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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

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

6. DATE OF SURVEY **0203/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
× A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 03/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/05/2016
(L33)

DETERMINATION APPROVAL

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

On February 3, 2016 a Post Certification Revisit (PCR) was completed by this Department and on March 10, 2016, the Department of Public Safety completed a PCR to verify compliance with deficiencies not corrected from the standard survey completed on November 6, 2015 and FMS completed on December 2, 2015. Based on the PCR we have determined the deficiencies issued pursuant to the standard survey completed on November 6, 2015 and the FMS completed on December 2, 2015, effective February 5, 2016.

As a result of the revisit findings, this Department discontinued the Category 1 remedy of State monitoring.

In addition, this Department recommended the following action related to remedies previously imposed:

- Per Instance CMP for deficiency cited at K48

- Mandatory denial of payment for new Medicare and Medicaid admissions, be rescinded.

The facility would be subject to a two year loss of NATCEP beginning January 6, 2016 as a result of a CMP assessed at not less than $5000.00.

Refer to the CMS 2567b forms(for health, life safety code and FMS revisits).

Effective February 5, 2016, the facility is certified for 76 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245324

March 11, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

Dear Ms. Jenkins:

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 February 5, 2016 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

March 11, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number S5324025, F5324025, F5324026

Dear Ms. Jenkins:

On January 19, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 24, 2016. (42 CFR 488.422)

On December 4, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $5,750.00 for the deficiency cited at K48 for the survey ending December 2, 2015. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 6, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of December 4, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on November 6, 2015 and a Federal Monitoring Survey (FMS) completed on December 2, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 31, 2015. The most serious deficiencies at the time of the revisit were found 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 February 3, 2016, the Minnesota Department of Health completed a PCR and on March 10, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 31, 2015 and an FMS survey completed on December 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 5, 2016.

Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 31, 2015, the standard survey completed on November 6, 2015 and the FMS completed on December 2, 2015, as of February 5, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 5, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in the CMS letter of December 23, 2015 and this Department's letter of January 19, 2016:

- Per instance civil money penalty, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 6, 2016, be rescinded. (42 CFR 488.417 (b))

As CMS notified you in their letter of December 4, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2016, as a result of being assessed a total civil money penalty of not less than $5,000.00.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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 Forms, (CMS-2567B) from the revisits.

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

Sincerely,

Mark Meath

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

Enclosure(s)

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245324	A. Building B. Wing	2/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/29/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/29/2016	ID Prefix F0327 Reg. # 483.25(j) LSC	Correction Completed 01/29/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	GL/mm	03/11/2016	33937	02/03/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/6/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245324	A. Building 01 - MAIN BUILDING 01 B. Wing	3/10/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 11/04/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/mm	03/11/2016	19251	03/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/4/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245324 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	02/05/2016	LSC K0018	12/14/2015	LSC K0020	02/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	02/26/2016	LSC K0027	12/15/2015	LSC K0029	12/15/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0033	02/26/2016	LSC K0038	02/26/2016	LSC K0048	12/08/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	12/02/2015	LSC K0051	12/18/2015	LSC K0052	12/18/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0054	12/07/2015	LSC K0074	12/02/2015	LSC K0076	12/03/2015

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 03/11/2016	SIGNATURE OF SURVEYOR 19251	DATE 03/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245324 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0143	01/08/2016				

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/mm	03/11/2016	19251	03/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/2/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**

2. STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

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

6. DATE OF SURVEY **12/31/2015** (L34)

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

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

1 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
2 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
3 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
4 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **76** (L18)

13. Total Certified Beds **76** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
_ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN: 24-5324

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 01/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
1- Merger, Closure
2- Dissatisfaction W/ Reimbursement
3- Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
5- Fail to Meet Health/Safety
6- Fail to Meet Agreement
OTHER
7- Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/05/2016
(L33)

DETERMINATION APPROVAL

C&TREMARKS-CMS1539FORM STATE AGENCY REMARKS

CCN: 24-5324

On December 31, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard. Completed on November 6, 2015. In addition, investigation of complaint number H5324052 was conducted and found to be unsubstantiated. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 6, 2015. The deficiency not corrected are as follows:

F0282 — S/S: D — 483.20(k)(3)(ii) — Services By Qualified Persons/per Care Plan
F0323 — S/S: D — 483.25(h) — Free Of Accident Hazards/supervision/devices
F0327 — S/S: D — 483.25(j) — Sufficient Fluid To Maintain Hydration

The most serious deficiencies in your facility were found 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.

As a result of our finding that your facility is not insubstantial compliance, this Department is imposing the following category 1 remedy:

State monitoring effective January 24, 2016. (42 CFR 488.422)

In addition, this Department is recommending the following action related to the imposed remedies in the CMS letter of December 23, 2015:

- Mandatory Denial of payment for new Medicare and Medicaid admissions, effective February 6, 2016, remain in effect
- Per Instance Civil Money Penalty, for deficiency cited at F48 (S/S=K), remain in effect.

Further, Federal law, as specified in the Act at Sections 1819(f'X2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment Therefore, Golden LivingCenter - Bloomington is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective *18DU81Y* 6, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If1his prohibition is not rescinded. Under Public Law 105-15 (H.R 968), you may request a waiver of 1his prohibition if certain criteria are met.
Refer to the CMS 2567 along with the facility's plan of correction and CMS 2567b for the results of this visit.

Certified Mail # 7015 0640 0003 5695 5477

January 19, 2016

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number S5324025, H5324052

Dear Ms. Jenkins:

On December 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2015 that included an investigation of complaint number H5324052. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 2, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. Conditions in the facility constituted immediate jeopardy to resident health or safety. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required.

On December 14, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs.

In addition, on December 14, 2015, CMS conducted a Post Certification Revisit to verify that your removal plan had been implemented and the immediate jeopardy situation had been removed. The Federal surveyor determined the immediate jeopardy was removed on December 14, 2015.

Since the facility continues to not be in substantial compliance as a result of the uncorrected deficiencies CMS is imposing the following enforcement remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions, effective February 6, 2016

Furthermore, the following previously imposed remedy detailed in the CMS letter of December 23, 2015 will remain in effect:

- Per Instance Civil Money Penalty of $5,750.00 for deficiency cited at F48 (S/S=K)

On December 31, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on November 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2015 . Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 6, 2015. The deficiency not corrected is as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0327 -- S/S: D -- 483.25(j) -- Sufficient Fluid To Maintain Hydration

The most serious deficiencies in your facility were found 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.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective January 24, 2016. (42 CFR 488.422)

In addition, this Department is recommending the following action related to the imposed remedies in the CMS letter of December 23, 2015:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 6, 2016, remain in effect.
- Per Instance Civil Money Penalty of $5,750.00 for deficiency cited at F48 (S/S=K), remain in effect.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden LivingCenter - Bloomington is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 6, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on December 28, 29, 30, and 31, 2015, to determine compliance with Federal deficiencies issued during a recertification survey exited on November 6, 2015. During this visit the following regulations were determined to uncorrected.	{F 000}	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan related to fluid restrictions for 1 of 1 resident (R133) whose fluids were restricted related to renal dialysis, and for 1 of 3 residents (R51) reviewed for accident hazards. Findings include: R133's 12/17/15, care plan directed staff: 12/10/15 FR [fluid restriction] decreased to 1200 cc per day. Continue Dialysis /ConCHO [consistent carbohydrate] offering 200 cc per meal." The care plan did not direct staff how to allocate the nursing portion of the 1200 ml fluid restriction. The undated Golden Living NA/R [nursing assistant/registered] Assignment sheet directed staff "Fluid restriction--No pink thermos cups."	{F 282}	POC Accepted DSoth 1/26/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 1-25-16

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

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{F 282}	Continued From page 1 R133 was observed sitting up in bed on 12/30/15 at 8:48 a.m. R133 was eating breakfast including eggs, toast, oatmeal, small cranberry juice, small coffee and a small orange juice. In addition, a covered pitcher of water with a drinking straw was on the bedside table. The outside of the pitcher was felt cool and was approximately three quarters full. R133 reported staff brought him a water pitcher with ice every day, and the pitcher on his bedside table was fresh earlier that day. A bottle of water and bottle of juice were also on the bedside stand, and a half case of small cans of pineapple juice were stored on the floor. R133 reported they had been there for the past month. R133 reported the staff had not talked to him about the amount of beverages available to him in his room. He stated he did not drink the water from the pitcher very often, but did take occasional sips when he had a "taste to drink water." On 12/30/15, at approximately 1:30 p.m. LPN-A reported R133's fluids were restricted, and staff were responsible for monitoring the amount of fluid he consumed each day. LPN-A explained R133 was provided a limited amount of water from his trays and nursing staff did not provide fluids. When asked how the fluids were being monitored, including the water from the pitcher in his room, LPN-A responded she was unaware R133 was being provided a pitcher of water in his room. LPN-A said R133 should not have been provided a pitcher of water at his bedside. The LPN immediately removed the pitcher from the room and informed R133 he should not have been provided free water in his room. LPN-A explained the night nursing assistants (NAs) delivered water pitchers to the residents.	{F 282}	F282 -The Care Plan for fluid restrictions for R133 is followed per MD orders. The Care Plan for R51 is being followed as it relates to falls interventions. -All residents that require care planned interventions for fluid restrictions or falls have the potential to be affected by the alleged practice. -Nursing staff have been educated to provide cares/interventions as identified in the resident Plan of Care and on the CNA assignment sheets. -Random weekly audits will be conducted of residents requiring Fluid restrictions and falls interventions to ensure that identified interventions are in place. Audits will be reviewed at QAPI and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 1/29/2016 RECEIVED JAN 25 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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(F 282)	Continued From page 2 On 12/30/15, at 2:10 p.m. the dialysis registered nurse (RN) from the dialysis clinic reported R133 had excess fluid removed during dialysis on multiple occasions since 12/16/15. The dialysis RN explained that based on R133's weight any amount of fluid removed from R133 over 2.8 liters was considered high. The dialysis RN reported, unless the pitcher was very small, R133 should not have been provided with a pitcher of water in his room, and in fact was prescribed a restriction of daily fluids of 1200 milliliters (ml/cc's). On 12/31/15 at 9:32 a.m. the registered dietitian (RD) confirmed R133 was prescribed a 1200 ml per day fluid restriction. The RD reported dietary provided some fluids at mealtime, and nursing staff provided the remaining mls and monitored R133's actual daily intake. The RD was unable to articulate the facility's system for coordinating how the remaining mls would be provided. RD was also unsure whether R133 should have been provided a pitcher of water in his room, but stated, "I would find it hard to believe they [nursing staff] are bringing him a water pitcher." The RD reported she was aware of the multiple beverages in R133's room and said staff had encouraged the residents to follow the fluid restrictions, and "did their best" to monitor his actual fluid consumption. On 12/31/15 at 10:21 a.m. the assistant director of nursing (ADON) confirmed R133 was prescribed a 1200 ml per day fluid restriction. The ADON explained nursing provided some fluids and dietary provided the rest. The ADON referenced the NA care delivery guide which directed staff to not provide R133 with pitchers of water at his bedside.	(F 282)		

