST SEVENTH PLACE, SUITE 220 P.O. BOX 64900 ST. PAUL, MN 55164-0900 TELEPHONE: (651) 201-4118 FAX: (651) 215-9697 EMAIL: MARK.MEATH@STATE.MN.US



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	riple construction		E SURVEY PLETED
		245222	B. WING		11/0	07/2013
	ROVIDER OR SUPPLIER	IATEAU		STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ГS	F 0	00		
	WILL SERVE AS Y	AN OF CORRECTION (POC) OUR ALLEGATION OF ON THE DEPARTMENT'S		RECEIVE	ED	
	ACCEPTANCE. YO	OUR SIGNATURE AT THE FIRST PAGE OF THE WILL BE USED AS		DEC 12 2013		
	UPON RECEIPT O	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE		COMPLIANCE MONITORING LICENSE AND CERTIFICA		
	REGULATIONS HA ACCORDANCE W 483.10(b)(4) RIGH	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. T TO REFUSE; FORMULATE	F	55		
SS=D	The resident has the refuse to participate and to formulate and	nves ne right to refuse treatment, to e in experimental research, n advance directive as aph (8) of this section.	S-l-	Preparation, submission implementation of this of Correction does constitute an admission of agreement with the facts	and Plan not f or and	
	specified in subpar related to maintaini procedures regardi requirements includ provide written info	mply with the requirements t I of part 489 of this chapter ng written policies and ng advance directives. These de provisions to inform and rmation to all adult residents	Montes	conclusions set forth on survey report. Our Pla Correction is prepared executed as a means continuously improve mulity of care and to c	n of and to the omply	
	or surgical treatmen option, formulate an includes a written d	It to accept or refuse medical nt and, at the individual's n advance directive. This lescription of the facility's ent advance directives and w.	Rec	with all applicable state federal regul requirements.	atory	

Any deficiency statement energing 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 FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245222 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - CHATEAU MINNEAPOLIS, MN 55404** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F155 F 155 Continued From page 1 F 155 The guardian of R24 and R24 has been provided verbal and written information regarding a resident's This REQUIREMENT is not met as evidenced right to accept or refuse medical by: treatment including risks and Based on observations, interview and document benefits range of motion programs review, the facility failed to ensure the risks and and splint wearing schedules. benefits were addressed and provided to the resident and/or representative when a Dynasplint All residents with ROM or (a splint that stretched joints that are lacking splinting programs will be audited range of motion) was refused to be donned for 1 for compliance and those residents of 1 resident (R24) who had a contracture of the and/or legal representatives will be right elbow/hand. provided verbal and written risks and benefits if they are refusing to Findings include: participate. 11 Nursing Staff will be educated on On 11/4/13, at 6:02 p.m. R24 was observed to be policy for Advanced Directives and in a tilting wheelchair in her room. R24's right the right to refuse treatments. knee, elbow, wrist, hand and fingers were visibly contracted. R24 was not observed to be wearing The Director of Nursing Services a splint at the time of the observation. (DNS) or designee will observe 2 resident's range of motion cares per On 11/5/13, at 3:25 p.m. R24 was randomly week and ensure risks and benefits observed to be in bed with no splint applied. are provided appropriately for any resident that refuses to participate. On 11/6/13, during observations from 7:34 a.m. DNS will report results of audits to • through 10:18 a.m. the following was observed the OA committee. and at no time was there a splint applied to The QA committee will review R24'sright hand, elbow, wrist and fingers. results of audits and decide if audits - At 8:11 a.m. NA-F visually laid eyes on R24, and need to be continued weekly, less then quickly left the day room. When asked if she received range of motion to her right arm, R24 than weekly or more than weekly. stated, "No." When asked if she did her own QA will dictate the continuation or exercises or tried to straighten out her own arm completion of this monitoring (do own her range of motion) R24 moved her left process based on the compliance arm and straightened it, then took the right hand noted. and lifted it slightly. When asked if she ever wore DNS will be responsible. a splint or brace on her arm, R24 shook her Completion date: December 17, head. "No." 2013. - At 9:10 a.m. NA-F stated she did not assist R24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SUF COMPLET	
245222 B. WING 11/07/2	2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - CHATEAU 2106 SECOND AVENUE SOUTH	
MINNEAPOLIS, MN 55404	
	(X5) DMPLETION DATE
F 155 Continued From page 2 with morning cares and R24 was assisted by the night shift staft. NA-F then did approximately four to five passive range of motion (PROM) repetitions to R24's leg and knee. NA-F then attempted to provide PROM to R24's right elbow, R24 hit at NA-F with her left hand twice. NA-F redirected R24, but the resident would not allow ROM. NA-F stopped the PROM (no PROM was provided to wrist or hand). - At 9:28 a.m. NA-F stated R24 'was able to move her left (side of the body) fine." NA-F stated she usually completed five to 10 repetitions of PROM on the right upper and lower extremity. - At 9:28 a.m. after surveyor questioned if R24 had a splint, NA-F retrieved a splint from the top drawer of the bedside stand. NA-F attempted to open R24's right hand and apply the splint. R24 called out 'Owl'' twice. NA-F was unable to open R24's right hand to apply the splint. R24 appeared calm, but would not allow NA-F to apply the splint, but stated it was usually could not apply the splint, 'but stated is boccasionally could not apply the splint, 'but stated is boccasionally could not apply the splint, 'but stated it was usually due to R24 pushing her away. During the observation, NA-F was unable to straighten R24's right ring and pinky finger, but was able to slightly open the rest of R24's hand. R24's hand would not form over the palm aspect of the splint, NA-F stated the refusal should be reported to the nurse and stated she would re-attempt to apply the splint. NA-F explained when R24's right ring and pinky finger, but was able to slightly open the rest of R24's hand. R24's hand would not form over the palm aspect of the splint. Stated the refusal should reatempt to apply the splint. NA-F explained when R24's flaw ato the refusal. NA-F was unclear when the splint should be applied and was unclear if R24 had more than one splint. - At 9:52 a.m. TMA-A stated she was unaware of the refusal and referred the surveyor to RN-D.	

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CENTERS FOR MEDICARE & MI	LDIOAID SERVICES				JIVIB INC	<u>). 0938-0391</u>
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
	245222	B. WING			11	/07/2013
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - CHATE	AU			106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 155 Continued From page 3 RN-D was present nearby had approached her regate PROM or wearing a splint and PROM of the upper of re-attempted for R24 dur On 11/6/13, at 12:40 p.m completed the ROM on F observation of her completes the ROM on ROM on RN-A was press Dynasplint was broken at to the company." RN-A sist therapy was involved with and was aware of the Dy RN-D and RN-A verified, or ROM, the refusal should r different staff when R24 r clear if R24's PROM was the NA staff or nursing. - At 1:17 p.m. the occupaes stated R24 "was on case occupational therapy]," bu ROM. OT-A stated she did the Dynasplint was broke notified and called the com OT-A stated she was unc broke, but believed it was weeks ago." OT-A stated "again" and they were now fixed. OT-A stated she off Dynasplint repaired when	arding R24's refusals of t. No splint was applied extremity was not ing the observations. A.RN-D stated she R24 prior to the leting ROM with a male DM was done "before I-D explained the splint in ght shift" and should be bed. RN-D stated the At the time of the sent and verified the nd "had been sent back tated occupational n sending the splint back nasplint being broken. if R24 refused the splint ld be reported. Both e-approach and/or try a refuses. RN-D was not usually completed by tional therapist (OT)-A load [being seen for ut not for splinting or id not write down when n, but verified she was mpany to have it fixed. lear when the Dynasplint s "approximately 1 1/2 - 2 the splint had broken w waiting to have it fered to have the	F 1	55			

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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL ND PLAN OF CORRECTION IDENTIFICATION N			TIPLE CONSTRUCTION			E SURVEY PLETED
		245222	B. WING			11/(	07/2013
	PROVIDER OR SUPPLIER	IATEAU		STREET ADDRESS, CITY, STATI 2106 SECOND AVENUE SOU MINNEAPOLIS, MN 55404	тн		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 155	information." OT-A maintenance progra when she "came of - At 1:28 p.m. OT-A case load on 9/18/1 management and F therapy was on 11/2 of the Nursing Prog program, FMP) data and OT-A indicated applied twice daily f second contour har hours twice daily "a directed to complete wrist and hand befo - At 1:35 p.m. OT-A R24's contracture's right elbow - 70 deg extension contractu limited to zero degre through five demon 90 degree for third of and five, second dig limits. OT-A stated taking off the splints therapy and R24 wo [the splint], but then OT-A stated R24 dig prior to PROM or sp the splints may have program may preve contractures. - At 1:46 p.m. OT-A her contracture's. R measurement. OT-/ straighten R24's rig pain and the contract degrees flexion. OT	verified R24 had a functional am for splinting and ROM f case load." a stated R24 was picked up on 2, for contracture R24's last day of occupational 30/12. OT-A provided a copy ram (functional maintenance ed 11/28/12. Both the FMP the Dynasplint was to be or an hour each time. A nd splint was to be applied two s R24 tolerates." The FMP e PROM of shoulder, elbow, ore applying the splint. A verified the measurements of at the end of therapy were: prees flexion; right wrist re's with passive flexion - ees; right hand digits three strated flexion contracture's at digit, 60 degrees for digits four git and thumb within functional R24 was refusing to wear and s while she was receiving buld "give permission to apply would take off the splint." d not require pain medication oblinting. OT-A stated although e been refused, the PROM nt progression of the approached R24 to measure 24 initially agree to allow the A slowly attempted to ht arm and elbow, R24 denied cture was measured at 95 -A stated "that's not better." asured at zero. R24 pushed	F 1	55	If continues		Page 5 of 53

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OMB NO	0938-0391

	15 FUR MEDICARE	& MEDICAID SERVICES	1				0920-0291	
	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		245222	B. WING			11/	07/2013	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - CI	HATEAU			106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 155	had pain. OT-A ver "was getting tighter measure the hand The care plan for p revised on 7/4/11, i TBI, hemiplegia an contracture's of bila was identified to ha contracture of the r as requiring total a daily living (ADLs), grooming. The care PROM exercises to daily and to report The care plan direct and splint [on for] 2 hours in the PM [at by PROM to right u all cares in residen The annual Minimu 11/7/12, indicated I short and long-term total dependence f non-ambulatory. R impairment of ROM extremities and bo extremities. A Brief was not completed The Care Area Ass dated 11/12/12, ide and long-term mer decision making sk presentation of psy had behavioral sym	not answer when asked if she ified R24's elbow contracture ." R24 would not allow OT-A to or finger contracture's. hysical functioning dated as dentified R24's risk factors of d R24 was admitted with ateral lower extremities; R24 ave hemiparesis and right arm. R24 was identified ssistance with all activities of including dressing and e plan directed to provide o legs and arms daily twice changes in ROM to the nurse. cted, "Put dynamic right wrist e hours in the morning and 2 ternoon or evening]. Followed upper extremity. Two staff for	F	155				
	ulaynoses included	d dementia, depression,			L			

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Event ID: URDS11

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		7101		1	0936-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE			(X3) DATE SURVEY COMPLETED		
		245222	B. WING			11/	/07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 155	traumatic brain inju indicated R24 was communication dat relied on others to i indicated R24 was able to understand. splinting or ROM. The care plan for be 4/15/13, identified p staff of hitting, pinch pulling at others hai resistive to cares." R24's refusal to we The care plan did n splint. The Quarterly MDS needed extensive a not changed in ADL MDS. The quarterly R24's functional RC The social services reviewed R24's soc identified R24 had t and referred to R24 record had no further refusals of cares or R24's Physician Ord splints to the right w morning and two ho Orders dated 10/28 therapy was to eval Review of R24's ID	ry (TBI) and anxiety. The CAA "at baseline." The CAA for ed 11/12/12, indicated R24 dentify and meet her needs, rarely understood and rarely The CAA's did not address ehaviors dated as revised obysical behaviors towards ning, kicking, grabbing or ir and R24 was "sometimes The care plan did not address at the Dynasplint or PROM. ot address a second contour dated 8/7/13, indicated R24 ssistance with eating, but had s or cognition from the annual MDS indicated no changes in DM. assessment dated 8/15/13, ial history prior to admission, he behavior of refusing cares 's care plan. The clinical er assessment of R24's status of her contractures. ders dated 8/29/13, directed rrist for two hours in the purs in afternoon. Physician's /13, indicated occupational uate and treat R24. T Progress Notes from	F	155			
	splints to the right w morning and two ho Orders dated 10/28 therapy was to eval Review of R24's ID 4/11/13, through 11/	rrist for two hours in the ours in afternoon. Physician's /13, indicated occupational uate and treat R24.					