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(F 282)	Continued From page 3 On 12/3/15 at approximately 11:30 a.m. the administrator reported the pitchers of water utilized by the facility held 650 mls of fluid. The medication and treatment administration records for 12/15, directed staff "Fluid restriction 1200 ml per day, dietary to offer no greater than 200 cc/meal, nursing allowed 600 cc per day every shift related to End Stage Renal Disease total cc each shift including dietary and nursing--total to not exceed 1200 cc per day." R133's post-treatment dialysis reports from 12/16/15 to 12/30/15, revealed R133 had more than 2.8 liters [L] of fluid removed on the following occasions: 1) 12/17/15, 3.1 L; 2) 12/22/15 3.0 L; 3) 12/24/15 3.1 L; 4) 12/26/15 3.6 L; 5)12/29/15 3.7 L; and 6) 12/30/15 3.6 L. The facility's 12/17/15,hydration policy directed staff "Each patient's fluid needs must be individually calculated with alterations based on objective data. For example, excess fluids may be contraindicated for patients with renal or cardiac distress. The fluids needs may be represented in a range." R51's care plan indicated the resident experienced a fall 10/15/15, resulting in a hip fracture. According to R51's care plan revised on 12/1/15, she was at risk for falls and had a history of falls. The care plan directed staff to keep call light and personal items within reach and for bed to be kept in low position so her feet touched the floor. R51 was observed in bed on 12/29/15, at 11:01	(F 282)		

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(F 282)	Continued From page 4 a.m. The call light was wrapped around the rail on the right side of the bed, and approximately seven inches below the surface of the mattress. When R51 was asked if she was able to engage the call light should she need assistance, the resident unsuccessfully attempted to reach for the call light and stated, "No, not quite." The bed control cord was also wrapped around the right bed rail. The bed height was waist-level and not in the low position. The assistant director of nursing (ADON) entered R51's room at 11:08 a.m. and R51 was again asked if she could reach her call light and again was unsuccessful. The ADON verified the placement of the call light was out of R51's reach, and said in addition, there were too many cords wrapped around the bed rail, which would have caused confusion for R51 should she need to summon help. The call button was then provided and the ADON prompted R51 to press the button. R51 was able to engage the call light system with moderate effort. The ADON then stated she was going to provide R51 with a pad-style button. The following day, 12/30/15, at 9:29 a.m. R51 was again observed in her bed. The bed was at waist-high position. The head of the bed was raised at approximately a 90 degree angle. A cloth incontinent pad was behind R51's upper body, and the pad-style call light was underneath the pad on R51's right side. The call light was place at shoulder level and six inches from her head. When R51 was asked if she could reach her call light, she looked around for it. She shook her head negatively indicating when she was unable to locate the call light. Later that morning, at 10:44 a.m. R51 remained in her bed. The call light was under the incontinent pad. The bed	(F 282)		

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{F 282}	Continued From page 5 height was at waist-level. On 12/31/15, at 9:01 a.m. R51 was in her bed. The bed was at waist-level and the call light was below the surface of the mattress to her right side and was out of R51's reach. At 9:08 a.m. a licensed practical nurse (LPN)-B stated R51 was capable of using her call light appropriately. A fall report dated 12/19/15, identified R51 as experiencing a fall from the wheelchair while in her room. She complained of pain in her buttocks following the fall. A nursing progress note for follow-up charting related to recent fall, dated 12/21/15, indicated the resident's bed was put "in low position." During an interview at 10:47 a.m. the ADON explained that R51's call light should have always been in place, as well as all other residents in the facility. The ADON stated, "It is our practice--it is what we do." She also stated that R51's bed should have been placed in the low position to minimize the risk for falls and accidents. The ADON explained, "This is what is care planned for her." The facility's undated Call Light, Use of policy directed staff to ensure "all call lights are placed on the bed at all times, never on the floor or bedside stand. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/ her how to use the call light."	{F 282}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to minimize the risk of injury for 1 of 3 residents (R51) reviewed for accident hazards. Findings include: R51 was observed in bed on 12/29/15, at 11:01 a.m. The call light was wrapped around the rail on the right side of the bed, and approximately seven inches below the surface of the mattress. When R51 was asked if she was able to engage the call light should she need assistance, the resident unsuccessfully attempted to reach for the call light and stated, "No, not quite." The bed control cord was also wrapped around the right bed rail. The bed height was waist-level and not in the low position. The assistant director of nursing (ADON) entered R51's room at 11:08 a.m. and R51 was again asked if she could reach her call light and again was unsuccessful. The ADON verified the placement of the call light was out of R51's reach, and said in addition, there were too many cords wrapped around the bed rail, which would have caused confusion for R51 should she need to	{F 323}	F323 -R51 has all care planned falls interventions in place. -All residents at risk of falling have the potential to be affected by the alleged practice. - Nursing staff have been educated to provide cares/interventions as identified in the resident Plan of Care and on the CNA assignment sheets. -Random weekly audits will be conducted of residents requiring falls interventions to ensure that identified interventions are in place. Audits will be reviewed at QAPI and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 1/29/2016	

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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{F 323}	Continued From page 7 summon help. The call button was then provided and the ADON prompted R51 to press the button. R51 was able to engage the call light system with moderate effort. The ADON then stated she was going to provide R51 with a pad-style button. The following day, 12/30/15, at 9:29 a.m. R51 was again observed in her bed. The bed was at waist-high position. The head of the bed was raised at approximately a 90 degree angle. A cloth incontinent pad was behind R51's upper body, and a pad-style call light was underneath the pad on R51's right side. The call light was place at shoulder level and six inches from her head. When R51 was asked if she could reach her call light, she looked around for it. She shook her head negatively when she was unable to locate the call light. Later that morning, at 10:44 a.m. R51 remained in her bed. The call light was under the incontinent pad. The bed height was at waist-level. On 12/31/15, at 9:01 a.m. R51 was in her bed. The bed was at waist-level and the call light was below the surface of the mattress to her right side and was out of R51's reach. At 9:08 a.m., a licensed practical nurse (LPN)-B stated R51 was capable of using her call light appropriately. R51's face sheet noted diagnoses including fracture of femur, dementia, and dizziness. She was admitted to hospice care on 11/21/15. The Care Area Assessment (CAA) for cognition dated 11/22/15, indicated R51 was able to use her call light at times, and she had moderate cognitive impairment. The falls CAA dated 11/22/15, noted approaches including ensuring the resident's cal light and belongings were kept within her reach.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 323)	Continued From page 8 A fall on 10/15/15, resulted in a hip fracture, and according to R51's care plan revised on 12/1/15, she was at risk for falls and had a history of falls. The care plan directed staff to keep call light and personal items within reach and for bed to be kept in low position so her feet touched the floor. A fall report dated 12/19/15, identified R51 as experiencing a fall from the wheelchair while in her room. She complained of pain in her buttocks following the fall. A nursing progress note for follow-up charting related to recent fall, dated 12/21/15, indicated the resident's bed was put "in low position." During an interview at 10:47 a.m. the ADON explained that R51's call light should have always been in place, as well as all other residents in the facility. The ADON stated, "It is our practice--it is what we do." She also stated that R51's bed should have been placed in the low position to minimize the risk for falls and accidents. The ADON explained, "This is what is care planned for her." The facility's undated Call Light, Use of policy directed staff to ensure "all call lights are placed on the bed at all times, never on the floor or bedside stand. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/ her how to use the call light."	(F 323)		
(F 327) SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with	(F 327)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 327)	Continued From page 9 sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fluid restrictions were followed for 1 of 1 resident (R133) whose fluids were restricted related to renal dialysis. Findings include: R133 was observed sitting up in bed on 12/30/15 at 8:48 a.m. R133 was eating breakfast including eggs, toast, oatmeal, small cranberry juice, small coffee and a small orange juice. In addition, a covered pitcher of water with a drinking straw was on the bedside table. The outside of the pitcher was felt cool and was approximately three quarters full. R133 reported staff brought him a water pitcher with ice every day, and the pitcher on his bedside table was fresh earlier that day. A bottle of water and bottle of juice were also on the bedside stand, and a half case of small cans of pineapple juice were stored on the floor. R133 reported they had been there for the past month. R133 reported the staff had not talked to him about the amount of beverages available to him in his room. He stated he did not drink the water from the pitcher very often, but did take occasional sips when he had a "taste to drink water." On 12/30/15, the water pitcher remained on R133's bedside 8:48 a.m. and 1:33 p.m. At 11:43 a.m. a licensed practical nurse (LPN)-A, checked R133's blood sugar, and all beverages were	(F 327)	F327 -Fluid restrictions for R133 are in place and monitored for compliance per the Care Planned interventions. -All residents on fluid restrictions have the potential to be affected by the alleged practice. -Nursing staff have been educated to provide interventions related to fluid restrictions as identified in the plan of care and the CNA assignment sheets. - Random weekly audits will be conducted of residents requiring fluid restriction interventions to ensure that identified interventions are in place. Audits will be reviewed at QAPI and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 1/29/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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{F 327}	Continued From page 10 within full view. At 1:24 p.m. R133's water pitcher was approximately half empty. R133 reported it was the same pitcher of water he had been provided that morning. LPN-A then reported R133's fluids were restricted, and staff were responsible for monitoring the amount of fluid he consumed each day. LPN-A explained R133 was provided a limited amount of water from his trays and nursing staff did not provide fluids. When asked how the fluids were being monitored, including the water from the pitcher in his room, LPN-A responded she was unaware R133 was being provided a pitcher of water in his room. LPN-A said R133 should not have been provided a pitcher of water at his bedside. The LPN immediately removed the pitcher from the room and informed R133 he should not have been provided free water in his room. LPN-A explained the night nursing assistants (NAs) delivered water pitchers to the residents. On 12/30/15, at 2:10 p.m. the dialysis registered nurse (RN) from the dialysis clinic reported R133 had excess fluid removed during dialysis on multiple occasions since 12/16/15. The dialysis RN explained that based on R133's weight any amount of fluid removed from R133 over 2.8 liters was considered high. The dialysis RN reported, unless the pitcher was very small, R133 should not have been provided with a pitcher of water in his room, and in fact was prescribed a restriction of daily fluids of 1200 milliliters (ml/cc's). On 12/31/15 at 9:32 a.m. the registered dietitian (RD) confirmed R133 was prescribed a 1200 ml per day fluid restriction. The RD reported dietary provided some fluids at mealtime, and nursing	{F 327}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	R 12/31/2015

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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(F 327)	Continued From page 11 staff provided the remaining mls and monitored R133's actual daily intake. The RD was unable to articulate the facility's system for coordinating how the remaining mls would be provided. RD was also unsure whether R133 should have been provided a pitcher of water in his room, but stated, "I would find it hard to believe they [nursing staff] are bringing him a water pitcher." The RD reported she was aware of the multiple beverages in R133's room and said staff had encouraged the residents to follow the fluid restrictions, and "did their best" to monitor his actual fluid consumption. On 12/31/15 at 10:21 a.m. the assistant director of nursing (ADON) confirmed R133 was prescribed a 1200 ml per day fluid restriction. The ADON explained nursing provided some fluids and dietary provided the rest. The ADON referenced the NA care delivery guide which directed staff to not provide R133 with pitchers of water at his bedside. On 12/3/15 at approximately 11:30 a.m. the administrator reported the pitchers of water utilized by the facility held 650 mls of fluid. R133's 11/3/15, Minimum Data Set assessment indicated the resident received renal dialysis, and was cognitively intact. A Nutrition Note, dated 12/17/15, revealed "Res [resident] has been on dialysis for 4.5 years. Current fluid restriction ordered is 1200 cc [1 cc=1 ml] per day, dietary to offer 200 cc per meal (600 cc) and nursing allowed 600 cc/day~nursing monitoring intake" The medication and treatment administration	(F 327)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(F 327)	Continued From page 12 records for 12/15, directed staff "Fluid restriction 1200 ml per day, dietary to offer no greater than 200 cc/meal, nursing allowed 600 cc per day every shift related to End Stage Renal Disease total cc each shift including dietary and nursing--total to not exceed 1200 cc per day." R133's 12/17/15, care plan directed staff: 12/10/15 FR [fluid restriction] decreased to 1200 cc per day. Continue Dialysis /ConCHO [consistent carbohydrate] offering 200 cc per meal." The care plan did not direct staff how to allocate the nursing portion of the 1200 ml fluid restriction. The undated Golden Living NA/R [nursing assistant/registered] Assignment sheet directed staff "Fluid restriction--No pink thermos cups." A 12/18/15, nurse practioner visit indicated R133 was diagnosed with end stage renal disease and required dialysis three times weekly. R133's post-treatment dialysis reports from 12/16/15 to 12/30/15, revealed R133 had more than 2.8 liters [L] of fluid removed on the following occasions: On 12/17/15, 3.1 L; on 12//15 3.0 L; on 12/24/15 3.1 L; on 12/26/15 3.6 L ; on 12/29/15 3.7 L; and on 12/30/15: 3.6 L. The facility's 12/17/15,hydration policy directed staff "Each patient's fluid needs must be individually calculated with alterations based on objective data. For example, excess fluids may be contraindicated for patients with renal or cardiac distress. The fluids needs may be represented in a range."	(F 327)		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245324	A. Building B. Wing	12/31/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/16/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **12/16/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/16/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **12/16/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/16/2015**	ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **12/16/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	01/19/2016	33043	12/31/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/6/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **11/06/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Conrad Simba, HFE NEII 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5324

On November 6, 2015 a standard survey was completed at this facility. The most serious deficiencies were cited at a scope and severity of G. The facility has been given an opportunity to correct before remedies would be imposed. In addition at the time of the standard survey, investigations of complaint numbers H5324051 and H5324052, were conducted. Complaint number H5324051 was found to be unsubstantiated and complaint number H5324052 was found to be substantiated at F314. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code, along with the facilitys plan of correction.