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION		). 0938-039 TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245222	B. WING		11	/07/2013
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD		
GOLDEN	I LIVINGCENTER - CH	HATEAU		106 SECOND AVENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 155	the splint or R24's r did not address the donning the splint.	not address unavailability of refusals to wear the splint, and risks versus benefits of	F 155			
	November 2013 inc - August - R24 did u refusal, not applied times out of 62 opp sheet indicated R24 splints both applied "PM." The first splin applied due to refus 62 opportunities. Th	eets August 2013 through dicated the following: not receive PROM due to due to "Other" or sleeping 18 ortunities. The treatment 4 had two Dynamic right wrist for two hours in morning and at ordered 12/4/09, was not sal or "Other" 31 times out of ne second splint ordered blied 18 out of 62 opportunities.				
	- September - R24 times out of 60 opp refused or "Other" 3 splint was refused of - October - R24 refu of 62 opportunities; "Other" 29 times ou second splint was r of 62 opportunities. - November - R24 of splint was not applie out of 12 opportunit	did not receive PROM 11 ortunities; the first splint was 33 times out of 60; the second or "Other" 24 times out of 60. used PROM seven times out refused the first splint or it of 62 opportunities; the efused or "Other" 21 times out				
	forward indicated R refusing the Dynasp sheets directed two record did not ident addition, the notes r include attempts to	al record August 2013, 24 had a consistent pattern of blint. Although the treatment separate splints, the clinical ify the different splints. In regarding refusals did not re-approach R24. The clinical 4's splint was "broken" in				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE S COMPL	
		245222	B. WING			11/07	7/2013
	PROVIDER OR SUPPLIER	IATEAU		STREET ADDRESS, CITY, STATE, 2 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD I THE APPROPR	BE 0	(X5) COMPLETION DATE
F 155	forms (undated and approximately 8:42 "NOC [night] shift to leave in bed. Put Dy leave on for 1 hour, arm, leave on 1 hour, are, lea	ted NAR (Nursing d) Assignment 3rd Floor l printed off by RN-A at a.m. on 11/6/13), directed, o get resident dressed and ynasplint on R [right] arm, PM shift to put DynaSplint R ur. NAR report to nurse when ." The sheet further directed, o legs & arms AM/PM." The s the use of another splint. a.m. the director of nursing of a potential decline in R24's the OT-A reported the ne elbow contracture to her ified R24's refusals were progress notes. DON stated n an "assessment period," but o documentation R24's seed prior to the current MDS DON stated the progress all the department heads, but efusals were evaluated. DON skeptical R24's ROM had d "cut [R24's] nails yesterday" xtend her elbow "pretty ed staff was aware of R24's staff should re-approach, staff and report the refusal to ted she was unclear R24 had a.m. the social worker (SW)-A re of R24's refusals to wear unclear when she was usal to wear the splint(s), "It " SW-A stated she read the	F 1		If continuatio		

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245222	B. WING	i		11/	07/2013
	PROVIDER OR SUPPLIER	IATEAU		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	had no assessmen SW-A verified the s wrote the CAA for b plan for behaviors, department was re- resident refusals. S guardian was notifi- splints or allow PRG discussion with the benefits would be of stated social service participation in the process, and the so "provide suggestion" behaviors (such as know of the resider nursing to notify he risk [for injury or de R24 as "lower risk." aware R24's contra splinting and ROM, unaware of any pot On 11/7/13, at 10:0 was no policy on re On 11/7/13, at 12:3 administrator stated care planning, asses motion, or splinting for behavior assess (resident assessme planning per the RA some documentatio behaviors done "on regardless of if the psychoactive medic	ry morning and verified R24 t of her refusals. Although ocial services department behaviors and wrote the care SW-A stated the nursing sponsible for assessing W-A was unclear if R24's ed of her refusals to wear the DM, SW-A stated any guardian regarding risk and completed by nursing. SW-A e involvement was through interdisciplinary team (IDT) ocial service role was to as and ideas" to address refusals) based on "what we at." SW-A stated she expected r "if resident where are higher cline]" and stated she viewed ' When asked if she was ential decline in R24's ROM. 8 a.m. the DON stated there fusals. 1 p.m. DON and the d there was no facility policy for essment of behaviors, range of . DON stated the facility policy sment was to follow the RAI ent instrument) process, care Al process and that there was on in the records regarding all residents" in the facility,	F	155			

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<u> </u>	AS FOR MEDICARE	& MEDICAID SERVICES			(	<u>MR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		245222	B. WING			11/	07/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CI	HATEAU			106 SECOND AVENUE SOUTH /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 155	clinical documenta notes "daily." On 11/7/13, at 1:22 contacted via telep she was assigned beginning of the ye 2013. The guardian refused "at times" a notified of R24's re the that Dynasplint being worn. The gu informed of the risk not wearing the Dy she had a "good ra therapy and in the a resident was goin therapy) because of guardian explained "coming up soon" a give her a detailed stated she would b care conference ar notified of the refus was not explained refusing the Dynas	age 10 stated staff "look at" the tion and read the progress the p.m. R24's guardian was hone. The guardian verified as R24's guardian since "the ar" in February 2013 or March in stated she was aware R24 and verified she was not fusal to wear the Dynasplint, or was not functional and not uardian stated she was not as versus benefits regarding nasplint. The guardian stated pport" with occupational past was notified by therapy if ng to be discharged (from of refusing to participate. The R24 had a care conference and she expected the staff to review of R24. The guardian e asking staff about that at the nd verified she expected to be sals. R24 and R24's guardian the risks versus benefits of plint nor was either party n information of the refuasl of	F -	155			
F 157 SS=D	483.10(b)(11) NOT (INJURY/DECLINE A facility must imm consult with the res known, notify the re or an interested far accident involving t		F 1	57			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY PLETED
	245222	B. WING		11/	07/2013
NAME OF PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - C	HATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
<ul> <li>physical, mental, o deterioration in hea status in either life clinical complication significantly (i.e., a existing form of tree consequences, or treatment); or a det the resident from t §483.12(a).</li> <li>The facility must a and, if known, the or interested family change in room or specified in §483. resident rights und regulations as spe this section.</li> <li>The facility must re the address and pl legal representative</li> <li>This REQUIREME by: Based on observa- review, the facility wear a Dynasplint are lacking range of guardian and phys</li> <li>Findings include: On 11/6/13, during through 10:18 a.m</li> </ul>	ificant change in the resident's r psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment need to discontinue an eatment due to adverse to commence a new form of discision to transfer or discharge he facility as specified in lso promptly notify the resident resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in ler Federal or State law or cified in paragraph (b)(1) of ecord and periodically update hone number of the resident's e or interested family member. ENT is not met as evidenced ation, interview and document failed to ensure refusals to (a splint that stretch joints that of motion) were reported to the ician for 1 of 1 resident (R24).	F 1	<ul> <li>R24 physician was noticly change in ROM and refine wear splint or allow ROM and during survey.</li> <li>R24 guardian was notified conference on 11/11/13.</li> <li>All residents on ROM/S programs charts will be refor refusals and documentate MD and guardians were not needed.</li> <li>Facility Notification of Ch Resident Health Status guideline has been review revised as needed.</li> <li>Licensed staff will be educate the Notification of Change in Resident Health Status guide</li> <li>DNS or designee will audit progress notes at least weekl compliance to notifying reside Physician/NP and Legal Representatives.</li> <li>DNS will report results of authe QA committee.</li> <li>The QA committee will revier results of audits and decide i need to be continued weekly than weekly or more than weekly than weekly or more than weekly than weekly or more than weekly or more than weekly or more than weekly than weekly or more than weekly or more than weekly or more than weekly than</li></ul>	at care plinting wiewed ion that ified as ange in clinical ed and ed on line. y for lent's dits to w audits less ekly. ion or g nce	

	SURVEY
245222 B. WING 11/0	7/2013
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GOLDEN LIVINGCENTER - CHATEAU       2106 SECOND AVENUE SOUTH         MINNEAPOLIS, MN 55404	
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY)     DEFICIENCY)     DEFICIENCY	(X5) COMPLETION DATE
F 157 Continued From page 12 R24 was observed to refuse to wear a contour splint. R24 was observed to refuse passive range of motion (PROM) to the upper body. On 11/6/13, at 12:40 p.m. a registered nurse (RN)-D explained the splint in R24's room was for the "right shift" and should be applied when R24 was in bed. RN-D stated the "Dynasplint was broken." At the time of the interview, the nurse manager (RN)-A was present and verified the Dynasplint was broken and "had been sent back to the company." RN-D and RN-A both verified if R24 refused the splint or ROM, the refusal should be reported. Both RNs stated staff should re-approach and/or try a different staff when R24 refuses. RN-D was not clear if R24's PROM was usually completed by the NA staff or nursing. Neither RN were clear if R24's PROM was usually completed by the NA staff or nursing. Neither RN were clear if R24's guardian or the physician were notified of the residents refusals. - At 1:17 p.m. the occupational therapist (OT)-A stated she did not write down when the Dynasplint was broken, but believed it was "approximately 1 1/2 - 2 weeks ago." OT-A stated the splint had broken "again" and they were now waiting to have it fixed. OT-A stated she offered to have the Dynasplint reparied when she heard it was broken but, "Because she [R24] wasn't on case load on 91/6/12, for contracture management and R24's last day of occupational therapy was on 11/30/12. OT-A provided a copy of the Nursing Program (functional maintenance program, FMP) dated 11/28/12. Both the FMP and OT-A indicated the Dynasplint was to be applied two hours twice daily for an hour each line. A second contour hand splint was to be applied two hours twice daily far hour each line. A second contour hand splint was to be applied two hours twice daily far an hour each line. A	

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245222 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH **GOLDEN LIVINGCENTER - CHATEAU MINNEAPOLIS, MN 55404** SUMMARY STATEMENT OF DEFICIENCIES ID **PROVIDER'S PLAN OF CORRECTION** (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 13 F 157 directed to complete PROM of shoulder, elbow, wrist and hand before applying the splint. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living, including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, "Put dynamic right wrist and splint [on for] 2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident room." The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired short and long-term memory problems, required total dependence for all activities of daily living (ADLs), and R24 was non-ambulatory. R24 was identified to have a impairment of ROM on one side of the upper extremities and both sides of the lower extremities. A Brief Interview for Mental Status was not completed due to R24's cognitive status. The Care Area Assessment (CAA) for cognition dated 11/12/12, identified R24 had impaired short and long-term memory, severely impaired decision making skills and, "Resident also has presentation of psychomotor retardation and has had behavioral symptoms of rejection of cares and physical abuse." The CAA indicated R24's diagnoses included dementia, depression, traumatic brain injury (TBI) and anxiety: R24 was "at baseline." The CAA for communication dated

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FORM APPROVED

PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245222	B. WING	. <u> </u>		11/	07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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)	D BE	(X5) COMPLETION DATE
F 157	11/12/12, indicated identify and meet he rarely understood a The CAA's did not a The care plan for be 4/15/13, identified p staff of hitting, pinch pulling at others hai resistive to cares." R24's refusal to we The care plan did n	ge 14 R24 relied on others to er needs, indicated R24 was nd rarely able to understand. address splinting or ROM. ehaviors dated as revised ohysical behaviors towards ning, kicking, grabbing or ir and R24 was "sometimes The care plan did not address ar the Dynasplint or PROM. ot address a second contour	F	157			a service a Service a service a se
	needed extensive a not changed in ADL	dated 8/7/13, indicated R24 ssistance with eating, but had s or cognition from the annual MDS indicated no changes in DM.					· · · · · ·
	reviewed R24's soc identified R24 had t and referred to R24 record had no further refusals of cares or	assessment dated 8/15/13, ial history prior to admission, he behavior of refusing cares 's care plan. The clinical er assessment of R24's status of her contractures.					
	splints to the right w morning and two ho R24's treatment she through November - August - R24 did r refusal, not applied times out of 62 oppo sheet indicated R24 splints both applied	ders dated 8/29/13, directed vrist for two hours in the burs in afternoon/evening. eets from August 2013 2103, indicated the following: not receive PROM due to due to "Other" or sleeping 18 ortunities. The treatment had two Dynamic right wrist for two hours in morning and t ordered 12/4/09, was not					

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STATEMENT	HS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	<u>. 0938-0391</u> E SURVEY IPLETED
		245222	B. WING			11/	07/2013
	PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 157	applied due to refus 62 opportunities. Th 1/9/13, was not app - September - R24 times out of 60 opp refused or "Other" 3 splint was refused of - October - R24 refu- of 62 opportunities; "Other" 29 times out second splint was r of 62 opportunities. - November - R24 of splint was not applie out of 12 opportunit applied due to "Oth Review of the clinic consistent pattern of Although the treatm separate splints, the the different splints. regarding refusals of re-approach R24. T R24's splint was "br October. The clinica R24's refusals were R24's physician. On 11/7/13, at 9:53 stated she was awa the splints, but was notified of R24's ref was some time ago progress notes even had no assessment unclear if R24's gua refusals to wear the stated any discussion	sal or "Other" 31 times out of he second splint ordered plied 18 out of 62 opportunities. did not receive PROM 11 portunities; the first splint was 33 times out of 60; the second or "Other" 24 times out of 60. fused PROM seven times out ; refused the first splint or ut of 62 opportunities; the refused or "Other" 21 times out	F	157			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		E SURVEY PLETED
		245222	B. WING		11/0	07/2013
	PROVIDER OR SUPPLIER	IATEAU		STREET ADDRESS, CITY, STATE, ZIP C 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	(NP)-F was contact she was unaware of Dynasplint or conto not notified the Dyn stated she could no NP-F stated she be of R24's condition was she did "wasn't as of the splint. When the progression was ex "healthcare standar progression/develo stated she was not regarding R24's con physician was on "r reassigned to the m On 11/7/13, at 12:3 (DON) verified the of the physician or gua patterns of refusal. On 11/7/13, at 1:22 contacted via teleph she was assigned a beginning of the ye 2013. The guardian refused "at times" a notified of R24's refit the that Dynasplint being worn. The gui informed of the risk not wearing the Dyn	ge 16 1 a.m. the nurse practitioner red via telephone. NP-F stated of R24's refusals to wear the ur splint and verified she was asplint was broken. NP-F to recall if she was notified. elieved the doctor was aware and referred the surveyor to lical director. NP-F stated s not expected to improve and concerned" with R24 refusing e potential for contracture cplained, NP-F agreed rds were to prevent further pment" of contractures. NP-F aware of the "small details" ndition, R24's regular assigned naternity leave" and R24 was hedical director until her return. 1 p.m. director of nursing clinical record lacked evidence ardian were notified of R24's p.m. R24's guardian was hone. The guardian verified as R24's guardian since "the ar" in February 2013 or March n stated she was aware R24 and verified she was not fusal to wear the Dynasplint, or was not functional and not ardian stated she was not s versus benefits regarding hasplint. The guardian stated pport" with occupational	. F1			
FORM CMS-25	therapy and in the p 567(02-99) Previous Versions	bast was notified by therapy if	1	Facility ID: 00937 If c	ontinuation sheet F	Page 17 of 53

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES ICARE & MEDICAID SERVICES