MDH
Minnesota Department of Health

Certified Mail # 7015 0640 0003 5695 5200

December 2, 2015

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number S5324025, H5324051, H5324052

Dear Ms. Jenkins:

On November 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324051 and H5324052.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324051 (found to be unsubstantiated) and H5324052 (that was found to be substantiated at F314).

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 16, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 6, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Certified Mail # 7015 0640 0003 5695 5200

December 2, 2015

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number S5324025, H5324051, H5324052

Dear Ms. Jenkins:

On November 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324051 and H5324052.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 6, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324051 (found to be unsubstantiated) and H5324052 (that was found to be substantiated at F314).

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;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 16, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 6, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies

(those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

Enclosure(s)

cc: Licensing and Certification File
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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

Enclosure(s)

cc: Licensing and Certification File

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Enhancing lives through innovative healthcare™

Certified Mail #7011 3500 0001 1432 1535

December 11th, 2015

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

RE: Project Number S5324025, H5324051, H5324052

Dear Mrs. Lantto;

Enclosed please find the plan of correction for the standard survey completed November 6th, 2015 at Golden LivingCenter - Bloomington. If you have any questions please contact me at (952) 283-2710.

Sincerely,

Emily Jenkins
Executive Director
Golden LivingCenter - Bloomington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Investigations of complaints H5324051 and H5324052, were completed at the time of the standard survey. H5324051 was unsubstantiated; H5324052 was substantiated at F314.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157 GL 12-14-15	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	12-11-15

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

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to ensure the primary physician was notified when pressure ulcers developed and worsened for 1 of 3 residents (R93) reviewed for pressure ulcers. Findings include: R93's progress note revealed the resident was admitted to the facility on 8/22/15, and although the resident had existing PUs on his feet, an 8/27/15, admission Minimum Data Set assessment (five days later) revealed R93 had "no stage 1 or greater" pressure ulcers. R93 subsequently developed at least two PUs while residing in the facility with various descriptions, but frequently referred to as "buttocks" wounds. Evidence was lacking in R93's medical record to show his primary physician (MD) and or nurse practitioner (NP) had been notified of the significant change in condition including when the PUs worsened.	F 157	F157 D -Resident #93 no longer resides at this facility. -Any resident that develops a pressure ulcer has the potential to be affected by the alleged practice -Licensed staff will be educated to notify the MD immediately upon discovery of a new pressure ulcer and to document such notification -Random weekly audits will be conducted of residents at risk of pressure ulcer development to ensure any changes in skin integrity have resulted in documentation of notification of MD. Audits will be reviewed at QAPI and action planned as needed. -DNS or Designee is the responsible party. -Corrective Action will be completed by 12/16/2015	

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F 157	Continued From page 2 The first indication of the presence of any sacrum/coccyx wound was in a NN dated 9/11/15. A significant change in condition was not identified, despite the development of new PUs. The note lacked specific information such as measurements, a physical description of the wounds, the stages of each wound, and a follow up plan. An Allina Hospice and Palliative Care Facility Visit Record note also indicated R93 was seen and the note referred only to existing "foot wounds." Hospice orders also dated 9/11/15, however, included zinc oxide barrier cream for "Buttock and sacral wounds." Subsequent notes revealed worsening of the PUs, for example: 1) 9/14/15 hospice nursing note (NN), "Wounds in buttocks are larger (not deeper) due to sitting in wc [wheelchair] all day...." 2) 10/11/15 NN "Right buttock and inner thigh wound: Open area near coccyx is 8 x 4 cm [centimeters], wound bed dark tissue, inferior region measures 3 x 2 cm open area without slough [soft non-living tissue], inner thigh open area measures 4 x 1.8 cm." 3) 10/11/15, hospice NN "RN assessment of R [right] buttock and sacral area, sacral wound is now larger, Stage IV w/ necrosis, scant sang drainage [full thickness tissue loss with exposed bone, tendon or muscle with dead tissue and small amount of bloody drainage]. 8 cm x 3 cm. R buttock ulcer now 4.5 x 2.25 cm." 4) 10/25/15 NN "bottom wound black in color and has a foul odor..." The description was minimal, but represented an extreme change to the wound when compared to descriptions in past notes and the physician was not notified. 5) 10/29/15, hospice NN revealed a visit was	F 157		

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F 157	Continued From page 3 made after an Allina home health aide reported a declining coccyx wound. 6) 10/30/15, hospice NN noted coccyx wound had obviously increased in size measuring 12 x 5 x 3 (depth) cm. Right lower buttock measured 3 x 2 cm. "Coccyx wound edge borders were non-blanchable and crusted. Wound bed necrotic [dead tissue]. 30-40% loose necrotic tissue noted. Serosanguineous [blood-tinged clear] drainage observed in large amounts." 7) 11/1/15, NN nurse practitioner (NP) saw resident 8) 11/1/15 hospice NN, "Sister requested hospice nurse visit to assess wound care." Wound care was provided by facility and hospice nurse. Coccyx wound was 10.5 x 4.5 cm with black necrotic tissue on 30 to 40% of wound. Ischial wound was 3.5 x 2 cm with odor. 24) 11/4/15, wound NN indicated R93 had an unstagable wound on the right buttock measuring 11 x 5 x 3.5 cm. "Undermining from 3 to 6 o'clock [larger than visible at skin level and face of clock used to describe direction] 5.5 cm to 9.0 cm." The two wounds were measured and staged as ischial tuberosity wound was "Stage III measure 3.3 cm x 2.0 cm, scrotal--1.5 cm x 1.0 cm. A physician order dated 11/4/15, indicated, "Unstageable [full thickness tissue loss in which actual depth is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed] Right buttock pressure ulcer." A NN showed the physician saw R93 the following day. An interview was conducted on 11/4/15, at 9:20 a.m. with a wound nurse from Allina, the director of nursing (DON) and the assistant director of nursing (ADON). The ADON reported that the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4 physician was notified of R93's wounds, but was unsure whether the physician or nurse practitioner (NP) had visualized the wounds, as "the 60 days are not up" (between required physician visits). Documentation did not reflect the physician had been notified of R93's wounds until notes reflected the NP saw the resident on 11/1/15 the physician on 11/5/15. On 11/4/15, at 9:49 a.m. the hospice nurse said the physician was notified of wound healing at hospice interdisciplinary (IDT) rounds, but had not visualized the ulcer adding, "Our docs [doctors] rarely come out to view wounds." On 11/4/15, at 12:17 p.m. the DON he would have expected documentation including measurements and physician notification. An undated Guideline Statement policy was, "To ensure that proper notifications are made when a resident has a change in health status." The definition of immediate was "As soon as possible no longer than 24 hours." In addition the policy indicated, "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there was a significant change in the resident's physical status, such as a deterioration in health or clinical complications. The criteria for clinical complications included, "such things as development of a stage 2 pressure sore when no ulcers were previously present at stage 2 or higher...."	F 157		
F 164	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 5 The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the right to personal privacy, for 1 of 40 sampled residents (R6) whose privacy was reviewed. Findings include: R6 was observed while in her bathroom with a	F 164	F164 -Resident #6 is afforded the right to personal privacy. -All residents have the potential to be affected by the alleged practice. -All nursing staff has been educated on the resident's rights to privacy. -Random weekly audits will be conducted to ensure resident's rights to privacy are maintained. Audits will be reviewed at QAPI and action planned as needed. -DNS or Designee is the responsible party. -Corrective Action will be completed by 12/16/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 164	Continued From page 6 nursing assistant (NA) on 11/4/15, at 1:16 p.m. The door was opened approximately half way. R6's roommate (R23) and her son were present in the room. The activities coordinator (AC) was standing in the doorway to R6's room, and was speaking to R23 and her son. R23's son then walked over to R6's side of the room and as he turned around, looked into the bathroom where R6 was seated on the toilet. He quickly turned away and returned to his mother's side of the room. Following the observation, the activities coordinator verified R23's son was on R6's side of the room, however, she was unaware R6 was using the toilet at the time. The activities coordinator said she would talk to the NA, as the bathroom doors should have always been closed when the bathroom was occupied or when a roommate was in the room. R6's Minimum Data Set dated 8/5/15 revealed R6 was severely cognitively impaired and required assistance from staff to use the toilet. On 11/4/15, at 1:24 p.m. the assistant director of nursing stated she expected a resident's door to their personal bathroom remain to be closed, especially in double rooms and when the roommate was present. On 11/6/15, at 8:50 a.m. the director of nursing and administrator said all resident bathroom doors were to have always been closed when occupied. A policy regarding residents' rights to personal privacy was requested but was not provided.	F 164		

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F 225 F 225 SS=D	Continued From page 7 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225 F 225	F225 D -R86 alleged incident of mistreatment has been reported to the ED and to OHFC and cleared following the submission of the investigation to OHFC. All newly hired staff members have had background checks, reference checks, and abuse training completed. -All residents have the potential to be affected by the alleged practice. -All staff will be educated on the Vulnerable Adult Abuse reporting requirements. Management has been educated on the requirements to have a completed background check, reference checks, and abuse training completed before staff may begin working with residents. - Audits will be completed on all incident reports to ensure timely reporting to appropriate authorities and initiation of investigation as needed. Audits will be completed on all newly hired staff to ensure background checks, reference checks and completion of VA training has been accomplished prior to initiation of work with residents. Audits will be reviewed at QAPI and action planned as needed. -ED or Designee is the responsible party -Corrective Action will be completed by 12/16/2015	

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F 225	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations of mistreatment were immediately reported to the administrator and designated State agency (SA) 1 of 1 resident (R86) who alleged abuse. In addition, the facility failed to ensure criminal background checks, reference checks and abuse training was completed for 4 of 5 employees (E1, E2, E3, E4) who were newly hired. Findings include: R86 was observed and interviewed on 11/2/15, at 3:10 p.m. During the interview, R86 reported a nursing assistant (NA) had abused her. R86 said the NA was "rough to me when I first got here" and treated her badly. R86 explained the NA dragged her into the shower and left her to take a shower on her own, when she in fact needed assistance. R86 further explained that the NA then threw towels at her and spoke to her in a degrading manner. R86 reported she was "devastated" and tried to "avoid her as much as possible." R86 confirmed the NA continued working with her but said, "She has changed her attitude and she has been helping and treating me better." R86 stated she had reported the incident to "therapy staff." The surveyor reported R86's allegation of mistreatment to the facility director of nursing (DON) and assistant director of nursing (ADON) on 11/2/15, at 6:47 p.m. R86's significant change Minimum Data Set	F 225		