	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		
		245222	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		07/2013
				2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
GOLDEN	LIVINGCENTER - C				RRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	DATE
F 157	Continued From p	age 17	F	57		
	therapy) because guardian explaine "coming up soon" give her a detailed	ing to be discharged (from of refusing to participate. The d R24 had a care conference and she expected the staff to d review of R24. The guardian be asking staff about this at the and verified she expected to be usals.				
	verified he was new wear the Dynasp MD stated in an " notify, and would	7 p.m. the medical director (MD) ot informed of R24's refusals to lint or that the splint was broken. 'ideal" situation he would be to expect notification to be he facility. MD stated he was a sian team which rounded in the y physicians).				
	Status policy (un consult the resid legal representa illness, significar condition. The p be provided if th significantly such or "commence a Although the po refusals of care, "Nursing judgen skilled care prov applied in a cas acceptable nurs	EASONABLE ACCOMMODATIO	it "	= 246		
SS=	A resident has t	the right to reside and receive facility with reasonable				
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	RS FOR MEDICARE		1			938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		245222	B. WING _			/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOLDEN	ILIVINGCENTER - CH	IATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 246	<ul> <li>preferences, excepthe individual or othendangered.</li> <li>This REQUIREMENDIAL</li> <li>This REQUIREMENDIAL</li> <li>Based on observative in the facility for the facility facility had no tubs</li> </ul>	f individual needs and t when the health or safety of her residents would be NT is not met as evidenced tion, interview and document ailed to accommodate hing for 2 of 2 residents (R99, choices. to the facility on 11/2/13. The included diagnoses of bipolar order, depression, anxiety ic pain. The Clinical Health 3, noted R99 was alert and sistent and reasonable. e plan dated 11/4/13, indicated rvision with bathing and did not reference. on 11/5/13, at 10:44 a.m. R99 e for baths and planned to take day. R99 reported staff told her ath. hurse (LPN)-A was interviewed 4 a.m. and LPN-A stated the for residents to bath. A tub a9's room, but it lacked a	F 24	<ul> <li>F246</li> <li>R99 has been discharg facility</li> <li>R52 will be offered a two soon as tub is available, been explained to resider is in agreement.</li> <li>All resident's will be asked bathing choices. Accom will be made as able excomedical condition we endangered.</li> <li>The facility has submitted for a bathtub on 12/10/20</li> <li>The facility expects bath installed between 12/112/23/2013.</li> <li>Nursing Staff will be excomediated by the expecting resident's regarding bathing.</li> <li>ED or designee will residents a weat accommodation of bathin</li> <li>Executive Director (ED) audit results to QA comm</li> <li>ED is responsible.</li> <li>The QA committee will results of audits and decineed to be continued weet than weekly or more that QA will dictate the contincompletion of this monit process based on the commoted.</li> </ul>	b bath as This has at and she d for their modations rept where ould be d the order 13. nub to be 6/13 and ducated on choices audit 3 ek for g choices. will report nittee. eview de if audits ekly, less a weekly. nuation or oring	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245222	B. WING			11/07/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CHATEAU				2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 246		ge 19 perational tubs were found.	F 2	246			
	Admission Record diagnoses of cirrho	to the facility on 1/2/13. The dated 1/2/13, included sis of the liver, alcohol lic pain and major depressive					
	Set (MDS) dated 2/ Interview of Mental (cognitively intact). between a tub bath sponge bath was v daily living (ADL) C did not address bat	nge in status Minimum Data /8/13, included a Brief Status (BIMS) score of 14 The MDS also noted choosing s, showed, bed bath or ery important. The activities of are Area Assessment (CAA) thing preference. The facility ddress bathing preferences.					
		rogress note dated 10/3/13, ented to person, place and time					
	stated a preference she was told a tub l	on 11/4/13, at 4:26 p.m. R52 to take a tub bath. R52 stated bath was not an option as ing tubs in the facility.					
	nurse (RN)-A repor	11/6/13, at 8:08 a.m. registered ted the facility did not have a se and if a resident requested a ot be an option.					
	11/7/13, at 10:00 a. sure if residents we was no tub availabl admissions stated t tub questions prior						
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: URDS1	I	⊦a	cility ID: 00937 If continuat	ion sheet	Page 20 of 53

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245222	B. WING			11/	07/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CHATEAU				21	TREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	reported she was n have a tub and tub	ge 20 on 11/7/13, at 10:06 a.m. R99 ot notified the facility did not baths are very important to of her medical problems.	F 2	246			
	The professional m the facility was inter a.m. and stated she	arketing (liaison) person for rviewed on 1/7/13, at 10:45 e doesn't talk to the residents ussed if the facility had a tub					
	assistant (NA)-A sta ask her for a tub ba	11/7/13, at 11:15 a.m. nursing ated sometimes residents will th but the facility did not have residents they can only have					
	and stated taking a	d on 11/7/13, at 11:23 a.m. tub bath was very important facility) did not have one so " d to do?"					
	12:51 p.m. and stat maintenance plan f administrator stated	the tub had not been been on the 2013 plan but					
F 280 SS=D	requested and was 483.20(d)(3), 483.1		F 2	80			
	incompetent or othe	e right, unless adjudged erwise found to be r the laws of the State, to					

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		AND HUMAN SERVICES		·		11/22/201 PPROVE 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245222		B. WING		11/07/2013			
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
GOLDEN	N LIVINGCENTER - CI	HATEAU		2106 SECOND AVENUE SOUTH			
				MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 280	<ul> <li>participate in planning care and treatment or changes in care and treatment.</li> <li>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observation, interview, and document review, the facility failed to identify and revise the care plan for refusals of wearing a Dynasplint (a splint that stretched joints that are lacking range of motion) for 1 of 4 residents (R24) reviewed for rehabilitation.</li> <li>Findings include:</li> <li>On 11/6/13, during observations from 7:34 a.m. through 10:18 a.m. R24 was observed to have contractures of the right elbow, wrist and hand. R24 was observed to refuse PROM to the upper body.</li> </ul>		F 24	<ul> <li>F 280</li> <li>R24's care plan has been revireflect her refusals of wearing splint.</li> <li>Care plans for other Residents history of refusing ROM/Splwill be reviewed and updat needed.</li> <li>Care planning process has reviewed and revised as needee</li> <li>Licensed staff will be educate the Care Planning process an updating care plans.</li> <li>DNS/Designee will complete 3 care plans a week for Ran motion/splinting programs and report progress of audits to the committee.</li> <li>The QA committee will prodirection or change when nece and will dictate the completion of this monit process based on the completion of this monit process based on the completion date: December 2013</li> </ul>	g her s with inting ed as been d. ed on audit ge of i will e QA ovide ssary on or oring iance		
		0 p.m. a registered nurse se manager (RN)-A both					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245222	B. WING			11/0 <sup>.</sup>	7/2013			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CHATEAU				2106 SECOND AVE	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 280	refusal should be re should re-approach when R24 refuses. PROM was usually nursing.	age 22 sed the splint or ROM, the eported. Both RNs stated staff and/or try a different staff RN-D was not clear if R24's completed by the NA staff or m Data Set (MDS) dated	F 2	280						
	11/7/12, indicated F short and long-term total dependence for non-ambulatory. R2 impairment of ROM extremities and bot extremities. The Ca for cognition dated impaired short and impaired decision n	R24 had severely impaired in memory problems, required for all ADLs, and R24 was 24 was identified to have a 1 on one side of the upper h sides of the lower are Area Assessment (CAA) 11/12/12, identified R24 had long-term memory, severely naking skills and, "Resident								
	and has had behav cares and physical R24's diagnoses in traumatic brain inju "at baseline." The C 11/12/12, indicated identify and meet he rarely understood a	on of psychomotor retardation ioral symptoms of rejection of abuse." The CAA indicated cluded dementia, depression, ry (TBI) and anxiety; R24 was CAA for communication dated R24 relied on others to er needs, indicated R24 was and rarely able to understand. address splinting or ROM.								
	needed extensive a not changed in ADL MDS. The quarterly R24's functional RC The social services	dated 8/7/13, indicated R24 assistance with eating, but had s or cognition from the annual MDS indicated no changes in DM. assessment dated 8/15/13, ial history prior to admission,								
FORM CMS-25	identified R24 had t and referred to R24 67(02-99) Previous Versions		1	Facility ID: 00937	If continuatio	n sheet Pa	ge 23 of 53			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245222	B. WING	i			11	/07/2013	
	PROVIDER OR SUPPLIER	HATEAU		210	REET ADDRESS, CITY, STATE, ZIP COD 6 SECOND AVENUE SOUTH NNEAPOLIS, MN 55404	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	ЗE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge 23	F	280				•• •	
	splints to the right v	ders dated 8/29/13, directed vrist for two hours in the ours in afternoon/evening.							
	R24's diagnoses in disorder, depressiv	cord dated 11/7/13, indicated cluded hemiplegia, anxiety e psychosis, dementia with nces, and intracranial							
	revised on 7/4/11, ic TBI, hemiplegia and contracture's of bila was identified to ha contracture of the ri	ight arm. R24 was identified							
	daily living, including care plan directed to legs and arms daily changes in ROM to directed, "Put dynar for] 2 hours in the m	sistance with all activities of g dressing and grooming. The o provide PROM exercises to twice daily and to report the nurse. The care plan mic right wrist and splint [on norning and 2 hours in the PM ng]. Followed by PROM to							
	right upper extremit resident room." - The care plan for I	y. Two staff for all cares in behaviors dated as revised					·		
	staff of hitting, pinch pulling at others hai resistive to cares." R24's refusal to wea	hysical behaviors towards ning, kicking, grabbing or r and R24 was "sometimes The care plan did not address ar the Dynasplint or PROM.							
	splint. Review of R24's ID	ot address a second contour Γ Progress Notes from							
		(5/13, indicated the Dynasplint technician on 10/15/13. The Obsolete Event ID: URDS			ID: 00937 If cont			Page 24 of 53	

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	13 FUR MEDICARE	A MEDICAID SERVICES			<u> </u>		. 0938	-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT CON	TE SURV VPLETE	
		245222	B. WING	i		11/	/07/20	13
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - CH	IATEAU		1	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	COMP	X5) PLETION ATE
F 280	the splint or R24's of R24's treatment sh - August - R24 did refusal, not applied times out of 62 opp sheet indicated R24 splints both applied "PM." The first splin applied due to refus 62 opportunities. Th 1/9/13, was not appli- - September - R24 times out of 60 opp refused or "Other" 3 splint was refused of - October - R24 refu of 62 opportunities; "Other" 29 times ou second splint was r of 62 opportunities. - November - R24 of splint was not applie out of 12 opportunit applied due to "Oth Review of the clinic consistent pattern of Although the treatm separate splints, the the different splints. regarding refusals of re-approach R24. T R24's splint was "br October and lacked evaluated.	Ige 24 not address unavailability of refusals to wear the splint. eets indicated the following: not receive PROM due to due to "Other" or sleeping 18 ortunities. The treatment 4 had two Dynamic right wrist for two hours in morning and nt ordered 12/4/09, was not sal or "Other" 31 times out of ne second splint ordered blied 18 out of 62 opportunities. did not receive PROM 11 ortunities; the first splint was 33 times out of 60; the second or "Other" 24 times out of 60. used PROM seven times out refused the first splint or it of 62 opportunities; the efused or "Other" 21 times out did not refuse PROM; the first ed due to "Other" four times ies; the second splint was not er" two out of 12 opportunities. al record indicated R24 had a of refusing the Dynasplint. ient sheets directed two e clinical record did not identify In addition, the notes did not include attempts to he clinical record indicated roken" in November and evidence R24's refusals were a.m. the social worker (SW)-A	F	280				
		re of R24's refusals to wear					1	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245222	B. WING		11/07/2013		
	PROVIDER OR SUPPLIER	IATEAU		STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COMPLETION		
F 280 F 282 SS=D	the splints, but was notified of R24's re was sometime ago progress notes even had no evaluation of she wrote the care completed the beh- care plan was not re refusals to wear the splint. 483.20(k)(3)(ii) SE PERSONS/PER C The services provide must be provided to accordance with ea care. This REQUIREME by: Based on observa- review, the facility plan interventions 1 of 3 residents (R Findings include: R30 was at risk for plan revised on 8/2 implementation to contour mattress of R30 's incident re 11/1/12, going forvinoted: A Minnesota Incide	a unclear when she was fusal to wear the splint(s), "It ." SW-A stated she read the ery morning and verified R24 of her refusals. SW-A verified plan for behaviors and avior CAA. SW-A verified the revised to address R24's e Dynasplint or the contour RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of NT is not met as evidenced ation, interview and document failed to ensure identified care were in place to reduce falls for 30) reviewed for accidents.		<ul> <li>F 282</li> <li>R30's care plan has been regarding fall interventions.</li> <li>All residents with falls in months care plans have reviewed and updated as new reviewed and revised if in on all current reside preparation for care conferinitial, quarterly annual or of condition MDS assessm completed.</li> <li>Facility Falls Management Guideline has been review revised as needed.</li> <li>Staff will be educated on u care plans as changes occur.</li> <li>DNS or designee to obser plan for interventions residents per week for r who have fallen in past mon</li> <li>DNS will report progress or to the QA committee.</li> <li>The QA committee will direction or change when ne and will dictate the continu completion of this morprocess based on the commoted.</li> <li>DNS will be responsible.</li> <li>Completion date: Decem 2013.</li> </ul>	a last 6 e been eded. a will be ndicated nts in rence as change ents are clinical wed and updating ve care for 2 esidents th. of audits provide ecessary ation or nitoring upliance		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED		
		245222	B. WING		· · · · · · · · · · · · · · · · · · ·	11/	07/2013	
NAME OF PROVIDER OR		HATEAU		2	TREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
PREFIX (EACH D	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
on the floo were casc: A MIR date down on k A MIR date floor near t On 11/6/13 a.m. R30's mattress o observed p bed. When inte registered contour ma was not or expect ide in place. The directe 11/7/13, at identified o residents. A care plan DON state F 311 483.25(a)( IMPROVE A resident services to specified in	ed 11/17, r next to ading off ed 2/6/13 nees ne: ed 11/2/1 the bed. 3, at 1:48 bed wa n it. On putting a rviewed nurse (F attress w n R30's b ntified ca prof nur 11:37 a care plan nning po d the fac 2) TREA /MAINTA is given paragra	(12, indicated R30 was found the bed with the "bed covers side of bed to the floor. 8, indicated R30 was found at to the bed. 3, indicated R30 was found on 8 p.m. and 11/7/13, at 10:12 s observed without a contour 11/7/13, at 11:32 a.m. staff was contour mattress on R30's on 11/7/13, at 11:07 a.m. the RN)-A unit manager verified the vas used for fall prevention and bed. RN-A stated she would are plan interventions would be sing (DON) was interviewed on .m. and stated she expected interventions to be in place for licy was requested and the cility did not have one. TMENT/SERVICES TO	FS	282				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	RS FOR MEDICARE	& MEDICAID SERVICES			OWR NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245222	B. WING		11/	07/2013
NAME OF	PROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CODI		
GOLDEN	I LIVINGCENTER - CH	IATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	Based on observa review, the facility f 1 of 3 residents (R independently com Findings include: R15 was observed which were caked underneath them. R15 had a quarterl completed on 9/11/ short term memory to be moderately in episodes of inatten dementia, disorgar retardation. She ne with personal hygie dependence with b The Care Area Ass 12/20/12, indicated and insight. She al impairment. Her hy and she at times w was able to particip personal cares and her personal hygie The plan of care, la had a physical fund resident's self-care staff to encourage cares, assist with nai The nursing assist	tion, interview, and document ailed to provide assistance for 15) who were unable to plete nail care. to have very long fingernails with black to brown substance y Minimum Data Set (MDS), '13; noted R15 had long and problems and was considered npaired. She did display tiveness, had a diagnosis of nized thinking and psychomotor eeded extensive assistance ene and was totally athing. essment (CAA) completed on I R15 had impaired judgment so had significant cognitive rgiene awareness was poor as resistive with cares. R15 bate in all aspects of her of her d needed limited assistance of ne. ast revised 9/17/12, noted R15 ctioning deficit related to the e impairment. The plan directed resident to make choices with lressing and personal hygiene	F 3	F 311 • R15's nails were cle 11/7/13, during the Resident's nails will be tr	survey. immed as Guardian usal on ls will be are clean e length. icated on nce with nail care tweek to leted in f care. report the QA provide eccessary iation or ponitoring mpliance	