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F 225	Continued From page 9 (MDS) dated 10/16/15, indicated R86 was cognitively intact. MDS also indicated R86 required one staff limited assist with bed mobility and transfers. The MDS also indicated that R86 required partial physical help with bathing. R86's care plan dated 10/15/15, identified, "My safety is at risk and there is a potential for abuse due to: hearing deficits, dx [diagnosis] of cancer, need for SNF [skilled nursing facility]placement." The goal was "I will be kept safe and free from abuse through my next review." Some of the interventions included: "Explain what you are going to do before providing care. Please explain my environment to me if I don't understand what is going on around me. Please keep others out of my room that don't belong there. Please remove me from potentially dangerous situations." During an interview on 11/4/15, at 4:15 p.m. the executive director (ED) and DON stated that the matter had been reported to the SA "yesterday, immediately after you made us aware." The ED and DON stated that they had interviewed R86, who reported the NA was "rough" to her and felt rushed by the employee. R86 had informed the ED and DON that she had reported to a physical therapy assistant (PTA)-D and occupational therapy assistant (OTA)-E. The ED and DON further explained that they had spoken to both the PTA-D and OTA-E and both confirmed that R86 had reported the incident to them as described above. During an interview on 11/5/15, at 8:36 a.m. PTA-D stated that R86 had reported to her "sometime back" about a shower incident, whereby R86 felt rushed by the NA and did not want take showers with the NA anymore. PTA-D	F 225		

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F 225	Continued From page 10 stated that she did not remember the exact words used, but R86 "sounded frustrated." PTA-D explained she did not immediately report it, as she did not think it was alleged abuse "based on her anxiety level, but I guess I should have done that." PTA-D confirmed she had been trained on abuse prohibition, as was able to identify some of the reportable situations such as "verbal, physical and mental" abuse. During a phone interview on 11/5/15, at 12:26 p.m. OTA-E confirmed that R86 had had reported to her that she was not comfortable receiving help with her showers from one of the NAs. OTA-E stated that R86 had reported to her that the NA was "rough to her" and preferred getting showers from "me because I was her main OT [occupational therapy] contact." OTA-E stated that she had reported R86's concerns to "the head of nursing." During a follow-up interview on 11/6/15, at 8:15 a.m. the ED stated her expectations was that the "therapy staff" should have reported to the "upper chain" so there would have been follow up on the resident's concern. During the abuse prohibition investigation, a review of newly hired employee files was completed and revealed the following: 1) E1 was a licensed practical nurse (LPN)-F who had a hire date of 10/6/15. There was documentation of reference check being completed before hired. 2) E2 was NA-E who had a hire date of 10/29/15. There was no documentation of NA certification verification and no evidence of abuse training	F 225		

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F 225	Continued From page 11 prior to working directly with residents. 3) E3 was NA-F who had a hire dated of 9/1/15. There was no documentation of a back ground check being completed, no NA certification verification and no evidence of abuse training prior to working directly with residents. 4) E4 was a dietary aide (DA)-A who had a hire date of 9/23/15. There was no documentation of a background check was completed and no evidence of abuse training prior to working directly with residents. During an interview on 11/6/15, at 8:15 a.m. the ED stated that the company was utilizing a new hiring system which has caused "some things to be missed out." ED verified the screening documentation was missing from the employees' files and abuse training was missed due to "changes." The ED explained that the hiring managers were responsible for making sure all paper work is in place but, "Unfortunately we do not have any human resource on site." A facility's abuse policy dated 3/12 directed that, "It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violations") are reported immediately to the Executive Director of the facility." The policy further directed that, "All applicants for employment in the facility shall, at a minimum, have the following screening checks conducted:	F 225		

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F 225	Continued From page 12 1. Reference checks with the current and/or past employer 2. Appropriated licensing board or registry check 3. Drug testing per facility policy 4. Fingerprinting as required by stated law 5. Criminal background check pursuant to facility policy or state law."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement its abuse prohibition policy to immediately report allegations of abuse to the facility administrator and designated State agency (SA) for 1 of 1 resident (R86) who alleged abuse. Findings include: A facility's 3/12, Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal And Minnesota State Vulnerable Adult Act Requirements, directed that, "It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations	F 226	F226 D -R86 alleged incident of mistreatment has been reported to the ED and to OHFC and cleared following the submission of the investigation to OHFC. -All residents have the potential to be affected by the alleged practice. -All staff will be educated on the Vulnerable Adult Abuse reporting requirements. - Audits will be completed on all incident reports to ensure timely reporting to appropriate authorities and initiation of investigation as needed. Audits will be reviewed at QAPI and action planned as needed. -ED or Designee is the responsible party. -Corrective Action will be completed by 12/16/2015	

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F 226	Continued From page 13 of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violations") are reported immediately to the Executive Director of the facility." On 11/2/15, at 3:10 p.m. R86 was observed in her room and was interviewed. R86 reported one staff member in the facility had abused her. R86 reported that one of the nursing assistants (NA) was "rough to me when I first got here" and treated her badly. R86 explained that the NA dragged her into the shower and left her to take a shower on her own, when she needed assistance. R86 further explained that the NA then threw towels at her and spoke to her in a degrading manner. R86 reported that she was devastated and tried to "avoid her as much as possible". R86 confirmed the NA has still been working with her, but "she has changed her attitude and she has been helping and treating me better." R86 stated she reported the incident to "therapy staff." The surveyor reported R86's allegation of mistreatment to the facility director of nursing (DON) and assistant director of nursing (ADON) on 11/2/15, at 6:47 p.m. During an interview on 11/4/15, at 4:15 p.m. the executive director (ED) and DON stated that the matter was reported to the SA "yesterday, immediately after you made us aware." The ED and DON stated that they had interviewed R86, who reported the NA was "rough" toward her and felt rushed by the employee. R86 had informed the ED and DON that she had reported to a physical therapy assistant (PTA)-D and occupational therapy assistant (OTA)-E. The ED	F 226		

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F 226	Continued From page 14 and DON further explained that they had spoken to both the PTA-D and OTA-E and both confirmed that R86 had reported the NA to them. During an interview on 11/5/15, at 8:36 a.m. PTA-D stated that R86 had reported to her "sometime back" about a shower incident, whereby R86 felt rushed by the NA and did not want take showers with the NA anymore. PTA-D stated that she could not remember R86's exact words, but the resident sounded frustrated. PTA-D stated that she did not report it because she did not think of it as abuse "based on her anxiety level, but I guess I should have done that." PTA-D confirmed she had been trained on abuse and identified some of the reportable situations as "verbal, physical and mental." During a phone interview on 11/5/15, at 12:26 p.m. OTA-E confirmed that R86 had had reported to her that she was not comfortable getting showers from one of the NAs. OTA-E stated that R86 had reported to her that the NA was "rough to her" and that R86 preferred getting showers from "me because I was her main OT [occupational therapy] contact." OTA-E stated that she had reported R86's concerns to "the head of nursing." During a follow-up interview on 11/6/15, at 8:15 a.m. the ED stated that her expectations was that the "therapy staff" should have reported to the 'upper chain" so that it would have received followed up.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 15 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident rooms and personal property was clean and free of odors for 4 of 12 residents (R6, R27, R40, R67) reviewed for environmental concerns. Findings include: R6's personal upholstered chair had a wet stain on the seat and the arm rest was dirty and soiled with a white substance on 11/2/15, at 2:41 p.m. A strong urine smell was also noted. The following morning, at 9:09 a.m. the urine odor and stains to the chair remained unchanged. On 11/4/15, at 10:33 p.m. again the chair remained stained on the seat and arm rest. The smell of urine was still detected, although not as strong as it had been on the previous days. The next day, on 11/6/15 at 8:23 a.m. the stains on the chair remained on the right arm rest and base of R6's chair. On 11/4/15, at approximately 11:15 a.m. the surveyor detected a strong smell of urine in the hallway on the 100 wing. When the surveyor walked into R67's room the smell of urine was immediately detected and the urine smell lingered throughout the 100 unit hallway affecting rooms at the end of the hallway. An environmental tour was conducted on 11/5/15, at 10:00 a.m. with the facility's manager director, executive director, housekeeping manager and district manager. The following rooms were	F 253	F253 E -R6, 16, 27, 40, 67 rooms have been deep cleaned. -All residents have the potential to be affected. -All resident rooms, as well as corridors and common user areas are checked for odors and cleanliness on a daily basis and deep cleaned as necessary. - Contracted Housekeeping and Laundry Services have been educated regarding the requirements maintain a sanitary, orderly, and comfortable interior and to ensure the facility is free of odors. - Audits will be conducted on a weekly and PRN basis. Audit results will be presented at QA&A for review and action planned as needed. - ED or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 253	Continued From page 16 observed to have a urine odor, unclean room or personal property unclean. 1) R67's room had a very strong urine odor that lingered into the hallway. During the environmental tour all four of the staff verified the odor as being urine. The manager of housekeeping stated he was aware of the urine smell in R67's rooms as "being a problem." He explained that housekeeping staff mopped the room 4-5 times a day and in addition, he did a top scrub of R67's room every other day. The facility's Odor Log was review on 11/4/15, at 1:34 p.m. and indicated R67's room had a top scrub completed on the following dates 11/1, 11/3, and 11/5/15, however for the month of 10/15, R67's room had a top scrub completed only five times. 2) R27's bathroom smelled of urine immediately when the door was opened. All four of the staff during the tour verified the odor as being urine. The manager of housekeeping explained that housekeeping staff should have been cleaning the bathrooms of every resident in the facility and verified there should have been no urine odors. 3) R6's personal cloth chair in her room had a large visible stain on the edge of the cushion that ran the entire length of the cushion. The manager of housekeeping verified that this should have been reported and cleaned. 4) R40's catheter bag was clipped to the bed frame where there was a visible sticky spot on the floor with clothing lint stuck to it that went from the urine bag to the head of his bed. In addition R40's room had a strong odor of cigarette smoke. The manager of housekeeping explained that R40's roommate is a smoker and the smell	F 253		

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F 253	Continued From page 17 lingered on his clothing, and verified that R40 room was in need of mopping. R40 was unable to be interviewed due to cognitive problems. The executive director stated she had not asked R40 if he preferred another room due to the smell of smoke. During the environmental tour the facility's manager director, executive director, housekeeping manager and district manager all verified the finding above. The executive director explained she expected resident room and personal property to be clean and free of urine odor. She verified that room during the environmental tour were unacceptable and residents should not have to smell urine or have unclean rooms. The facility's 1/1/00 Housekeeping In-Service, 7-Step Daily Washroom Cleaning policy indicated the purpose was "To show housekeeping employees the proper method to sanitize a washroom or bathroom in a long-term care facility." The policy, however, lacked instruction for staff as to how to minimize urine odors and how to clean residents' personal property when soiled.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medication	F 281		

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F 281	Continued From page 18 inhalation aerosol was properly administered in accordance with manufacturer's instructions and standards of practice for 1 of 1 resident (R125) whose inhalation aerosol administration was observed. Findings include: R125's was observed on 11/3/15, at 10:00 a.m. while the inhalation medication Symbicort (to open the airway) was administered by a licensed practical nurse (LPN)-B. LPN-B handed R125 his inhaler and the resident administered two puffs and handed the inhaler back to LPN-B, who then walked away and placed the inhaler back into the medication cart. When asked if Symbicort required the technique of rinsing the mouth after use to minimize the risk for fungal infection (thrush) in the mouth and throat LPN-B replied, "I don't think so. Not this one." R125's admission Minimum Data Set dated 9/30/15, indicated diagnoses including dementia and chronic obstructive pulmonary disease (COPD). R125's care plan dated 10/6/15, indicated an alteration in respiratory status due to COPD, with a goal to remain free of exacerbation (worsening symptoms) of COPD. Interventions were to administer medications as ordered. Also noted was impaired communication and cognition. R125 required verbal cues from staff to completed activities of daily living, and staff was to anticipate his needs and provide assistance with oral care. R125's 11/15, medication administration record (MAR) directed staff to administer Symbicort	F 281	F281 D -R 125 receives his inhalation aerosol in accordance with manufacturer's instructions and standards of practice. -Residents requiring the use of an inhalation aerosol have the potential to be affected. -Licensed staff will be educated on the standards of practice for the administration of inhalation aerosols. -Random weekly audits will be conducted on residents receiving inhalation aerosols to ensure appropriate administration of medication. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 281	Continued From page 19 aerosol 160-4.5 micrograms 2 puff inhaled orally two times a day. Staff was also to offer a glass of water to rinse out the mouth after using the inhaler device. LPN-B explained that the facility did not offer annual training on medication administration nor were random audits conducted of medication passes, however, instruction was offered when a new medication was put into the medication cart. During an interview on 11/5/15, at 7:54 a.m. with LPN-C it was explained staff should have been following manufacturer's instruction as well as what was posted on the MAR regarding how to administer Symbicort inhalation medication. LPN-C verified staff should have been following the manufacturer's guidelines to rinse mouth, swish and spit for R125. The Symbicort manufacturer's instruction (revised date 2012) indicated to "Rinse mouth with water and spit the water out after each dose (2 puffs), do not swallow the water. This will help to lessen the chance of getting a fungal infection (thrush) in the mouth and throat." The facility's 11/11, Oral Inhalation Administration policy indicated the purpose "is to allow for safe, accurate and effective administration of medication using an oral inhaler..." The procedure included step by step guidance that instructed staff to review package insert if unfamiliar with the inhalation device provided and for steroid inhalers [Symbicort] provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup.	F 281		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=E	Continued From page 20 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to follow the care plan for 2 of 4 residents (R6, R51) reviewed for accidents, 1 of 3 residents (R17) reviewed for dental care, 1 of 1 resident (R133) reviewed for dialysis, and 1 of 3 residents (R46) reviewed for pressure ulcers. Findings include: R6's care plan revised 8/18/15, noted the resident was at risk for falls due to poor safety awareness, required assistance to transfer/ambulate, and received daily anti-depressant medication. The care plan directed staff to stay with resident in the bathroom to prevent falls and to keep the call light within reach of resident. In addition, the NA Assignment Sheet directed staff to stay with (resident) while toileting to prevent falls. R6 was heard calling out from the adjoining hallway on 11/3/15, at 9:08 a.m. When the surveyor entered her room, she was found in her bathroom waving a clean incontinent product and asking for help. Although three facility staff walked past the room, each failed to stop to assist R6. At 9:46 a.m. a licensed practical nurse (LPN)-C stated she was uncertain if R6 was safe to be left in her bathroom unattended.	F 282	F282 E -The care planned interventions for R6, 17, 46, 51, and 133 are being followed. -All residents have the potential to be affected. -All nursing staff will be educated to provide cares in compliance with identified interventions in the resident care plan. -Random weekly audits will be conducted on resident(s) to ensure appropriate cares have been completed in conjunction with identified care plan interventions. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2016	

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F 282	Continued From page 21 On 11/5/15, at 1:47 p.m. the assistant director of nursing (ADON) explained, "When a fall occurs, interventions are put into place. I expect all interventions to be carried through." On 11/6/15, at 10:10 a.m. R6 was observed in her bed with the telephone in her hand. Her call light was on the floor behind the headboard. LPN-C came to assist R6 and explained she was not "really" capable of using her call light. R51's care plan revised 10/12/15, noted the resident was at risk for falls related to a fall history and daily use of anti-depressant medication. She had experienced a fall with a hip fracture on 10/13/15. The care plan directed staff to keep call light available and in easy reach. The NA Assignment Sheet noted R51 was at risk for falling. R51 was observed sitting in her room on 11/6/15, at 8:39 a.m. Her call light was wrapped around the rail on her bed. The bedside table was in front of the rail. When asked, R51 stated she could not reach her call light. The surveyor then called NA-A into the room. NA-A verified the call light was not within R51's reach "especially with the table in the way." She believed a therapy staff person had assisted R51 to her room. At 8:43 a.m. the ADON also verified the call light was not within reach for R51. She stated, that all staff, including therapy, was required to place a call light within reach of a resident when in their room. R17's care plan, revised 9/24/15, directed staff to assist with oral care, brushing upper and lower dentures and ensure dental exams as necessary.	F 282		

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F 282	Continued From page 22 On 11/2/15, at 3:28 p.m., R17 was in his room and observed to be edentulous (absent of teeth). When R17 asked explained he had a full set of dentures but did not wear them "because they hurt." The Care Area Assessment for dental care, dated 9/16/15, stated, "Resident is edentulous but wears an upper and lower denture. He has loose fitting dentures per oral/dental form 7-2-15. Routine dental referral recommended. Non-urgent dental care needs. Reline dentures? Nsg [nursing] brushes dentures and assists with oral care. No c/o [complaints] pain or discomfort." During an interview on 11/4/15, at 9:38 a.m., LPN-C stated that after the oral assessment on 7/2/15, there was no follow-up to reline R17's dentures and no further dental appointments were made. During an interview on 11/6/15, at 9:12 a.m. the administrator stated she expected staff to follow the care plan and carry out all interventions for each resident. R133's care plan dated 10/27/15, indicated R133 had altered kidney function, received hemodialysis, had AV Fistula (provides a long-lasting site though which blood can be removed and returned during hemodialysis) was at risk for infection related to related to fistula, anemia, fatigue and bleeding. Interventions included observe for signs of infection at fistula site, monitor for signs of bleeding, monitor for excessive weight gain between treatments and auscultate and palpate fistula daily for pulse/bruit.	F 282		

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F 282	Continued From page 23 R133 explained in an interview on 11/4/15, at 8:53 a.m. he went to DaVita dialysis on Tuesday, Thursday and Saturday at 5:30 a.m. Upon returning from dialysis, he waited four hours then removed the dressing that was placed on his left upper arm over his dialysis access site. An admission Minimum Data Set (MDS) for R133 dated 10/27/15, indicated the resident was cognitively intact, required assistance of one staff for activities of daily living and transferring, and had diagnoses including end stage renal failure. During an interview on 11/4/15, at 8:56 a.m. a registered nurse (RN)-A verified he was the nurse assigned to care for R133 that day and said "I have only been on this floor today so I don't know much about him [R133]." RN-A stated he monitors R133 dialysis access site for bruits and thrill but there is no place for him to record the results. RN-A verified that he does removes R133 dressing over his dialysis access site d/t R133 does this all by himself. In an interview on 11/5/15, at 7:05 a.m. LPN-E verified he was assigned to care for R133 that day. LPN-E was unsure what days the resident had dialysis, where R133's access site was located (e.g. fistula), how much fluid he was allowed by nursing, or when his dialysis dressing was to be removed. LPN-E explained he was new to the floor and would need to review the resident's care plan. LPN-E stated when R133 comes back from dialysis he monitors his dialysis access site for infection and bleeding. LPN-E verified that although staff should have been recording R133's dressing changes to his dialysis site, signs of infection, bruits and thrills, it was not	F 282		

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F 282	Continued From page 24 being completed. During on interview on 11/6/15, at 9:18 a.m. a LPN-G stated around 6:00 p.m. last evening she checked R133 bruit/thrill and noticed R133 dressing was intact. LPN-G then stated between 8:00 p.m. and 9:00 p.m. when she checked on R133 his dressing over his dialysis access site/fistula was removed and R133 was not able to tell her who removed the dressing. A review of R133 nursing notes lacked documentation from staff that R133's dialysis access site was being monitored for infections, bleeding, bruit/thrills or dressing change, daily weight nor was there any place for staff to document the monitoring. R133's 11/15, medication administration record and treatment administration record was reviewed, which lacked any indication that staff was to monitor R133's dialysis access site for signs and symptoms of infection or to monitor and provide dressing changes to the dialysis access site. The facility's policy and procedure titled Dialysis Guideline revised date 10/5/15, indicated for staff to "Remove fistula/graft-dressing evening of dialysis treatment...check fistula for bruit or feel for a thrill...best after dressing is removed...If unable to feel a pulse or hear a bruit...call the dialysis unit immediately." R46's hospice care plan dated 6/13/14, directed the hospice nurse and home health aide (HHA) to provide weekly services and the social worker/chaplain to provide services on a monthly	F 282		

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F 282	Continued From page 25 basis. It instructed the staff to monitor and assess the wounds on his legs, to monitor skin on his bottom and scrotum, and for the facility staff to provide heel treatment in hospice nurse absence. The facility care plan dated revised 8/31/15, instructed staff to coordinate care plan with hospice, evaluate effectiveness of medications and interventions, diabetic foot monitoring, float heels with placement of pillow, boots or Heelzup cushion, weekly skin assessments to be complete and notify hospice of any change in condition or medication change. On 11/2/15, at 5:30 p.m. R46 was observed sitting in wheelchair in the dining room with his daughter, he had a light blue thick foot protectors on his feet/legs. On 11/4/15, at 7:45 a.m. the resident was laying in his bed on his back with his heels pressed directly on the bed. In addition on 11/5/15, at 8:30 a.m. R46 was observed lying in bed on his back, with his legs bent and heels pressed against the mattress. A new cushion was observed in resident's room sitting in the chair, no boot protectors were located in room at this time. At 11:30 a.m. he was in dining room with his daughter, at 1:19 p.m. the resident was still observed sitting in his wheelchair visiting with daughter. On 11/6/15, at 7:10 a.m. R46 was observed laying in his bed on his back with his knees bent and heels directly on the bed. R46's quarterly Minimum Data Set (MDS) dated 8/20/15, indicated the resident had a diagnosis that included heart failure, hypertension, peripheral vascular disease, diabetes, cerebral vascular disease depression and dementia. The	F 282		

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F 282	Continued From page 26 resident required extensive assistance with all his activities of daily living (ADL). The skin category indicated R46 was at risk for developing pressure ulcers, and currently had unhealed stage 1 and 2 pressure ulcers. The current skin and ulcer treatment included a pressure reducing device for his bed and chair, pressure ulcer care, ointments and medications. It was also noted under special treatment and programs the resident was receiving hospice services. The Braden scale dated 8/20/15, had a total score of 15 classifying the resident at high risk for pressure ulcers. The facility had completed sporadic weekly skin monitoring and pressure ulcer measurements from 5/7/14 to 4/8/15. The weekly skin reviews completed during the resident shower days did not capture the wound measurements. The hospice and palliative care visit records were requested the following dates were the only visits provided by the facility and documentation of wound measurements: -On 5/19/15, indicated the resident had 3 open areas on his bottom and on 8/10/15, during the visit it was documented the heel wound was measuring 4 cm x 3 cm and there were no other ulcers noted. -On 8/16/15, included heel measurements 2 cm x 1.5 cm and there was no drainage. -On 9/11/15, included comfort and wound care, right heel was measuring 3 cm x 1.4 cm and there was a new open are on the left great toe. Tegafoam was applied. -On 9/14/15, included wound care with heel measuring 1.7 cm x 1.7 cm with slight foot odor and drainage. Also new open area to left buttock. Instruction was to continue barrier cream to	F 282		