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Event ID: URDS11 Facility ID: 00937

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SUR COMPLETE	
	ν.	245222	B. WING			11/07/20	013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 2106 SECOND AVENUE S MINNEAPOLIS, MN 55	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPT FICIENCY)	ВЕ СОМ	(X5) IPLETION DATE
F 311	dependent in this a R15 was observed 11/5/13 at 3:30 p.m	as R15 was considered to be	F 3	311			
	assistant (NA)-E w she had assisted F earlier in the day. S resident to comple- the resident refuse	6/13, at 8:44 a.m. with nursing as completed. NA-E reported 815 with her personal cares 6he reported she assisted the te personal hygiene however d to have nail care completed. t she was aware of "the dirt s nails."					
	registered nurse (F observed R15's fin very dirty and need	7/13, at 2:11 p.m. with RN)-B was completed. RN-B gernails and verified they were led to be cleaned. RN-B nt's nails should be cleaned e dirty.					
	was completed. NA the resident to "was encouraged her or	A-C on 11/7/13, at 2:14 p.m. A-C reported he had assisted sh up this morning" but had not attempted to clean her nails. dent's nails were dirty and					
		7/13, at 2:21 p.m. with RN-A I-A verified R15's nails needed					
	director of nursing reported she expect	7/13, at 2:30 p.m. with the (DON) was completed. She ted nursing staff to ensure the re clean. She also reported the					

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CENTER	AS FOR MEDICARE	& MEDICAID SERVICES			0	VIB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245222	B. WING			11/0	07/2013
NAME OF F	PROVIDER OR SUPPLIER			ŞTF	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CI	HATEAU			6 SECOND AVENUE SOUTH NNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311 F 318 SS=D	facility had no polic 483.25(e)(2) INCRI IN RANGE OF MO Based on the comp resident, the facility with a limited range appropriate treatme range of motion an decrease in range This REQUIREME by: Based on observa review, the facility f range of motion (R residents (R24) in t rehabilitation. Findings include: On 11/4/13, at 6:02 in a tilting wheelcha knee, elbow, wrist, contracted. R24 wa a splint at the time	y regarding nail care. EASE/PREVENT DECREASE TION prehensive assessment of a r must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion. NT is not met as evidenced tion, interview and document ailed to ensure a decline in OM) was prevented for 1 of 4 the sample reviewed for MI and fingers were visibly as not observed to be wearing		311 318	<ul> <li>guidelines have been reviewed</li> <li>Nursing staff will be educat approaches and re-approach encourage participation in ran motion programs.</li> </ul>	sed to sals. Motion d for s with herapy plans ly or sments als to ll be linical d. red on hes to hge of bed orative rve 2 es per lan of	
	observed to be in b	observations from 7:34 a.m.			Continued on Page 31		
L				<b>F</b> . 10			

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STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:		1 · ·			(X3) DATE SURVEY COMPLETED		
		245222	B. WING	à		11/	07/2013	
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE CON		
F 318	and at no time was R24'sright hand, elk - At 8:11 a.m. NA-F then quickly left the received range of m stated, "No." When exercises or tried to (do own her range of arm and straighten and lifted it slightly. a splint or brace on head, "No." - At 9:10 a.m. NA-F with morning cares night shift staff. NA- to five passive rang repetitions to R24's attempted to provid R24 hit at NA-F with redirected R24, but ROM. NA-F stoppe provided to wrist or - At 9:28 a.m. NA-F move her left (side she usually complet PROM on the right - At 9:32 a.m. after had a splint, NA-F r drawer of the bedsic open R24's right hand to appeared calm, but the splint by gently p NA-F stated she "oo splint," but stated it	the following was observed there a splint applied to bow, wrist and fingers. Visually laid eyes on R24, and day room. When asked if she notion to her right arm, R24 asked if she did her own o straighten out her own arm of motion) R24 moved her left ed it, then took the right hand When asked if she ever wore her arm, R24 shook her stated she did not assist R24 and R24 was assisted by the F then did approximately four e of motion (PROM) leg and knee. NA-F then e PROM to R24's right elbow, h her left hand twice. NA-F the resident would not allow d the PROM (no PROM was hand). stated R24 "was able to of the body) fine." NA-F stated ted five to 10 repetitions of upper and lower extremity. surveyor questioned if R24 etrieved a splint from the top de stand. NA-F attempted to nd and apply the splint. R24 would not allow NA-F to apply pushing NA-F's hands away. ccasionally could not apply the was usually due to R24	F	318	Contid	audits less ekly. on or g		
		During the observation, NA-F ohten R24's right ring and						

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<u>CENTERSE</u>	-OR MEDICARE	& MEDICAID SERVICES			C	MB NO	. 0938-0391	
STATEMENT OF I AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		245222	B. WING			11/	07/2013	
NAME OF PROV	/IDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIV	INGCENTER - CH	IATEAU			2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
pin of the ref sta NA re- and NA ap ond - A the RN had PR and re- On cor obs resz [R2 the app "Dy lac of t the bad of the and of the RN had RN A RN had RN A RN A RN A RN A RN A RN A RN A RN	R24's hand. R24 e palm aspect of usal should be re- ated she would re- h-F explained whe approach, use di d to report to the rsing assistant st h-F was unclear v plied and was un e splint. t 9:52 a.m. TMA- e refusal and refe J-D was present i d approached he ROM or wearing a d PROM of the u attempted for R2 a 11/6/13, at 12:40 mpleted the ROM servation of her of sident. RN-D state 24] got out of bed be room was for th- plied when R24 v ynasplint [a splint king range of mo the interview, RN be Dynasplint was ck to the compan- erapy was involve d was aware of th I-D and RN-A ver ROM, the refusal is stated staff when	ge 31 s able to slightly open the rest 's hand would not form over the splint. NA-F stated the eported to the nurse and attempt to apply the splint. en R24 refused, staff was to fferent staff to re-approach nurse was the procedure aff was to follow for refusals. when the splint should be clear if R24 had more than "A stated she was unaware of rred the surveyor to RN-D. hearby and verified no staff r regarding R24's refusals of a splint. No splint was applied pper extremity was not '4 during the observations. D p.m. RN-D stated she for R24 prior to the completing ROM with a male ed ROM was done "before I." RN-D explained the splint in e "night shift" and should be was in bed. RN-D stated the that stretched joints that were tion] was broken." At the time -A was present and verified broken and "had been sent y." RN-A stated occupational d with sending the splint back he Dynasplint being broken. ified if R24 refused the splint should be reported. Both ould re-approach and/or try a R24 refuses. RN-D was not f was usually completed by	F 3	318				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			1 ' <i>'</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245222	B. WING				11/07/2	1/07/2013	
NAME OF PROVIDER OR SUP		ATEAU		21	REET ADDRESS, CITY, STATE, ZIP COE 06 SECOND AVENUE SOUTH INNEAPOLIS, MN 55404	DE			
PREFIX (EACH DEFI	CIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD E	BE CO	(X5) MPLETION DATE	
stated R24 "w occupational f ROM. OT-A s the Dynasplin notified and c OT-A stated s broke, but bel weeks ago." ( "again" and th fixed. OT-A st Dynasplint rep broken but, "E load [at the tir information." ( maintenance when she "ca - At 1:28 p.m. case load on management therapy was c of the Nursing program, FMF and OT-A indi applied twice second contor hours twice da directed to co wrist and hand - At 1:35 p.m. R24's contracc right elbow - 7 extension con limited to zero through five d 90 degree for	r nursi the oc vas on therap tated s t was l alled the he wa ieved DT-A s hey we ated s baired Becaus ne], I c OT-A s progra me off OT-A 9/18/12 and R 9/18/12 and R 9/18/12 and R 9/18/12 and R 0 CT-A 1/3 9 Progra me left daily fo ur han aily "as moleted defoi OT-A ture's 70 degre emons third dig	ng. ccupational therapist (OT)-A case load [being seen for y]," but not for splinting or she did not write down when broken, but verified she was ne company to have it fixed. s unclear when the Dynasplint it was "approximately 1 1/2 - 2 tated the splint had broken re now waiting to have it he offered to have the when she heard it was se she [R24] wasn't on case didn't record all that verified R24 had a functional um for splinting and ROM	F3	118					

PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

A. BUILDING     A. BUILDING     11/07/2013       NAME OF PROVIDER OR SUPPLIER     B. WING     11/07/2013       GOLDEN LIVINGCENTER - CHATEAU     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG	STATEMENT OF DEFICIENT	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       GOLDEN LIVINGCENTER - CHATEAU     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)		non	IDENTIFICATION NUMBER.	A. BUILI	JING	G		MPLETED
GOLDEN LIVINGCENTER - CHATEAU       2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       (X5) COMPLETIN DATE			245222	B. WING	3 £		11	/07/2013
PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         COMPLETE DATE					2	2106 SECOND AVENUE SOUTH		
	PREFIX (EACH I	CH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETION DATE
F 318 Continued From page 33 taking off the splints while she was receiving therapy and R24 would 'give permission to apply [the splint], but then would take off the splint.' OT-A stated R24 did not require pain medication prior to PROM or splinting. OT-A stated although the splints may have been relused, the PROM program may prevent progression of the contractures. - At 1:46 p.m. OT-A approached R24 to measure her contractures. B24 work was measured at 95 degrees flexion. OT-A stated 'that's not better." R24's wrist was measured at 95 degrees flexion. OT-A stated 'that's not better." R24's wrist was measured at 95 degrees flexion. OT-A stated 724 selbow contracture 'was getting tighter.'' R24 would not allow OT-A to measure the hand or finger contracture's. The care plan for physical functioning dated as revised on 7/4/11, identified R24's risk factors of TBI, hemiplegia and R24 was admitted with contracture's of bilateral lower extremities; R24 was identified to have hemiparesis and contracture of the right arm. R24 was identified as requiring total assistance with all activities of daily living, including dressing and grooming. The care plan directed to provide PROM exercises to legs and arms daily twice daily and to report changes in ROM to the nurse. The care plan directed, 'Put dynamic right wrist and splint [on for ]2 hours in the morning and 2 hours in the PM [afternoon or evening]. Followed by PROM to right upper extremity. Two staff for all cares in resident froom.'' The annual Minimum Data Set (MDS) dated 11/7/12, indicated R24 had severely impaired	taking off t therapy an [the splint] OT-A state prior to PF the splints program m contracture - At 1:46 p her contra- measurem straighten pain and th degrees fle R24's wris OT-A away had pain. O "was gettir measure th The care p revised on TBI, hemip contracture was identif contracture as requirin daily living, care plan o legs and ai changes in directed, "F for] 2 hours [afternoon right upper resident ro	iff the splint and R24 wint], but ther ated R24 di PROM or sign the may prevent tures. Sp.m. OT-A tracture's. Ferement. OT- en R24's rigd the contration of rist was mere vay, would in a flexion. OT rist was mere vay, would in the contration of the rist in ring total as may, including in ROM to a ring total as mon or evenir per extremit room." ual Minimum	s while she was receiving yould "give permission to apply in would take off the splint." id not require pain medication plinting. OT-A stated although we been refused, the PROM ent progression of the A approached R24 to measure R24 initially agree to allow the A slowly attempted to ght arm and elbow, R24 denied acture was measured at 95 T-A stated "that's not better." easured at zero. R24 pushed not answer when asked if she ified R24's elbow contracture the result of the result of the states "R24 would not allow OT-A to or finger contracture's. hysical functioning dated as dentified R24's risk factors of d R24 was admitted with ateral lower extremities; R24 we hemiparesis and ight arm. R24 was identified assistance with all activities of g dressing and grooming. The to provide PROM exercises to v twice daily and to report the nurse. The care plan mic right wrist and splint [on norning and 2 hours in the PM ng]. Followed by PROM to ty. Two staff for all cares in m Data Set (MDS) dated		318	3		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				) DATE SURVEY COMPLETED	
		245222	B. WING	i		11/	07/2013	
	PROVIDER OR SUPPLIER	IATEAU		2	BTREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 318	total dependence for non-ambulatory. R2 impairment of ROM extremities and bot extremities. The C for cognition dated impaired short and impaired decision n also has presentation and has had behav cares and physical R24's diagnoses in traumatic brain inju indicated R24 was communication date relied on others to it indicated R24 was able to understand. splinting or ROM. The OT - Therapist Summary dated 3/1 for wheelchair adap prevent injury. The care plan for be 4/15/13, identified p staff of hitting, pinch pulling at others hai resistive to cares." R24's refusal to wea The care plan did n splint.	n memory problems, required or all ADLs, and R24 was 24 was identified to have an 1 on one side of the upper h sides of the lower are Area Assessment (CAA) 11/12/12, identified R24 had long-term memory, severely naking skills and, "Resident on of psychomotor retardation ioral symptoms of rejection of abuse." The CAA indicated cluded dementia, depression, ry (TBI) and anxiety. The CAA "at baseline." The CAA for ed 11/12/12, indicated R24 dentify and meet her needs, rarely understood and rarely The CAA's did not address Progress & Discharge //13, indicated R24 was seen otations to protect her skin and ehaviors dated as revised ohysical behaviors towards ning, kicking, grabbing or ir and R24 was "sometimes The care plan did not address ar the Dynasplint or PROM. ot address a second contour	F	318				
	needed extensive a not changed in ADL	dated 8/7/13, indicated R24 ssistance with eating, but had s or cognition from the annual Pain indicated R24 had no		and another and an a				