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F 282	Continued From page 27 buttocks, encourage offloading and laying down after meals. -On 9/21/15, included wound care and the heel was measuring 3 cm x 2.4 cm was very tender to touch, no new orders. -On, 9/28/15, wound care was provided and wounds assessed, however no measurements indicated. -On 10/2/15, included wound care using medihoney in wound bed and cover with mediplex border. The facility staff reported increased odor and secretions. -On 10/5/15, New wound care orders included, wash with normal saline, apply 500 mg crushed Flagyl to wound bed for 14 days, cover with Tegafoam or Mepilex dressing. Wrap with Kerlix for added cushion and call hospice with any changes in wound status. -On 10/12/15, intervention included assess effectiveness of Flagyl in wound bed of right heel, no measurements taken. -On 10/22/15, noted to plan to get wound nurse consult to evaluate heel, however no appointment was documented, and no new measurements of wound taken. -On 11/2/15, wound care performed and right heel measuring 6 cm x 4.5 cm x .5 cm, 100% yellow slough, no odor. -On 11/4/15, right heel wound is now unstageable pressure ulcer, measuring 5.0 cm x 5.0 cm. Recommend iodine and foam dressing changing every 1-2 days, no open areas on the buttocks noted. Continue to use barrier cream to prevent ulcers. In addition, a hospice wound nurse evaluated the right heel and provided suggestions and new orders, the coccyx was also observed to be red, blanch able and excoriation noted in area of the buttocks. Continue to monitor and measure areas.	F 282		

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F 282	Continued From page 28 -On 11/6/15 updated orders instructed the staff to clean the wound, apply Betadine to wound base, apply foam dressing, measure wound and document with each dressing change. Change every 2 days or as needed. Document review of the facility nursing progress notes and weekly nursing summary notes reiterated the hospice nurse observations and generally noted the right heel wound, red buttocks, and treatments daily. However the facility did not take weekly wound measurements, or monitor the skin. When interviewed on 11/4/15, at 8:30 a.m. the hospice nurse verified the resident had a pressures ulcer on his heel that had gotten worse, however she was unaware of the measurements of the wound, the current treatment plan and interventions for the pressure ulcer. She was also unaware of the pressure ulcers on the resident's coccyx. She was not given weekly wound measurements by the facility staff. The hospice nurse stated she has only worked with the resident for a couple of months and there was another nurse prior to her. The physician orders dated 5/11/15 instructed the staff to conduct weekly skin assessments. On 11/4/15, at 8:30 a.m. the director of nursing (DON) could not verify R46's wound measurements or who was responsible for monitoring, the current size of the pressure ulcers, the current treatment plan, nor could he answer any questions related to coordinated care and services with hospice. The assistant director of nursing (ADON) and the licensed practical nurse (LPN)-C was unaware of the condition of the pressure ulcers, the treatment and	F 282		

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F 282	Continued From page 29 coordinated services with hospice. The staff could not verify where R46s protective boots were located and when the intervention was discontinued. Hospice had requested for the facility to monitor the skin weekly, contact them with any changes in the condition of the pressure ulcers. On 11/5/15, at 9:02 a.m. the DON verified the weekly wound measurements had not been completed, stated the resident just saw a hospice wound nurse yesterday and now the heel pressure ulcer is unstageable. On 11/5/15 at 7:30 a.m. NA-B stated the facility nurse takes care of the resident's pressure ulcers, she is unaware of what hospice does for the resident and the only interventions she will do for the resident is put socks on him, offloading at times and doesn't use heel protectors. She was unaware of interventions related to reduce the risk of skin breakdown. The nursing assistant assignment sheet instructed the staff to turn and reposition the resident every 2 hours side to side, to only have him up for ½ hour after meals due to wounds and to use the blue Prevalon boots on both feet at all times. The undated document titled Skin Integrity Guideline indicated the purpose of the policy was to provide a comprehensive approach for monitoring skin conditions and decrease pressure ulcer and/or wound formation by implementing appropriate interventions. The facility instructed the nursing assistants to report any changes in skin to licensed nursing and document the changes. The licensed nurse will be responsible to performing weekly skin evaluation/observations and document using the "Wound Evaluation Flow Sheet."	F 282		

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F 309	Continued From page 30	F 309	F309 D	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate and maintain ongoing communication with hospice staff for 2 of 2 residents (R93, R46) who developed pressure ulcers and had hospice services, and to coordinate services with dialysis staff for 1 of 1 resident (R133) who was receiving dialysis. Findings include: R93 was observed on 11/2/15, at 3:11 when a licensed practical nurse (LPN)-H changed the resident's soiled dressing to a coccyx pressure ulcer. LPN-H reported "The hospice nurse does wound care." R93's progress note revealed the resident was admitted to the facility on 8/22/15, on hospice for esophageal cancer with metastases (spread of cancer) to the spine causing paraplegia (paralysis of lower body and a known risk factor for the development of PUs). An Allina Hospice and Palliative Care Facility Visit	F 309	-R46 is monitored and evaluated to ensure the interventions, cares, and services provided meets his needs at the end-of-life to maintain his highest level of well-being. R133 receives coordinated services between the dialysis center and this facility. His access site is monitored every shift for Thrill/Bruit as well as signs/symptoms of infection and recorded in the medical record. His fluid intake is monitored q shift and his dressing is kept in place per dialysis protocol. R93 is no longer a resident at this facility. -Residents receiving hospice/end of life services or Dialysis have the potential to be affected. -Licensed staff will be educated to provide interventions, cares, and services to enable the resident to maintain his/her highest level of well-being in accordance with the resident's wishes and to document deviations/refusals from the care planned interventions as the resident wishes. They have also been educated on the requirements to monitor dialysis residents for proper fluid intake levels, access site for thrill/bruit, signs/symptoms of infection, and access site dressings and emergency cares.	

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F 309	Continued From page 31 Record note also indicated R93 was seen by a hospice and a wound nurse on 9/11/15, and a note referred only to existing "foot wounds." Hospice orders also dated 9/11/15, however, included zinc oxide barrier cream for "Buttock and sacral wounds." Subsequent notes revealed a pattern of inconsistent communication or follow through within the facility and between facility staff and hospice nurses. A summary of the notes follows: 1) 9/14/15 hospice nursing note (NN), "Wounds in buttocks are larger (not deeper) due to sitting in wc [wheelchair] all day...." The nurse recommended off loading to relieve pressure to the wounds. 2) 9/21/15, hospice NN contained comments about foot wounds 3) 10/11/15, hospice NN included initial wound measurements. "RN assessment of R [right] buttock and sacral area, sacral wound is now larger, Stage IV w/ necrosis, scant sang drainage [full thickness tissue loss with exposed bone, tendon or muscle with dead tissue and small amount of bloody drainage]. 8 cm x 3 cm. R buttock ulcer now 4.5 x 2.25 cm." 4) 10/29/15, hospice NN revealed a visit was made after an Allina home health aide reported a declining coccyx. "POC [plan of care] coordinated with staff." (R93's POC dated 9/2/15, for right foot abrasion, 9/8/15 for left toe abrasion, 9/11/15 for PU risk, and on 10/11/15 for two open areas to right buttock/sacral area.) 5) 10/30/15, hospice NN noted coccyx wound had	F 309	- Random weekly audits will be conducted on resident(s) to ensure appropriate cares have been completed in conjunction with identified care plan interventions. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 309	Continued From page 32 obviously increased in size measuring 12 x 5 x 3 (depth) cm (first notation of depth). Right lower buttock measured 3 x 2 cm. "Coccyx wound edge borders were non-blanchable and crusted. Wound bed necrotic. 30-40% loose necrotic tissue noted. Serosanguineous [blood-tinged clear] drainage observed in large amounts. POC reviewed with unit nurse on duty." The hospice NN planned to try to return the following week to coordinate with wound nurse. 6) 11/1/15, NN noted the nurse practitioner (NP) saw the resident and the hospice nurse measured R93's wounds. 7) 11/1/15 hospice NN, "Sister requested hospice nurse visit to assess wound care." Wound care was provided by facility and hospice nurse. Coccyx wound was 10.5 x 4.5 cm with black necrotic tissue on 30 to 40% of wound. Ischial wound was 3.5 x 2 cm with odor and Flagyl (antibiotic) was ordered. An interview was conducted on 11/4/15, at 9:20 a.m. with a wound nurse from Allina home care, the director of nursing (DON) and the assistant director of nursing (ADON) while awaiting the hospice nurse's arrival. The wound nurse reported, "I consult with hospice for wounds. This is the first time I'm seeing these wounds." The hospice nurse then joined the interview. The hospice RN reported hospice staff documented in their own electronic medical record in interdisciplinary team (IDT) notes. She added, "But the facility cannot see them," because they lacked access. In addition, hospice nurses did not read the facility's NN, rather relied on verbal exchanges of information regarding progress and changes in condition.	F 309		

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F 309	Continued From page 33 On 11/4/15, at 10:40 a.m. the hospice RN (RN-F) said she found out R93 had wounds from facility staff. She verified she had not measured them until "his week" and reported, "I used barrier cream. I'm not sure how they knew it was getting deeper without measurements." RN-F explained she took over on 10/30 from the previous hospice nurse. Preventive measures were the responsibility of "both hospice and the facility" and hospice did "suggest turns," (repositioning), etc. RN-F stated regarding R93, "His wounds are declining as he is declining." The following day hospice notes were requested, however, were not provided. On 11/4/15, at 12:17 p.m. the DON reported he was aware of R93's PUs, but thought hospice was completing wound assessments, as there was a note indicating they would be treating the ulcers. The DON said most communication was via telephone with the hospice agency, and NN should have reflected this. R46's quarterly Minimum Data Set (MDS) dated 8/20/15, indicated diagnoses including peripheral vascular disease, diabetes, and dementia. The resident required extensive assistance with all activities of daily living (ADLs). It was noted R46 was at risk for developing PUs, and had unhealed Stage I and II PUs. The current skin and ulcer treatment included a pressure reducing device for his bed and chair, PU care, ointments and medications. It was also noted the resident was receiving hospice services. A hospice care plan dated 6/13/14, directed the hospice nurse to provide weekly services including to monitor and assess the wounds on	F 309		

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F 309	Continued From page 34 his legs, to monitor skin on his buttocks and scrotum, and for the facility staff to provide left heel treatment in hospice nurse's absence. R46's care plan dated revised 8/31/15, instructed staff to coordinate care plan with hospice, evaluate effectiveness of medications and interventions, diabetic foot monitoring, float heels with placement of pillow, boots or Heelzup cushion, weekly skin assessments and notify hospice of any change in condition or medication change. The hospice and palliative care visit records were requested and the following was provided: 1) 5/19/15, indicated R46 had three open areas on his buttocks 2) 8/10/15, heel wound measured 4 x 3 cm and no other ulcers identified 3) 8/16/15, heel measurements 2 x 1.5 cm and no drainage 4) 9/11/15, comfort and wound care, right heel PU measured 3 x 1.4 cm and there was a new open area on the left great toe. 5) 9/14/15, wound care with heel measured 1.7 x 1.7 cm with slight foot odor and drainage. Also new open area to left buttock (not specified). Instruction was to continue barrier cream to buttocks, encourage offloading and lying down after meals. 6) 9/21/15, included wound care and the heel was measuring 3 x 2.4 cm was very tender to touch, no new orders. 7) 9/28/15, wound care provided and wounds assessed, however, no measurements, staging, or wound descriptions were documented 8) 10/2/15, wound care using Medi-honey in wound bed and covered with Mepilex border. The	F 309		

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F 309	Continued From page 35 facility staff had reported increased odor and secretions. 9) 10/5/15, New wound care orders included, wash with normal saline, apply 500 mg crushed Flagyl to wound bed for 14 days, cover with Tegafoam or Mepilex dressing. Wrap with Kerlix for added cushion and call hospice with any changes in wound status. 10) 10/12/15, intervention included assess effectiveness of Flagyl in wound bed of right heel, no measurements, staging, or description of the various wounds were documented. 11) 10/22/15, plan to request wound nurse consult to evaluate heel, and no new measurements, staging or descriptions of the wounds were documented. 12) 11/2/15, wound care performed and right heel measured 6 x 4.5 x .5 cm with 100% yellow slough, no odor. 13) 11/4/15, right heel now unstageable PU, measuring 5.0 x 5.0 cm. No staging to description of the wounds was documented. Recommended iodine and foam dressing changing every one to two days, no open areas on the buttocks noted. Continue use of barrier cream to prevent ulcers. In addition, a hospice wound nurse evaluated the right heel and provided suggestions and new orders. The coccyx was also observed to be red, blanchable and excoriated. "Continue to monitor and measure areas." 14) 11/6/15 updated orders instructed the staff to clean the wound on heel area, apply Betadine to wound base, apply foam dressing, measure wound and document with each dressing change, change every two days or as needed. NN and weekly nursing summary notes reiterated the hospice nurse's observations and only generally noted the right heel wound, red	F 309		

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F 309	Continued From page 36 buttocks, and daily treatments. However, weekly wound measurements, staging, and descriptions of the skin was not specifically documented. When interviewed on 11/4/15, at 8:30 a.m. the hospice nurse verified R43 developed a PU on the heel which had worsened. She was unaware of wound measurements, or the current treatment plan and interventions for the PU. She was also unaware of the PUs on the resident's coccyx, and wound information had not been provided by facility staff. The hospice nurse reported she had only worked with R46 for the past couple months, and another hospice nurse worked with the resident prior to this. The hospice care plan included weekly skin monitoring by facility staff, and then contacting the hospice nurse with any change in skin condition and/or the status of the PUs. On 11/5/15, at 9:02 a.m. the DON verified the weekly wound measurements had not been completed, stated the resident just saw a hospice wound nurse "yesterday" and it was determined the heel ulcer was now unstageable. R133 explained in an interview on 11/4/15, at 8:53 a.m. he went to DaVita dialysis on Tuesday, Thursday and Saturday at 5:30 a.m. Upon returning from dialysis, he waited four hours then removed the dressing placed over his fistula (how blood is removed and returned) after dialysis. R133's care plan dated 10/27/15, indicated R133 had altered kidney function, received hemodialysis, had AV Fistula, was at risk for infection, anemia, fatigue and bleeding.	F 309		

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F 309	Continued From page 37 Interventions included observe for signs of infection at fistula site, monitor for signs of bleeding, monitor for excessive weight gain between treatments and auscultate and palpate fistula daily for pulse/bruit. During an interview on 11/4/15, at 8:56 a.m. a registered nurse (RN)-A verified he was the nurse assigned to care for R133 that day and said "I have only been on this floor today so I don't know much about him." RN-A stated he monitored R133 dialysis access site for bruit and thrill, but there was no place on the treatment record to record the results. RN-A verified R133 removed his own dressing after dialysis. In an interview on 11/5/15, at 7:05 a.m. LPN-E verified he was assigned to care for R133 that day. LPN-E was unsure what days the resident had dialysis, where R133's access site was located (fistula), how much fluid he was allowed by nursing, or when his dialysis dressing was to be removed. LPN-E explained he was new to the floor and would need to review the resident's care plan. LPN-E stated when R133 returned from dialysis he monitored the dialysis access site for infection and bleeding. LPN-E verified that although staff should have been recording R133's dressing changes, signs of infection, bruit and thrill, it was not being documented. During an observation and interview on 11/6/15, at 9:14 a.m. R133 was observed without a dressing to his fistula site. R133 explained he had removed it last evening, but did not recall the time. He reported staff had not checked his dialysis site that morning. During an interview on 11/6/15, at 9:18 a.m. a	F 309		

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F 309	Continued From page 38 LPN-G stated around 6:00 p.m. last evening she checked R133 bruit/thrill and noticed R133 dressing was intact. LPN-G then stated between 8:00 p.m. and 9:00 p.m. when she checked on R133 his dressing over his dialysis access site/fistula was removed and R133 was not able to tell her who had removed the dressing. R133's nursing notes lacked documentation from staff indicating the dialysis site was being monitored for infections, bleeding, bruit/thrill or dressing changes, and daily weights were not taken, nor was there direction on the treatment record directing staff to monitor and record information. R133's 11/15, the medication administration record (MAR) and treatment administration record (TAR) was reviewed, which lacked any direction for staff to monitor R133's dialysis access site for signs and symptoms of infection or to monitor and provide dressing changes to the dialysis access site. The facility's policy and procedure titled Dialysis Guideline revised date 10/5/15, indicated for staff to "Remove fistula/graft-dressing evening of dialysis treatment...check fistula for bruit or feel for a thrill...best after dressing is removed...If unable to feel a pulse or hear a bruit...call the dialysis unit immediately."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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F 314	Continued From page 39 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide preventive measures including assessment and monitoring, and failed to provide appropriate care and treatent for pressure ulcers (PUs) for 2 of 3 residents (R93, R46) reviewed for PUs. R93 and R46 suffered actual harm when PUs developed and worsened at the facility. Findings include: R93 was observed on 11/2/15, at 2:37 p.m. sitting up in bed with the head of the bed at an approximate 45 degree angle (known to add pressure to the buttocks area). Although the bed mattress included a alternating pressure-reducing powered air mattress, the air pump at the foot of the bed had no indicator lights on, and no sound was emitted from the pump. At 2:52 p.m. on 11/2/15, a licensed practical nurse (LPN)-C was asked by the surveyor to look at the pump. LPN-C stated the pump had been turned off and said, "I wonder if it's gotten unplugged." She unsuccessfully tried several ways to restart the pump before getting assistance from LPN-H. LPN-H was able to turn the pump back on and acknowledged, "It was turned off." LPN-H said they'd need to get staff to assist R93 out of bed so the mattress could fill	F 314	F314 G -R93 is no longer a resident at this facility. R46 is offered cares and services to promote healing of pressure ulcers. -Residents identified as at risk for the development of pressure ulcers have the potential to be affected. -Nursing staff will be educated to provide cares and services as, identified in the care plan, that promote healing of pressure ulcers. Licensed staff has been educated to document refusals/non-compliance with the recommended interventions/cares. -Random weekly audits will be conducted on residents with identified pressure ulcers to ensure cares and services offered promote healing of said pressure ulcer(s), identified care plan interventions and/or documentation of refusal/non-compliance with identified cares/interventions. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 314	Continued From page 40 with air. At 2:55 p.m. on 11/2/15, nursing assistant (NA)-C was and a second NA, were observed to help R93 get out of bed. During the observation it was noted R93 had been incontinent of feces. The resident was also observed to have a wound on the right sacral area of the buttock. Although the NAs were observed to cleanse the resident's rectal and buttock areas, there was still fecal matter noted in the resident's wound. NA-C told the second NA, "You have to get [LPN-H] to change the dressing. It's soiled." The wound's dressing was observed to have slid off the wound and down into the incontinent garment. The dressing appeared soiled with what appeared to be drainage from the wound and feces. When the surveyor inquired when R93 had last been repositioned or changed, NA-C stated, "We turn him every two hours, I've just changed shifts so I don't know know what time he was turned last." At 3:11 p.m. on 11/2/15, LPN-H was observed to redress the wound. At that time, LPN-H stated, "the hospice nurse does his wound care." LPN-H also stated the hospice nurse had measured the resident's wounds and updated the dressing orders the previous day. LPN-H further indicated the goal for the wounds included, "...just pain relief and odor control." During the wound care, it was observed the resident had the pressure ulcer on the right side of the sacrum/coccyx (tailbone) and another on the right ischial tuberosity (lower buttock near upper thigh). R93's admission progress note indicated the resident had been admitted to the facility on 8/22/15, with Hospice services due to diagnoses including esophageal cancer with metastasis	F 314		

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F 314	Continued From page 41 (spread of cancer) to the spine causing paraplegia (paralysis of lower body and a known risk factor for the development of pressure ulcers). The admission notes indicated R93 had existing pressure ulcers (PUs) on his feet. However, an admission Minimum Data Set assessment completed 8/27/15 (five days later) was coded to indicate R93 had "no stage 1 or greater" pressure ulcers. Subsequent progress notes indicated R93 developed two additional PUs while residing in the facility frequently referred to as "buttocks" wounds. On 9/11/15, a note by the wound nurse indicated the resident had a sacrum/coccyx wound. However, the note lacked documentation of measurement, physical description of the wound, or wound staging. An Allina Hospice and Palliative Care Facility Visit Record also dated 9/11/15, indicated R93 was seen by the hospice wound nurse from Allina. The note only referenced previously existing "foot wounds." However, hospice orders dated 9/11/15, included orders for zinc oxide barrier cream to be applied to "Buttock and sacral wounds." Additional wound documentation included: 1) 9/14/15 hospice nursing note (NN), "Wounds in buttocks are larger (not deeper) due to sitting in wc [wheelchair] all day...." The hospice nurse recommended off loading to relieve pressure to the wounds. The documentation did not include assessment of the wound including measurement, staging, description of wound appearace, or identification of potential causal factors. 2) 9/18/15, hospice NN indicated a visit had been	F 314		

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F 314	Continued From page 42 conducted for wound care. The documentation did not include assessment of the wound including measurement, staging, description of wound appearace, or identification of potential causal factors. 3) 9/21/15, hospice NN included notes about the resident's foot wounds, but did not include informaiton about the 'buttock' wounds. The documentation did not include assessment of the wounds including measurement, wound appearace, or identification of potential causal factors. An order dated 9/21/15, was written to change the toe wound dressing and included, "continue other wound cares as previously ordered." 4) 9/22/15, a facility NN indicated R93 had gone on an outing to the casino with family at 9:30 a.m. with plans to return at 6:00 p.m. The note lacked evidence the resident and/or family had been educated regarding the risks of prolonged sitting for potential worsening of the resident's PUs. In addition, upon the resident's return to the facility, there was no follow up note documented to identify whether or not the resident's skin was assessed after he'd been out all day. 5) 9/29/15, hospice NN indicated wound care had been provided however, no wound assessment such as measurement, staging, description of wound appearace, or identification of potential causal factors was recorded. 6) 9/28/15, a significant change facility NN indicated R93 had fallen and was found "sitting on foot pedals." The note indicated, "no injuries." The record lacked any assessment of the resident's buttock wounds after the fall onto the	F 314		

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F 314	Continued From page 43 metal food pedals to determine wether there had been any increased skin damage as a result. Multiple post-fall notes followed and at no time were the buttock wounds mentioned. 7) 10/5/15, hospice NN revealed order changes including: "cream to coccyx changed to a clear critic barrier from zinc as staff reports zinc barrier too harsh to skin." The documentation did not include assessment of the wounds including measurement, staging, description of wound appearace, or identification of potential causal factors. 8) 10/11/15 NN included the first measurements since R93's 'buttock' wounds had been identified on 9/11/15. The wounds were documented as, "Right buttock and inner thigh wound: Open area near coccyx is 8 centimeters (cm) x 4 cm, wound bed dark tissue, inferior region measures 3 cm x 2 cm open area without slough [soft non-living tissue], inner thigh open area measures 4 cm x 1.8 cm." The note also included some description of wound appearances, and indicated a wound nurse visit had been requested to re-evaluate and provide a new treatment order "as current order is not effective." 9) 10/11/15, hospice NN also documented wound measurements however, the measurements were inconsistent with the measurements by the facility. The hospice NN included, "RN assessment of R [right] buttock and sacral area, sacral wound is now larger, Stage IV [full thickness tissue loss with exposed bone] w(with)/necrosis [dead tissue], scant sang (sanguinous) drainage [small amount of bloody drainage]. 8 cm x 3 cm. R buttock ulcer now 4.5 x 2.25 cm." Mepilex and Allevyn dressings were	F 314		