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STATEMENT OF DEFICIENCIES       [X1] PROVIDERSUPPLENCIA       [X2] AULTIFLE CONSTRUCTION       [X2] AULTIFLE       [X2] AUL							IND NO	. 0330-0391	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, GITY, STATE, 2P CODE       COLDEN LIVINGCENTER - CHATEAU     2166 SECOND AVENUE SOUTH MINNEAPOLIS, NN 55404       OX41D PROVIDERS OF NAME STREMENT OF DEFICIENCIES EACH-DERFLOAKOW MIST BE PROVIDENCE OF STULL REQULATORY ON LSC DENTFYING INFORMATION)     PROVIDERS OF NAME STREMENT OF DEFICIENCIES EACH-DERFLOAKOW MIST BE PROVIDENCE OF STULL REQULATORY ON LSC DENTFYING INFORMATION)     PROVIDERS OF NAME STREMENT OF DEFICIENCIES EACH-DERFLOAKOW MIST BE PROVED BY STULL REQULATORY ON LSC DENTFYING INFORMATION)     PROVIDERS OF NAME STREMENT CORRECTION ACTION SOUTH AND CONTRACT ON THE APPROPRIATE DEFICIENCY       F 318     Continued From page 35 visible symptoms of discomfort, that R24 offered no facial expressions or verbal protest to object to movement r/t pain or discomfort, and identified R24 would show lidgeling of her hand or leg. The quarterly MDS indicated no changes in R24's functional ROM.     F 318       The comprehensive Narrative Assessment dated 5/8/13, and the Quarterly Interdisciplinary Resident Review dated 8/7/13, the Pain Assessment in Advanced Dementia (PAINAD) dated 9/15/13, all indicated R24 had no pain signs or symptoms. PAINAD indicated R24 would express pain with body language only.     F 10 Psychiatric Progress Note dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of reluing cares and referred to R24's careplan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures.       The Psychiatric Progress Note dated 8/29/13, directed splints to the right wrist for two hours in the morning and t				1 · ·					
NAME OF PROVIDER OR SUPPLIER     STREET ADORESS, CITY, STREE, 28 CODE       GOLDEN LIVINGCENTER - CHATEAU     Its Street ADORESS, CITY, STREE, 28 CODE       (X4) ID PHETK TAC     SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROVEMUES BUTH MINEAPOLIS, MN 55404     D PROVIDERS PLAND CORRECTIVE ACTION BOULD BE CROSS-REFREENCED TO THE APPROPRIATE DEFICIENCY ACTION PROVIDERS SUMMARY STATEMENT OF DEFICIENCIES (RCAS) PREPRENENT OF DEFICIENCIES (RCAS) PREPRENENT (RCAS) PREPRENE			245222	B. WING			11	/07/2013	
PIER/IX TAG       IEAD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSCIDENTIFYING INFORMATION)       PREPX TAG       (EACH CORRENTIES ACTION Solutions DEFICIENCY)       CONVERTIFYING INFORMATION)       DATE         F 318       Continued From page 35 visible symptoms of discomfort, that R24 offered no readial expressions or verbal protest to object to movement r/t pain or discomfort and identified R24 would show fidgeting of her hand or leg. The quarterly MDS indicated no changes in R24's functional ROM.       F 318       F 318         The comprehensive Narrative Assessment dated 5/8/13, and the Quarterly Interdisciplinary Resident Review dated 8/7/13, the Pain Assessment in Advanced Dementia (PAINAD) dated 9/15/13, all indicated R24 had no pain signs or symptoms. PAINAD indicated R24 would express pain with body language only.       Assessment in Advanced Dementia (PAINAD) dated 9/15/13, all indicated R24 had no pain signs or symptoms of Her contractures.         The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of relusing cares and referred to R24's care plan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures.         The Psychiatric Progress Note dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in atternoon. Physician's Orders dated 10/28/13, indicated necupational therapy was to evaluate and treat R24.         Review of R24's IDT Progress Notes from 4/11/13, lincloget 11/28/13, indicated the Dynasplint was "repaired" by a technician on 10/15/13. The progress notes did not address unavailability of			HATEAU		2	106 SECOND AVENUE SOUTH	•••••••••••••••••••••••••••••••••••••••	,	
<ul> <li>visible symptoms of discomfort, that R24 offered no facial expressions or verbal protest to object to movement r/t pain or discomfort and identified R24 would show fidgeting of her hand or leg. The quarterly MDS indicated no changes in R24's functional ROM.</li> <li>The comprehensive Narrative Assessment dated 5/8/13, and the Quarterly Interdisciplinary Resident Review dated 8/7/13, the Pain Assessment in dvanced Dementia (PAINAD) dated 9/15/13, all indicated R24 had no pain signs or symptoms. PAINAD indicated R24 would express pain with body language only.</li> <li>The social services assessment dated 8/15/13, reviewed R24's social history prior to admission, identified R24 had the behavior of refusing cares and referred to R24's care plan. The clinical record had no further assessment of R24's refusals of cares or status of her contractures.</li> <li>The Psychiatric Progress Note dated 8/29/13, directed splints to the right wrist for two hours in the morning and two hours in afternoon. Physician's Orders dated 10/28/13, indicated occupational therapy was to evaluate and retar R24.</li> <li>Review of R24's IDT Progress Notes from 4/11/13, through 11/5/13, indicated the Dynasplint was "repaired" by a technician on 10/15/13. The progress notes did not address unavailability of</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION	
	F 318	visible symptoms o no facial expression movement r/t pain R24 would show fic quarterly MDS indic functional ROM. The comprehensive 5/8/13, and the Qua Resident Review d Assessment in Adv dated 9/15/13, all ir signs or symptoms express pain with b The social services reviewed R24's soci identified R24 had ta and referred to R24 record had no furth refusals of cares or The Psychiatric Pro- indicated R24's mo and identified R24 had activity. R24's Physician Or splints to the right v morning and two ho Orders dated 10/28 therapy was to eval Review of R24's ID 4/11/13, through 11, was "repaired" by a progress notes did	f discomfort, that R24 offered ns or verbal protest to object to or discomfort and identified dgeting of her hand or leg. The cated no changes in R24's e Narrative Assessment dated arterly Interdisciplinary ated 8/7/13, the Pain anced Dementia (PAINAD) ndicated R24 had no pain . PAINAD indicated R24 would ody language only. e assessment dated 8/15/13, cial history prior to admission, the behavior of refusing cares I's care plan. The clinical er assessment of R24's e status of her contractures. of and behavior was stable nad decreased psychomotor ders dated 8/29/13, directed wrist for two hours in the burs in afternoon. Physician's i/13, indicated occupational uate and treat R24. T Progress Notes from /5/13, indicated the Dynasplint technician on 10/15/13. The not address unavailability of	F	318				

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			r				. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE			(X3) DATE SURVEY COMPLETED	
		245222	B. WING			11.	/07/2013
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CH	HATEAU			2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	November 2013 inc - August - R24 did refusal, not applied times out of 62 opp sheet indicated R24 splints both applied "PM." The first splir applied due to refus 62 opportunities. Th 1/9/13, was not appli- - September - R24 times out of 60 opp refused or "Other" 3 splint was refused or - October - R24 refu of 62 opportunities; "Other" 29 times ou second splint was r of 62 opportunities. - November - R24 of splint was not applie out of 12 opportunit applied due to "Oth Review of the clinic forward indicated R refusing the Dynasp sheets directed two record did not ident addition, the notes r include attempts to record indicated R2 November and Octo Review of the undat Assistant/Registere forms (undated and	eets August 2013 through dicated the following: not receive PROM due to due to "Other" or sleeping 18 ortunities. The treatment 4 had two Dynamic right wrist for two hours in morning and at ordered 12/4/09, was not sal or "Other" 31 times out of he second splint ordered blied 18 out of 62 opportunities. did not receive PROM 11 ortunities; the first splint was 33 times out of 60; the second or "Other" 24 times out of 60. used PROM seven times out refused the first splint or at of 62 opportunities; the efused or "Other" 21 times out did not refuse PROM; the first ed due to "Other" four times ies; the second splint was not er" two out of 12 opportunities. al record August 2013, 24 had a consistent pattern of blint. Although the treatment separate splints, the clinical ify the different splints. In regarding refusals did not re-approach R24. The clinical 4's splint was "broken" in ober.	F	318			
	approximately 8:42	a.m. on 11/6/13), directed,					

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	13 FUR MEDICARE	A MEDICAID SERVICES	<b>.</b>		0	<u>WR NO</u>	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC				TE SURVEY MPLETED
		245222	B. WING			11/	/07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	TREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	"NOC [night] shift to leave in bed. Put D leave on for 1 hour, arm, leave on 1 hour, pynaSplint is on/off "PROM exercises t form did not address On 11/7/13, at 8:42 (DON) was notified ROM. DON stated measurements of th "yesterday" and ver documented in the R24 was currently i stated there was no refusals were asses assessment period notes were read by was unclear if the re expressed she was declined, as she ha and observed her e straight." DON state refusals and stated attempt a different s the nurse. DON sta another splint. On 11/7/13, at 9:53 stated she was awa the splints, but was notified of R24's ref was some time ago progress notes even had no assessment	<ul> <li>b get resident dressed and ynasplint on R [right] arm,</li> <li>PM shift to put DynaSplint R ur. NAR report to nurse when</li> <li>The sheet further directed,</li> <li>o legs &amp; arms AM/PM." The sis the use of another splint.</li> <li>a.m. the director of nursing of a potential decline in R24's the OT-A reported the ne elbow contracture to her ified R24's refusals were progress notes. DON stated n an "assessment period," but o documentation R24's ssed prior to the current MDS</li> <li>DON stated the progress all the department heads, but efusals were evaluated. DON skeptical R24's ROM had d "cut [R24's] nails yesterday" xtend her elbow "pretty ed staff was aware of R24's staff should re-approach, staff and report the refusal to ted she was unclear R24 had</li> <li>a.m. the social worker (SW)-A ire of R24's refusals to wear unclear when she was usal to wear the splint(s), "It ." SW-A stated she read the ry morning and verified R24 of her refusals. Although</li> </ul>	F3	318			
	wrote the care area	ocial services department assessments (CAA) for the care plan for behaviors,					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245222	B. WING	ì		11/	07/2013
	PROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	SW-A stated the nuresponsible for ass SW-A was unclear of her refusals to w SW-A stated any di regarding risk and by nursing. SW-A st involvement was the interdisciplinary tea social service role w and ideas" to addrear refusals) based on resident." SW-A sta notify her "if residen injury or decline]" a "lower risk." When contracture could p	ursing department was sessing resident refusals. if R24's guardian was notified wear the splints or allow PROM, liscussion with the guardian benefits would be completed stated social service mough participation in the am (IDT) process, and the was to "provide suggestions ess behaviors (such as "what we know of the ated she expected nursing to int where are higher risk [for and stated she viewed R24 as asked if she was aware R24's progress without splinting and ined she was unaware of any	F	318			
	On 11/7/13, at 10:0 was no policy on re On 11/7/13, at appr stated the Dynaspli facility. "I just wasn together, then we ti On 11/7/13, at 10:4 (NP)-F was contact she was unaware of Dynasplint or if the stated she could no NP-F stated she be of R24's condition as speak with the med R24's condition was she "wasn't as cond	08 a.m. the DON stated there					

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
		245222	B. WING			11	/07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		· .
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	progression was ex "healthcare standar progression/develo stated she was not regarding R24's cor physician was on "r reassigned to the m On 11/7/13, at 11:13 representative (SR) via telephone. SR s Dynasplint on "a co confirmed he was n being broken, but w SR stated he was p repaired on his nex week" and stated po significant" and exp screw." SR stated he needed to be repair 10/15/13. SR verifie replacement splint a protocol while the s When asked about splint, SR stated he authorization" for ar be fitted for a Dynas planning to "group h the repair when he resident. SR stated off the facility's thera physician's order. S wearing schedule, s tolerance, provide a on the resident. I re asked if R24 did not would R24's contract	plained, NP-F agreed ds were to prevent further pment" of contracture's. NP-F aware of the "small details" ndition, R24's regular assigned naternity leave" and R24 was nedical director until her return. 3 a.m. the sales of or Dynasplint was contacted tated he had repaired R24's uple of occasions" and notified about the Dynasplint vas unclear what was wrong. Idanning to have the splint t visit "the first part of next ast repairs were not "anything lained repairs were usually "a new as notified the splint ed "most recently" on ed he did not provide a and was unclear on the plint was out of commission. the delay in repairing the was "waiting for an nother resident in the facility to splint. SR explained he was nis visit" and was going to do was up to fit the other Dynasplints were fitted based apy assessment and the R explained, "I provide a such as building up to picture of how it should look by on the therapist." When t wear the splint consistently,	FS	318			

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	15 FOR MEDICARE	E & MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245222	B. WING	i		11/	/07/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CI	HATEAU			2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	not informed to cor understood R24 to frequently" prior to stated he was unay the R24's Dynaspli On 11/7/13, at 12:3 administrator state care planning, asse motion, or splinting for behavior assess (resident assessme planning per the R/ some documentativ behaviors done "or regardless of if the psychoactive media facility did not com of behaviors. DON clinical documentation notes "daily." On 11/7/13, at 1:22 contacted via telep she was assigned a beginning of the ye The guardian state "at times" and verif R24's refusal to we Dynasplint was not The guardian state risks versus benefit Dynasplint. The guar apport" with occup was notified by the be discharged (fror to participate. The guardian tate)	e urgent and confirmed he was ne sooner. SR stated he have "refused the splint the splint requiring repair. SR ware of facility staff repairing	F	318			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	IPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		245222	B. WING			11/	07/2013
	PROVIDER OR SUPPLIER	HATEAU		STREET ADDRESS, CITY 2106 SECOND AVENUE MINNEAPOLIS, MN	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	R24. The guardian staff about that at t verified she expect refusals.	ige 41 o give her a detailed review of stated she would be asking he care conference and ed to be notified of the p.m. the OT-A and DON both	F3	18			
	attempted to re-me several attempts R hands away and re not respond to que	asure R24's hand. After 24 continued to push staff fused measurement. R24 did stions regarding pain or used with non-verbal					
F 323	(MD) verified he wa refusals to wear the was broken. MD st expected he would notification to be do stated he was a pa rounded in the facil resident sustained decline in ROM of t to the splint not bei directed by the plan 483.25(h) FREE O	= ACCIDENT	F 3	23			
SS=D	HAZARDS/SUPER The facility must er environment remain as is possible; and						

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

Event ID: URDS11

Facility ID: 00937

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PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245222	B. WING		11/	07/2013		
	PROVIDER OR SUPPLIER N LIVINGCENTER - CH	IATEAU		STREET ADDRESS, CITY, STATE, ZIP COD 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETIO DATE		
F 323	This REQUIREMEN by: Based on observat review, the facility fa for falls prevention residents (R15, R30 Findings include: The facility failed to they had establishe R30 who were iden R15 was observed lying on her bed. A bedroom, placed by strips were observed was wearing "fuzzy R15 was observed walking the hall on twearing "blue fuzzy loose fitting and the The slippers appear R15 was again obseved walking the hall on twearing "blue fuzzy loose fitting and the The slippers appear R15 was again obseved walking the hall on twearing "blue fuzzy The care area asse 12/12/12, indicated forgetful and had im She displayed episo being inattentive and was resistive at time on the unit. She had impairment. The CA	NT is not met as evidenced ion, interview and document ailed to ensure interventions were implemented for 2 of 3 b) reviewed for accidents. implement the interventions d to prevent falls for R15 and tified a risk for falls. on 11/4/13, at 4:13 p.m., to be commode was in her the side of her bed. Non skid d on the floor by her bed. She blue slippers." on 11/5/13, at 3:30 p.m. he unit, using her walker and ankle slippers" which were seam in the back was torn. red very old and well worn. erved on 11/6/13, at 7:38 a.m. he unit, using her walker and slippers." ssments (CAA), completed on R15 was often confused and paired decision making skills. des of d disorganized thinking. She swith cares and wandered visual and hearing A identified R15 was at risk falls. She wore appropriate	, F 3	<ul> <li>F 323</li> <li>Resident 15 slippers were for shoes during survey.</li> <li>A concave mattress was R30's bed during sur 11/7/13.</li> <li>All residents with falls months will be reviewed interventions have implemented or discont appropriate.</li> <li>IDT will ensure fall interfor all residents who have in place on all current repreparation for care confinitial, quarterly annual of condition assessme completed.</li> <li>Facility Falls Management Guideline has been revierevised if needed</li> <li>Nursing Staff and IDT provided education on Management Clinical and the importance of Fall interventions in place.</li> <li>DNS or designee to resident and room to e prevention interventio implemented for 2 resid for residents who have h conference that week.</li> <li>DNS or designee will reprof audits to the QA comm</li> <li>Completion date: Dece 2013</li> </ul>	placed on rvey, on in last 6 to ensure been inued as erventions fallen are sidents in erence as or change ents are at clinical ewed and will be the Falls Guideline laving all observe nsure fall ns are ents/week ad a care ort results ittee.			

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Facility ID: 00937

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PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

	IOT OTT MEDIO/ ITE		·····				. 0330-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245222	B. WING			11/	07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	medication regime The plan of care, la R15 was at risk for falls, past history of displaying unsafe b prevent falls include placing the call ligh mattress, educate t actions would affec wear anti-slip socks slipping, keeping he of clutter, observe f remind her to use h encourage R15 to u unsteady or weak. R15 fell on the floor told staff she forgot the fall, she was ref In addition, she was walker while ambula slippers were remot the use of correct s indication of any inji R15 was involved in from 3/6/13 to 4/5/1 falls. The discharge occupational therap poor walker use and contributing factors R15 fell on 4/19/13, on the floor at the fo staff she had slid to in front of her. She s skin tear and a bruis	was not a factor for falls. st revised on 12/20/12, noted falls related to her history of falling and fractures and ehavior. The interventions to ed an assessment of pain, t within reach, contour he resident on how her t her safety, encourage R15 to so bed, footwear to prevent er environment well lit and free or side effects of medication, her walker at all times and use a wheelchair when she is c on 3/5/13, at 8:00 a.m. She to use her walker. As result of erred to occupational therapy. s re-educated to use her ating and removed non-stick ved and staff were to enforce lippers. There was no ury to the resident.	F	323			

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		AND HUMAN SERVICES				PRINTED: FORM OMB NO.	APPR	OVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE		ΞY
		245222	B. WING	I		11/(	)7/201	3
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODI			
GOLDEN	LIVINGCENTER - CH	IATEAU			106 SECOND AVENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X! COMPL DA	ETION
F 323	recent change in ro commode and had noted the resident v bladder bowel urge interventions were f shift would assist th every two hours and rearranged to reduce light was in reach of The resident fell on heard calling from h the resident sitting from h the resident sitting from h the resident sitting from h the resident sitting from h the bottom. The resident turned and underlying reason f wear inappropriate well-fitting shoes ar slippers." They also stand to ensure a c door of her room. On 6/20/13, at 3:10 She was found sittin the bed. She was w both feet. R15 repo floor. Risk factors in falls and impaired s judgment. The reco included "check all sliding shoes." In ac placed on the floor commode. R15 was found on the 10/12/13, at 8:15 p.	y awareness/judgment, a commate, was using the a hard time with change. It was "probably" responding to ncy. The recommended to use a night light and night he resident to the commode d her room was to be ce clutter. In addition, the call	F	323			· · · ·	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: URDS1	1	Fac	ility ID: 00937 If conti	nuation sheet P	age 45	of 53

PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		245222	B. WING			11/	07/2013
	PROVIDER OR SUPPLIER	IATEAU		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404	•	
(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 323	while ambulating. S and was not using f conditions were ide was determined to and was not using f recommendation w reach. They also of and referred the res treat for endurance On 10/14/13, at 5:0 slipped and fell in th personal strength p been ambulating ar of what had happer her history of falls a awareness/judgmer was using her walke interventions include footwear, ensuring o obstacles, ensure a reach, use of night f meals and ensure b R15 fell on 11/1/13, out of bed per her re Prior to the fall, accos investigation, she w contributing factors and impaired safety was wearing slipper adaptive equipment post fall report noted assistance when tra to her bed to prevent	he was wearing gripper socks her walker. No underlying ntified. The causative factor be that she lost her balance her walker. The Post Fall as that call light be within fered the resident a night light sident to physical therapy to 0 p.m. R15 lost her balance, he dayroom due to loss of er the post fall report. She had hd was unable to inform staff hed. Contributing factors were nd her impaired safety nt. She was wear slippers and er. The recommended post fall ed changing the resident's environment was clear of ssistive devise was within light. Offer fluids/food between hed was in the low position. at 10:55 a.m. when she slid eport and found on the floor. ording to the post fall	FS	323			

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PRINTED: 11/22/2013, FORM APPROVED

STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DA1	. 0938-0391 TE SURVEY MPLETED
		245222	B. WING	i		11	07/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - CH	IATEAU			2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	The quarterly Minim completed on 9/11/ independent with tra supervision with loc She was unsteady r standing but was at staff assistance. Sh on and off the toilets transfer but again a staff assistance. Sh ambulated. The Nursing Assista 11/6/13, at 7:46 a.m dependent with all a staff were to encour wear (not old slippe An interview with re- completed on 11/5/1 R15 was a fall risk a She reported one of forget to use her wa balance and fall. Sh call light but could n she had used it to a did not know if the re- call light. She also re "blue slippers" from she was always able reported the slippers bottoms of them had An interview with nu completed on 11/6/1 R15 had the common falls. She indicated te excessive amount o	age 46 num Data Set (MDS) (13, indicated R15 was ansfers and needed comotion on and off the unit. moving from seated to ble to stabilize herself without ne was also unsteady moving is and any surface to surface able to steady herself without ne used a walker when she ant Care sheet obtained on n. indicated R15 was activities of daily living and rage R15 to wear proper foot ers) when she was out of bed. egistered nurse (RN)-A was 13, at 2:39 p.m. She reported and had fallen several times. If the factors was she would alker and then would lose her ne indicated the resident had a not remember the last time; ask for staff assistance. She resident could even use the reported they had removed the the resident six times and e to relocate them. She is were very worn and the d no skid protection. ursing assistant (NA)-E was 13, at 8:44 a.m. NA-E reported ode by her bed to prevent the resident would use an of toilet paper and then trip eported R15 did not have any	F3	323			

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PRINTED: 11/22/2013 FORM APPROVED

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		245222	B. WING			11	/07/2013
NAME OF	PROVIDER OR SUPPLIER	I	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1	/07/2015
GOLDEN	N LIVINGCENTER - CH	HATEAU			2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	other shoes, other to opened the residen observed to have a the bottom. A beige and NA-E dug throus second shoe. Upon nursing assistant to the beige shoes on. The facility's policy, interdisciplinary tam prevention plan of of falls. The policy also assess the resident necessary treatmen Condition Report-Po- nurse is to ensure a implemented and th interdisciplinary tea Condition Report-Po- recommendations v R30 did not have fa identified by the car On 11/6/13, at 1:48 a.m. R30's bed was mattress on it. On 1 observed putting a obed. The "at risk for falls" directed a contour n The Comprehensive dated 12/12/12, not and had a history of	than the blue slippers. NA-E nt's closet. The closet was a three foot pile of clothing on e tennis shoe was observed ugh the clothing and found the n request, R15 did allow the o remove the slippers and put n. revised 2013, directed the n to evaluate the fall care for residents "at risk" for so directed licensed nurses to at after a fall and provide nt and initiate the Change in Post fall/Trauma. The licensed appropriate interventions are he care plan was updated. The am is to review the Change of Post Fall and make additional within 72 hours of the fall.	F3	323			

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PRINTED: 11/22/2013 FORM APPROVED

STATEMENT OF DEPICIENCIES AND PLANDER OF CORRECTION       (XI) PROVIDER VALUEA IDENTIFICATION NUMBER: 245222       (XI) PROVIDER OF SUPPLIEA BUILDING       (XI) PROVIDER OF SUPPLIEA 245222       (XI) PROVIDER OF SUPPLIEA BUILDING       (XI) PROVIDER OF SUPPLIEA 245222       STREET ADDRESS, CITY, STATE, ZIP CODE 2105 SECOND VENUE SOUTH MINEAPCOLS, MN S5040       (XI) PROVIDER OF SUPPLIEA 245222       STREET ADDRESS, CITY, STATE, ZIP CODE 2105 SECOND VENUE SOUTH MINEAPCOLS, MN S5040       (XI) PROVIDER OF SUPPLIEA 2105 SECOND VENUE SOUTH MINEAPCOLS, MN S5040       (XI) PROVIDER OF SUPPLIEA 2105 SECOND VENUE SOUTH MINEAPCOLS, MN S5040         (XI) PROVIDER OF PROVIDER OF PERCENTION PERCENT TAG       SUMMARY STREPENT OF DEFICIENCES 500 STREPORT ACT ON SECON PERCENT ACT ON SECON PERCENT ACT ON SECON CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY       (XI) PROVIDER OF SUPPLIEA 200 STREPORT ACT OF THE ADDRESS OF THE ADDRESS OF THE ADDRESS OF SUPPLIEA 200 STREPORT ACT OF THE ADDRESS OF THE ADDRESS OF THE ADDRESS OF THE ADDRESS OF SUPPLIEA 200 STREPORT ACT OF THE ADDRESS OF T	CENTER	Real Contemporary AS FOR MEDICARE	& MEDICAID SERVICES			C	MB NC	. 0938-0391
MAKE OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       COLDEN LIVINGCENTER - CHATEAU     STREET ADDRESS, CITY, STATE, ZIP CODE       CALL     SUMMARY STATELEXT OF DEFICIENCES, IECAH OPERCINARY OWNEST BE PROVEDED BY PULL REGULATORY ON LSC IDENTIFYING INFORMATION)     D       F 323     Continued From page 48 bed. A Comprehensive Narrative Assessment dated 5/8/13, noted to continue same intervention to prevent falls.     F 323       The Clinical Health Status assessment dated 8/7/13, indicated R30 had a fall risk score of 13, which indicated at risk for falls.     F 323       The Annual Minimum Data Set (MDS) dated 8/7/13, indicated R30 had a fall with injury since the prior assessment dated 8/2/13, indicated R30 had a naively discore. The MDS indicated R30 had moderately impaired cognitive skills or daily decision making. R30 was noted on the MDS to have had a fall with injury since the prior assessment dated 8/2/13, indicated R30 was trisk for falls.       A Minnesota Incident Report (MIR) dated 11/1/12, indicated R30 had so for dails.     A Minnesota Incident Bdo was found on the floor next to the bed do: - On 11/2/13, indicated R30 was found on the floor next to the bed.       When interviewed on 11/7/13, at 11:07 a.m. the registered nurse (RN). A unit manager verified the contour mattress was used of rail prevention and was not on R30's bed. RN-A stated she would expect identified are plan interventions would be in place.								
IMAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, OTY, STATE, JP CODE         COLDEN LIVINGCENTER - CHATEAU       International Content of the Chateau       Street Addresses out the Chateau         (X4) ID PPEFEX       SUMMARY STATEMENT OF DEFICIENCIES (REACH BEFICIENCY MIST BE PREVEDED BY FULL REQUEATORY ON LISC DEXITIFYING INFORMATION)       ID PROVIDERS THAN FOR CONRECTION OF DEFICIENCIES (REACH BEFICIENCY MIST BE PREVEDED BY FULL REQUEATORY ON LISC DEXITIFYING INFORMATION)       ID PREVENT ACT ON STREET ADDRESS, OTY, STATE, JP COULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY       Other Con- PARENCE (REACH BEFICIENCY ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY       Other Con- PARENCE (REACH BEFICIENCY ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY       Other Con- PARENCE (REACH BEFICIENCY TAG       Other Con- PARENCE (REACH BEFICIENCY ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY       Other Con- PARENCE (REACH BEFICIENCY TAG       Other Con- PARENCE (REACH BEFICIENCY TAG       Other Con- PARENCE (REACH BEFICIENCY TAG       Other Con- PARENCE (REACH BEFICIENCY (REACH			245222	B. WING	i		11	/07/2013
MINREEPOLIS MINREENTER - CHAILED       IX41.00     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISST BE PROVED BY BLL (REQULATORY ON LSC DENTIFYING INFORMATION)     D ID PREVIX TAG     PROVIDERS THANGT CONRECTIVE ACTION SHOULD BE CRUDS REPREDENT ON THE APPROPRIATE DEFICIENCY     Configure Deficiency action Should be cruds and the property action of the APPROPRIATE DEFICIENCY     Configure Deficiency action Should be cruds and the property action of the APPROPRIATE DEFICIENCY     Configure Deficiency action of the APPROPRIATE DEFICIENCY     Configure Deficiency action of the APPROPRIATE DEFICIENCY     Configure Deficiency Deficiency action of the APPROPRIATE DEFICIENCY     Configure Deficiency Deficiency Deficiency Deficiency     Configure Deficiency Deficiency Deficiency     Configure Deficiency Deficiency     Configure Deficiency     Configure Deficiency     Configure Deficiency     Configure Deficiency     Configure Deficiency     Configure Deficiency       F 323     Continued From page 48 bed.     F 323     F 323     F 323     F 323     Configure Deficiency     Configure Deficiency <td>NAME OF I</td> <td>PROVIDER OR SUPPLIER</td> <td></td> <td>•</td> <td></td> <td>STREET ADDRESS, CITY, STATE, ZIP CODE</td> <td></td> <td></td>	NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
Image: Proceeding of the process of the proces of the process of the proces of the process of the proce						2106 SECOND AVENUE SOUTH		
PREFX       IEACH DEPRCINCY MUST BE PRECEDED BY FULL       PREFX       TAG       IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COUNTER ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COUNTER APPROPRIATE <td>GOEDEN</td> <td>ENHAGE ITEN - OF</td> <td></td> <td></td> <td></td> <td>MINNEAPOLIS, MN 55404</td> <td></td> <td></td>	GOEDEN	ENHAGE ITEN - OF				MINNEAPOLIS, MN 55404		
<ul> <li>bed.</li> <li>A Comprehensive Narrative Assessment dated 5/8/13, noted to continue same intervention to prevent falls.</li> <li>The Clinical Health Status assessment dated 8/7/13, noted R30 had a fall risk score of 13, which indicated at risk for falls.</li> <li>The Annual Minimum Data Set (MDS) dated 8/7/13, indicated R30 had diagnoses to include schizophrenia and anxiety disorder. The MDS indicated R40 had diagnoses to include schizophrenia and anxiety disorder. The MDS indicated R30 had moderately impaired cognitive skills for daily decision making. R30 was noted on the MDS to have had a fall with injury since the prior assessment and required supervision and one person assist with bed mobility.</li> <li>The Care Area Assessment dated 8/23/13, indicated R30 fell in room near the bed.</li> <li>On 11/17/12, indicated R30 was found on the floor next to the bed with the "bed covers were cascading off side of bed to the floor."</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>On 11/2/13, indicated R30 was found on floor near the bed.</li> <li>In the interviewed on 11/7/13, at 11:07 a.m. the registered nurse (RN)-A unit manager verified the contour mattress was used for fall prevention and was not on R305 bed. RN-A stated she would expect identified care plan interventions would be in place.</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION
	F 323	bed. A Comprehensive M 5/8/13, noted to comprevent falls. The Clinical Health 8/7/13, noted R30 M which indicated at m The Annual Minimu 8/7/13, indicated R3 schizophrenia and a indicated R30 had m skills for daily decis the MDS to have ha prior assessment a one person assist w The Care Area Asse indicated R30 was A Minnesota Incider indicated R30 fell in - On 11/17/12, in floor next to the bed cascading off side o - On 2/6/13, indic knees next to the be - On 11/2/13, indic knees next to the bed. When interviewed of registered nurse (R contour mattress wa was not on R30's be expect identified car in place.	Narrative Assessment dated natinue same intervention to Status assessment dated nad a fall risk score of 13, risk for falls. Im Data Set (MDS) dated 30 had diagnoses to include anxiety disorder. The MDS moderately impaired cognitive ion making. R30 was noted on ad a fall with injury since the nd required supervision and with bed mobility. essment dated 8/23/13, at risk for falls. Int Report (MIR) dated 11/1/12, room near the bed. dicated R30 was found on the d with the "bed covers were of bed to the floor." cated R30 was found down on ed. icated R30 was found on floor on 11/7/13, at 11:07 a.m. the N)-A unit manager verified the as used for fall prevention and ed. RN-A stated she would re plan interventions would be	F	323	3		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	0. 0938-0391 FE SURVEY MPLETED
		045000	A. BUILD				
		245222	B. WING			11	/07/2013
	PROVIDER OR SUPPLIER	HATEAU		2	TREET ADDRESS, CITY, STATE, ZIP CODE 106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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
	identified care plan residents. A care planning pol DON stated the fac The Falls Managen revised 2013, direc are care planned w interventions." The Falls Risk/Post undated, directed fo "assure any identifie place." 483.55(b) ROUTINI SERVICES IN NFS The nursing facility an outside resource §483.75(h) of this p covered under the S dental services to m resident; must, if ne making appointment transportation to an must promptly refer damaged dentures This REQUIREMEN by: Based on observati review, the facility fa	m. and stated she expected interventions to be in place for icy was requested and the ility did not have one. Thent Clinical Guidelines policy ted "Residents at risk for falls ith individualized a Fall Assessment Process for residents at risk for falls, ed equipment needed is in E/EMERGENCY DENTAL must provide or obtain from e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each cessary, assist the resident in ts; and by arranging for d from the dentist's office; and residents with lost or to a dentist. IT is not met as evidenced on, interview and document illed to ensure dental services R15) reviewed for dental	F 3	.12			
	37/02.00) Provinue Vereione (	Obsolato Event ID: LIDD 31		PROFESSION VICTORIA			

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PRINTED: 11/22/2013 FORM APPROVED OMB NO 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-03 E SURVEY
				JG		
NAME OF	PROVIDER OR SUPPLIER	245222	B. WING _			07/2013
	LIVINGCENTER - CI			STREET ADDRESS, CITY, STATE, ZIP CODE 2106 SECOND AVENUE SOUTH		
GOLDEI	LIVINGCENTER - CI			MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
	Findings include: R15 was observed teeth. R15 had diagnosis quarterly Minimum on 9/11/13; noted F memory problems a moderately cognitiv episodes of inattent and psychomotor re extensive assistance was totally depende The Care Area Asse 12/20/12, indicated and insight. She als impairment. Her hyg R15 was able to pai her personal cares of her personal hygi refused many cares cares. She had a hi evaluations and did oral exam other tha mouth when open for noted there were vis teeth and likely cario assessment indicate addressed in the ca encourage oral hygi the resident allowed The plan of care, las had chewing difficult risk for dental proble her natural tooth los	to have discolored broken that included dementia. The Data Set (MDS), completed 15 had long and short term and was considered to be ely impaired. She displayed tiveness, disorganized thinking etardation. She needed ee with personal hygiene and ence with bathing. essment (CAA) completed on R15 had impaired judgment o had significant cognitive giene awareness was poor. ticipate in all aspects of her of and needed limited assistance ene. The CAA indicated R15 and had no desire for oral story of refusing dental not allow staff to complete an n a cursory looking into the or talking or eating. The CAA sible broken and cracked bus (decayed). The ed that this would be re plan and staff were to ene and offer dental exams if	F 41	<ul> <li>2 F 412</li> <li>Resident 15 was offered de but refused to go to appor Guardian informed.</li> <li>All residents will be audite time dental care was offere offered if it was not offere last year.</li> <li>IDT will ensure all reside offered dental service preparation for care conferinitial, quarterly or char condition assessments completed.</li> <li>Care conference Summary been updated to clearly services were offered and a or refused.</li> <li>DNS or designee will audit Conference Summaries weet</li> <li>The QA committee will rev results of audits and decide need to be continued weekly than weekly or more than we QA will dictate the continuat completion of this monitorin process based on the complimoted.</li> <li>DNS and ED will be respon</li> <li>Completion date: Decem 2013</li> </ul>	intment . d for last ed and be ed in the lents are ces in rence as ange of are note has y show accepted t 3 Care ekly. iew if audits y, less eekly. ation or ng iance sible.	

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

Facility ID: 00937

If continuation sheet Page 51 of 53

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PRINTED: 11/22/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES       (X) IPROVIDERSUPPLIENCIA DENTIFICATION NUMBER:       (X) IPROVIDERSUPPLIENCIA DENTIFICATION NUMBER:       (X) IPROVIDERSUPPLIENCIA 245222       (X) IPROVIDERSUPPLIENCIA B. WING       (X) IPROVIDERSUPPLIENCIA B.		15 FUR MEDICARE	& MEDICAID SERVICES			C	WB NC	<u>). 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS. OTV. STATE. 2/P CODE         GOLDEN LIVINGCENTER - CHATEAU       STREET ADDRESS. OTV. STATE. 2/P CODE         (X4) ID PREEX       SUMMARY STATEMENT OF DEPICIENCIES EACH DEPRICED DY FULL RECAL DEPRIVOR US TO EPRICED DY FULL TAG       PROVIDER SPLAN OF CORRECTION (EACH OWN OR LSC DENTFRING WORKATION)       PROVIDER SPLAN OF CORRECTION (EACH OWN OR LSC DENTFRING WORKATION)       OWNELT ON (EACH OWN OR LSC DENTFRING WORKATION)       PROVIDER SPLAN OF CORRECTION (EACH OWN OR LSC DENTFRING WORKATION)       OWNELT ON (EACH OWN OR LSC DENTFRING WORKATION)       DeFICIENCY       OWNELT ON (EACH OWN OR LSC DENTFRING WORKATION)       OWNELT ON (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNEL (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNEL (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNELT ON (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNELT ON (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNEL (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNELT (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNELT (EACH OWNEL & PHOPORIATE DEFICIENCY)       OWNELT (EACH OWNEL & P								
2108 SECOND AVENUE SOUTH MINNEAPOLIS, MM 5304       IMI D TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICENCY MUST BE PRECEDED BY FULL REQUATORY OR LSCIDENTIFYING INFORMATION)     IP     PREFX FAG     CACHO OR SOURCE CONTRACTOR (EACH OPERICINE AND OF CORRECTION (EACH OPERICENCY)     IP     IP <td< td=""><td></td><td></td><td>245222</td><td>B. WING</td><td></td><td></td><td>  11</td><td>/07/2013</td></td<>			245222	B. WING			11	/07/2013
MINNEAPOLIS, MN 55404       IMAILID IMAILID TAG     SUMMARY STATEMENT OF DEFICIENCIES PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID ID PROVIDENTIFYING INFORMATION PRECEDE OF THE APPROPRIATE DEFICIENCY       F 412     Continued From page 51 cares as needed, educate resident on risk/benefits of refusal of oral care, inspect oral cavity for bleeding gums or other issues as allowed and refer for dental services as needed.     F 412     F 412       The Nursing Assistant (NA) Care sheet, obtained on 11/6/13, directed staff to assist R15 with her personal hygiene, which would include oral hygien, as R15 was considered to be dependent in the area.     F 412       A review of the care conference summaries held 3/18/13, 6/17/13, and 9/16/13, noted a section where the resident or the representative were to be asked if they wanted a dental consultation. That was not addressed in any of the care conferences held.       R15 was observed on 11/6/13, at 7:38 a.m. in the day room. She was eating breakfast independently atter the staff had served her the meal. She was served a pancake, oatmeal, scrambled eggs and ground meet. She ate about 50% of the food served.       An interview on 11/6/13, at 8:44 a.m. with NA-E was completed. She reported that she had assisted R15 with personal cares. An interview on 11/7/13, at 2:14 p.m. with NA-C was completed. NA-C reported he ad assisted	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFix TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFix TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFix TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFix TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL       DEFICIENCY	GOLDEN	I LIVINGCENTER - CH	IATEAU					
<ul> <li>cares as needed,educate resident on risk/benefits of refusal of oral care, inspect oral cavity for bleeding gums or other issues as allowed and refer for dental services as needed.</li> <li>The Nursing Assistant (NA) Care sheet, obtained on 11/6/13, directed staff to assist R15 with her personal hygiene, which would include oral hygeine, as R15 was considered to be dependent in the area.</li> <li>A review of the care conference summaries held 3/18/13, 6/17/13, and 9/16/13, noted a section where the resident or the representative were to be asked if they wanted a dental consultation. That was not addressed in any of the care conferences held.</li> <li>R15 was observed on 11/6/13, at 7:38 a.m. in the day room. She was seating breakfast independently after the staff had served her the meal. She was served a pancake, oatmeal, scrambled eggs and ground meet. She ate about 50% of the food served.</li> <li>An interview on 11/6/13, at 8:44 a.m. with NA-E was completed. She reported that she had assisted R15 with personal cares but the resident had refused oral cares.</li> <li>An interview on 11/7/13, at 2:14 p.m. with NA-C was completed. NA-C reported he had assisted</li> </ul>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
offered oral cares. An interview on 11/5/13, at 2:39 p.m. with registered nurse (RN)-A. She reported R15's teeth were in poor condition and was unable to determine when she was last seen by a dentist.		cares as needed,ed risk/benefits of refu cavity for bleeding of allowed and refer for The Nursing Assists on 11/6/13, directed personal hygiene, w hygeine, as R15 wai in the area. A review of the care 3/18/13, 6/17/13, ar where the resident of be asked if they wai That was not addre conferences held. R15 was observed of day room. She was independently after meal. She was serv scrambled eggs and 50% of the food ser An interview on 11/6 was completed. She assisted R15 with p had refused oral cares. An interview on 11/5 registered nurse (Rf teeth were in poor c	ducate resident on sal of oral care, inspect oral gums or other issues as or dental services as needed. ant (NA) Care sheet, obtained d staff to assist R15 with her hich would include oral as considered to be dependent e conference summaries held nd 9/16/13, noted a section or the representative were to nted a dental consultation. ssed in any of the care on 11/6/13, at 7:38 a.m. in the eating breakfast the staff had served her the red a pancake, oatmeal, d ground meet. She ate about ved. 6/13, at 8:44 a.m. with NA-E e reported that she had ersonal cares but the resident res. 7/13, at 2:14 p.m. with NA-C -C reported he had assisted rsonal cares but had not	F 4	-12			

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PRINTED: 11/22/2013
FORM APPROVED
OMB NO 0938-0391

	10 T ON MEDICANE	& MEDICAID SERVICES			0	VID INU.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	
		245222	B. WING			11/0	7/2013
	PROVIDER OR SUPPLIER	HATEAU		STREET ADDRESS, 2106 SECOND AVE MINNEAPOLIS, I			.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	care conferences b	t dental services are offered as but the documentation did not rified a dental consultation	F 4	12			
							2 14 - 12 14 - 12
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FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: URDS1	1	Facility ID: 00937	If continuatio	n sheet Pa	re 53 of 53

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	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	T	5222023	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION g 01 - Main Building 01	COMPLETED
		245222	B. WING		12/12/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
GOLDEN	I LIVINGCENTER - CH	IATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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 COMPLETIC
K 000	INITIAL COMMENT	ſS	K 00	N T C 5014	RECEIVED IA
21-14	THE FACILITY'S P ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR LE BOTTOM OF THE FIRST S-2567 WILL BE USED AS		POCOK K67 W/AW for K67	/ED JAN 1 6 2014
de: 1-	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.		W/AW + 1-27-1	Y
-13-73	Minnesota Departm time of this survey, was found not in sur requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care. THE PLAN OF		RECEIVE	<b>P</b>
[]		R THE FIRE SAFETY		JAN 2 1 2014	
ENT	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145		MN DEPT. OF PUBLIC SAFE STATE FIRE MARSHAL DIVIS	SION
	By email to:				
OBATOR	ORECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		245222	B. WING		12/1	2/2013
AME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CH	IATEAU		106 SECOND AVENUE SOUTH IINNEAPOLIS, MN 55404		
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K 000	Continued From pa Marian.Whitney@s	-	K 000			
	DEFICIENCY MUS FOLLOWING INFC 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre Golden Livingcente with a partial basen constructed in 1963	what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. r Chateau is a 4-story building, nent. The facility was and was determined to be of				
K 067	sprinklered through alarm system with f and spaces open to for automatic fire de facility has a capaci census of 58 beds a The requirement at NOT MET as evide	uction. The facility is fully fire out. The facility has a fire full corridor smoke detection the corridor that is monitored epartment notification. The ity of 69 beds and had a at the time of the survey. 42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 067	K067	AV	J
SS=F	with the provisions in accordance with	, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,		<ul> <li>Waiver requested. Re to justification on form Part IV Recommendar for Waiver of Specific Life Safety Code Provisions.</li> </ul>	n tion	

121110-1222	and the second process of the second s	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/13/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED		
		245222	B. WING		· · · · · · · · · · · · · · · · · · ·		12/1	2/2013	
NAME OF I	PROVIDER OR SUPPLIER				RESS, CITY, STATE, Z				
GOLDEN	I LIVINGCENTER - CH	IATEAU			D AVENUE SOUTH LIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EAC	ROVIDER'S PLAN OF CH CORRECTIVE ACT S-REFERENCED TO DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE	
K 067	This STANDARD is Based on observat not be verified that is and air conditioning accordance with the NFPA 90A, Section system could affect Findings include: On facility tour betw on 12/12/2013, observentilation system h corridors without ref appears that the on continuous operation bathroom fans.	s not met as evidenced by: ions and interviews, it could the facility's general ventilating system (HVAC) is installed in a LSC, Section 19.5.2.1 and 2-3.11. A noncompliant HVAC	ΚO	67					
ORM CMS-25	67(02-99) Previous Versions (	Obsolete Event ID: URDS21		Facility ID: 00937		If continuat	ion sheet	Page 3 of 3	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7425

November 22, 2013

Mr. Ryan Onstad, Administrator Golden LivingCenter - Chateau 2106 Second Avenue South Minneapolis, MN 55404

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5222023

Dear Mr. Onstad:

The above facility was surveyed on November 4, 2013 through November 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Golden LivingCenter - Chateau November 22, 2013 Page 2 and the Time Period For Correction.

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

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

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

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAII	O CERTIFIC	CATION	AND TRANSMITTAL	ID: URDS
	PART I -	TO BE COMPL	ETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00937
1. MEDICARE/MEDICAID PROVIDER (L1) 245222	NO.	3. NAME AND AD (L3) GOLDEN LI			ГЕАU	<ol> <li>TYPE OF ACTION: <u>2</u> (L8)</li> <li>Initial 2. Recertification</li> </ol>
2.STATE VENDOR OR MEDICAID NC (L2) 543433500		(L4) 2106 SECON (L5) MINNEAPO		SOUTH	(L6) <b>55404</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) <b>04/01/2006</b>	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 11/07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	013 (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 DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds	<b>69</b> (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN X 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>[F)8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>69</b> (L17)		pliance with Prog ents and/or Appli		* Code: <b>B</b> , <b>5</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF 69	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAI See Attached Remarks	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Jonathan Hill, HFE NE	II	12	2/12/2013	(L19)	Kamala Fiske-Downing	, Enforcement Specialist 2/24/14 (L20)
PAR	Г II - ТО ВЕ (	COMPLETED B	BY HCFA RF	· · /	L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Par	Υ	20. COM	PLIANCE WITH		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>10/01/1978</b>	BEGINNINC	G DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	•
		VE SANCTIONS	( - /		03-Risk of Involuntary Terminatio	n OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00454				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: URDS PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00937

#### C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5222

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

#### Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Monday, January 27, 2014 1:08 PM
То:	'rochi_lsc@cms.hhs.gov'
Cc:	robert.rexeisen@state.mn.us; 'Onstad, Ryan 16 [BH00871]'; Dietrich, Shellae (MDH);
	'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne
	(MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	Golden Livingcenter - Chateau (245222) K67 Annual Waiver Request - Previously
	Approved - No Changes

This is to inform you that GLC Chateau is requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-13-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor Office: 651-201-7205 Cell: 651-470-4416 Health Care & Corrections Fire Inspections Minnesota State Fire Marshal Division Est. 1905 445 Minnesota St., Suite 145, St Paul, MN 55101-5145 FAX: 651-215-0525 Web: fire.state.mn.us

#### Name of Facility

DDALWALAL.

GGNSC Minneapolis Chateau dba: Golden Living Center - Chateau

## PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)		JUSTIFICATION	
NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	needed according to the estimate scope. Also, this cost does add approximately \$86,400 to \$194,400 to the overall costs of 8 to 15 years to recoup the costs. This approximation will n as air handler maintenance, tub/shower room renovations, flor maintenance or services. A complying HVAC system has a large scope of work include the facility residents. The estimate states that the work will ab the same time. This is especially challenging when the medica residents who prefer to remain in their rooms and get agitated and 4th floor. The dining room, the kitchen, and staff offices a for a ratio of 1:1.89. The facility staffs at a rate of 4.77 hours p The building is 50 years old and there are no known plans for concerns of whether or not the new HVAC system would put t which is not allowed against LSC. There are also concerns ab required or if the penetration of load bearing walls to install red. B. The waiver of such unmet provisions will not adversely affe The type of building and the way the building is outfitted and s construction. The interior finishes are of Class A or Class B. T features are an EST and Notifier fire alarm system with full con notification; complete supervised automatic wet standpipe sprichemical system. Annual service and maintenance contracts a that is in accordance with LSC 19.7.2.2. The facility does oper operate under safe drver policies.	e hardship in accordance with CMS SOM 2480C because: ost of upgrading the HVAC system to be in compliance with NFPA s of major structural engineer work or major structural work related to not include the cost of financing, which will need to be done in able of the project. Under current CMS reimbursement rates, it is estimatu- ueed to be extended when taking into account the costs of current fa- boring replacements, plus routine equipment and service projects ar d at this particular facility. A project with a scope of this scale will fo- le to be done in 4 resident rooms at the same time. This has the po- al, mental, and psychological states of our residents are taken into 1, aggressive, and abusive when disturbed in this capacity. The resi- re located on the first floor. On an average day, there is about 35 st over patient, per day. the facility to be replaced and no end date has been determined fo- the facility out of compliance due the the fact that the corridors will to bout whether the building electrical system is adequate to handle the quired duct work would adversely affect the structural integrity of the strider system throughout ; portable fire extinguishers are located on and spaces open to the corridor that is moni- inkler system throughout ; portable fire extinguishers are located on are in place to keep all systems in effective operating condition. The ate under safe smoking policies and procedures, fire policies, fire wo on each floor, so there is a total of eight smoke compartments in the ate under safe smoking policies and procedures, fire policies, fire wo on each floor, so there is a total of eight smoke compartments in the structure is a total of eight smoke compartments in the	The facility is a type II (222) type moke. The facility's life safety or ad to automatic fire department additional HVAC equipment
Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature	Fire Safety	Office State Fire Marshal	Date 1-27-14

	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	T	5222023	OMB NO. 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	COMPLETED
		245222	B. WING		12/12/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
OLDEN	I LIVINGCENTER - CH	IATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
K 000	INITIAL COMMENT	ſS	K 00	n te sola	RECEIVED JA
31-14	THE FACILITY'S P ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		POCOK K67 W/AW for K67	/ED JAN 1 6 2014
de: 1-	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.		W/AW T. FS 1-27-1	Y
-13-73	Minnesota Departm time of this survey, was found not in sur requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care. THE PLAN OF		RECEIVE	<b>P</b>
[]		R THE FIRE SAFETY		JAN 2 1 2014	
ENT.	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145		MN DEPT. OF PUBLIC SAFE STATE FIRE MARSHAL DIVIS	SION
	By email to:				
ORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 8 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245222	B. WING		12	/12/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - CH	IATEAU		2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETM DATE
K 000	Continued From pa Marian.Whitney@s	-	K 000			
K 067 SS=F	DEFICIENCY MUS FOLLOWING INFC 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for correprevent a reoccurre Golden Livingcente with a partial basen constructed in 1963 Type II(222) constru- sprinklered through alarm system with f and spaces open to for automatic fire defacility has a capaci- census of 58 beds a The requirement at NOT MET as evide NFPA 101 LIFE SA Heating, ventilating, with the provisions in accordance with	what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. r Chateau is a 4-story building, nent. The facility was and was determined to be of uction. The facility is fully fire out. The facility has a fire full corridor smoke detection the corridor that is monitored epartment notification. The ity of 69 beds and had a at the time of the survey. 42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	K 067	K067 • Waiver requested. Ret to justification on for Part IV Recommendat for Waiver of Specifit Life Safety Code Provisions.	m ation	S

121110-1222	and the second process of the second s	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/13/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED		
		245222	B. WING		· · · · · · · · · · · · · · · · · · ·		12/1	2/2013	
NAME OF I	PROVIDER OR SUPPLIER				RESS, CITY, STATE, Z				
GOLDEN	I LIVINGCENTER - CH	IATEAU			D AVENUE SOUTH LIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EAC	ROVIDER'S PLAN OF CH CORRECTIVE ACT S-REFERENCED TO DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE	
K 067	This STANDARD is Based on observat not be verified that is and air conditioning accordance with the NFPA 90A, Section system could affect Findings include: On facility tour betw on 12/12/2013, observentilation system h corridors without ref appears that the on continuous operation bathroom fans.	s not met as evidenced by: ions and interviews, it could the facility's general ventilating system (HVAC) is installed in a LSC, Section 19.5.2.1 and 2-3.11. A noncompliant HVAC	ΚO	67					
ORM CMS-25	67(02-99) Previous Versions (	Obsolete Event ID: URDS21		Facility ID: 00937		If continuat	ion sheet	Page 3 of 3	