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F 314	Continued From page 44 applied. The 10/11/15 assessments documented by the facility and hospice nursing staff lacked consistent staging and/or full descriptions of the appearance of each wound. 10) 10/12/15, hospice NN showed R93 went out with family, so unable to assess the "worsened" right buttock wound. The plan was for the nurse to return later that week to assess the wound. There was no documentation of education on PU cause/prevention with the resident. No follow up NN indicating how long the resident sat, nor a skin exam and description of skin condition after prolonged sitting. 11) 10/13/15, at 9:44 p.m. NN indicated, "...complaint of butt pain," with no indication wound assessment was then performed, nor education provided related to prolonged sitting and wound deterioration, nor any cosideration of how long the resident had been potentially sitting on the PUs. 12) 10/25/15, NN "...wound black in color and has a foul odor..." Although the wound description was minimal, it did represent a change to the wound from previous noted descriptions. In addition, as a result a wound nurse consult had been arranged. The NN indicated the coccyx wound had deteriorated due to being "near rectum/stool." 13) 10/29/15, a hospice NN indicated a visit had been made after an Allina home health aide had reported a declining coccyx wound. The NN included: "POC [plan of care] coordinated with staff." R93's care plan was reviewed and	F 314		

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F 314	Continued From page 45 included: 9/2/15, "right foot abrasion", 9/8/15, "Left toe abrasion," 9/11/15, PU (actual or at risk), and 10/11/15, two "open areas to right buttock/sacral area." There had been no additional changes to the resident's care plan after 10/11/15. 14) 10/30/15, hospice NN noted coccyx wound had increased in size. The coccyx wound measurement was identified as 12 x 5 x 3 (depth) cm. The right lower buttock wound measured 3 x 2 cm. The notes indicated: "Coccyx wound edge borders were non-blanchable and crusted. Wound bed necrotic. 30-40% loose necrotic tissue noted. Serosanguineous [blood-tinged clear] drainage observed in large amounts. Due to where wound is located near rectal opening, stool becomes lodged into wound crevices and must be thoroughly cleansed of stool after each incont episode and wound cares repeated. POC reviewed with unit nurse on duty." However, the facility's wound interventions for the POC remained unchanged. The hospice NN indicated the nurse planned to try to return the following week to coordinate with wound nurse. 15) 10/30/15 an order was written to discontinue previous wound care [Allevyn to larger and Mepilex to smaller buttock wounds. Although a reason for the change was not documented, a new change procedure directed staff to"...loosely pack wound with moist dressing]...." 16) 10/31/15, NN indicated R93 returned from an outing at 6:00 p.m. and "refused" to lie down. NN's did not reflect a departure time, nor risk/benefit education. Documentation lacked a follow up note to indicate when the resident did lie down and whether the resident's skin was	F 314		

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F 314	Continued From page 46 examined. 17) 11/1/15, NN noted the nurse practitioner (NP) was providing cares and hospice nurse measured the wounds. 18) 11/1/15 hospice NN, "Sister requested hospice nurse visit to assess wound care." Wound care was provided by facility and hospice nurse. Coccyx wound was 10.5 x 4.5 cm with black necrotic tissue on 30 to 40% of wound. Ischial wound was 3.5 x 2 cm with odor, and Flagyl (antibiotic) was ordered with each dressing change for wound odor. Wound care three times daily and as needed for stooling or loosening of the dressing. Although the measurements were smaller, the assessment was incomplete, lacking depth measurement and wound appearance description that would have shown actual or lack of progress toward healing. 19) 11/2/15, NN regarding wound care provided, observed by surveyor as above 20) 11/3/15, facility dietary note revealed the first nutrition assessment since an 8/25/15, admission Nutrition Assessment form (with check boxes but no information relevant to wound healing issues). The note indicated the resident was receiving hospice and had skin concerns on toes and buttocks, which was contradicted later in the note when it indicated "Skin is intact." 21) 11/4/15, wound NN indicated R93 had an unstagable wound on the right buttock measuring 11 x 5 x 3.5 cm. "Undermining from 3 to 6 o'clock [larger than visible at skin level and face of clock used to describe direction] 5.5 cm to 9.0 cm." New treatment with Iodoform packing was	F 314		

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F 314	Continued From page 47 recommended daily and as needed. The two wounds were measured and staged as ischial tuberosity wound (first measurement of this wound) was "Stage III measure 3.3 cm x 2.0 cm, scrotal--1.5 cm x 1.0 cm. Recommend Triad wound paste" twice daily and as needed. New orders were written. A rationale for the change in treatment was not documented. A physician order dated 11/4/15, indicated, "Unstageable [full thickness tissue loss in which actual depth is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed] Right buttock pressure ulcer" dressing packing was changed to one inch Iodoform (anti-infection material) packing strips into the wound and right ischial tuberosity wound dressing was changed from Mepilex to Triad wound paste. A NN showed the physician saw R93 the following day, but did not indicate whether the physician visualized any wounds. The past four Weekly Skin Reviews were reviewed and were vague and incomplete. All noted a check mark for foot wounds. On both 9/19/15 and 10/3/15, a brief description was documented. A NN note 10/3/15, included a brief description of the buttocks wounds including, "open area to coccyx; zinc barrier cream applied." On 10/17/15, a brief description of buttocks wounds indicated "drainage" and wound cleanser was used for stool removal. On 10/31/15, "2 open areas to right buttock area; drsgs [dressings] dry and intact tonight." An interview was conducted on 11/4/15, at 9:20 a.m. with a wound nurse from Allina home care, the director of nursing (DON) and the assistant	F 314		

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F 314	Continued From page 48 director of nursing (ADON) while waiting for the hospice nurse to arrive. The wound and the hospice nurse planned to perform ulcer cares and measurements together. The wound nurse reported, "I consult with hospice for wounds. This is the first time I'm seeing these wounds." The hospice nurse then joined the interview. The ADON said the physician had been notified of R93's wounds but was unsure whether he or the nurse practitioner (NP) had visualized the wounds yet. The ADON stated, "The goal is to maintain the wounds, not to heal." The hospice RN reported they documented in their own electronic medical record in the hospice interdisciplinary team (IDT) notes. She added, "But the facility cannot see them," because they lacked access. In addition, hospice nurses did not read the facility's NN, rather relied on verbal exchanges of information regarding progress and changes in condition. On 11/4/15, at 9:49 a.m. the wound nurse and a hospice case manager were observed during wound dressing changes and measurements for R93. The wound nurse measured and reported the coccyx wound had depth and undermining. She stated, "I'd say it was unstageable. There's granulation tissue [pink or red tissue of the healing process] with about 50% eschar [dark colored dead tissue]. We'll change the dressing order to Iodoform ribbon" (for potential bacteria from dead tissue). The wound nurse measured the ischial tuberosity wound and said it was Stage III but noted no depth, although slight depth was observed by the surveyor. Following the observation the hospice nurse said the physician was notified of wound healing at hospice interdisciplinary (IDT) rounds, but had not visualized the ulcer adding, "Our docs [doctors]	F 314		

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F 314	Continued From page 49 rarely come out to view wounds." On 11/4/15, at 10:40 a.m. the hospice RN (RN-F) said she found out R93 had wounds from facility staff, and the wounds developed from pressure and excoriation (open skin due to moisture). She had not measured them since her initial measurements "this week." "I used barrier cream. I'm not sure how they knew it was getting deeper without measurements." RN-F explained she took over on 10/30 from the previous hospice nurse. Preventive measures were the responsibility of "both hospice and the facility" and hospice did "suggest turns," (repositioning), etc. RN-F stated regarding R93, "His wounds are declining as he is declining." His mood and affect were also declining and he participated in fewer hobbies and in the past week had less of an appetite. Communication of this observation, however, was not noted on the registered dietitian note the previous day. The following day hospice notes were requested, however, were not provided. On 11/4/15, at 12:17 p.m. the DON reported he was aware of R93's PUs, but though hospice was completing wound assessments, as there was a note indicating they would be treating the ulcers. Regarding the policy the DON stated he would have expected documentation including measurements, physician notification. He would expect the facility nurses to follow standard training, and that the care plan would be updated with the change in condition in September when the wounds were first noted. The DON said most communication was via telephone with the hospice agency, and NN should have reflected this. R46 was observed on 11/4/15, at 7:45 a.m.	F 314		

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F 314	Continued From page 50 11/5/15, at 8:30 a.m. and again on 11/6/15, at 7:10 a.m. R46 was observed lying in bed on his back with his knees bent with his heels pressing directly on the mattress. R46's quarterly Minimum Data Set (MDS) dated 8/20/15, indicated diagnoses including peripheral vascular disease, diabetes, and dementia. The resident required extensive assistance with all activities of daily living (ADLs). It was noted R46 was at risk for developing PUs, and had unhealed Stage I and II PUs. The current skin and ulcer treatment included a pressure reducing device for his bed and chair, PU care, ointments and medications. It was also noted the resident was receiving hospice services. The Braden Scale (for predicting PU risk) dated 8/20/15, was scored 15 classifying the resident at high risk for PUs. The facility completed sporadic weekly skin monitoring and PU measurements from 5/7/14 to 4/8/15. The weekly skin monitoring lacked wound measurements and descriptions. A hospice care plan dated 6/13/14, directed the hospice nurse to provide weekly services including to monitor and assess the wounds on his legs, to monitor skin on his buttocks and scrotum, and for the facility staff to provide left heel treatment in hospice nurse's absence. R46's care plan dated revised 8/31/15, instructed staff to coordinate care plan with hospice, evaluate effectiveness of medications and interventions, diabetic foot monitoring, float heels with placement of pillow, boots or Heelzup cushion, weekly skin assessments and notify hospice of any change in condition or medication change.	F 314		

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F 314	Continued From page 51 The hospice and palliative care visit records were requested and the following was provided: 1) 5/19/15, indicated R46 had three open areas on his buttocks 2) 8/10/15, heel wound measured 4 x 3 cm and no other ulcers identified 3) 8/16/15, heel measurements 2 x 1.5 cm and no drainage 4) 9/11/15, comfort and wound care, right heel PU measured 3 x 1.4 cm and there was a new open area on the left great toe. 5) 9/14/15, wound care with heel measured 1.7 x 1.7 cm with slight foot odor and drainage. Also new open area to left buttock (not specified). Instruction was to continue barrier cream to buttocks, encourage offloading and lying down after meals. 6) 9/21/15, included wound care and the heel was measuring 3 x 2.4 cm was very tender to touch, no new orders. 7) 9/28/15, wound care provided and wounds assessed, however, no measurements, staging, or wound descriptions were documented 8) 10/2/15, wound care using Medi-honey in wound bed and covered with Mepilex border. The facility staff had reported increased odor and secretions. 9) 10/5/15, New wound care orders included, wash with normal saline, apply 500 mg crushed Flagyl to wound bed for 14 days, cover with Tegafoam or Mepilex dressing. Wrap with Kerlix for added cushion and call hospice with any changes in wound status. 10) 10/12/15, intervention included assess effectiveness of Flagyl in wound bed of right heel, no measurements, staging, or description of the various wounds were documented.	F 314		

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F 314	Continued From page 52 11) 10/22/15, plan to request wound nurse consult to evaluate heel, and no new measurements, staging or descriptions of the wounds were documented. 12) 11/2/15, wound care performed and right heel measured 6 x 4.5 x .5 cm with 100% yellow slough, no odor. 13) 11/4/15, right heel now unstageable PU, measuring 5.0 x 5.0 cm. No staging to description of the wounds was documented. Recommended iodine and foam dressing changing every one to two days, no open areas on the buttocks noted. Continue use of barrier cream to prevent ulcers. In addition, a hospice wound nurse evaluated the right heel and provided suggestions and new orders. The coccyx was also observed to be red, blanchable and excoriated. "Continue to monitor and measure areas." 14) 11/6/15 updated orders instructed the staff to clean the wound on heel area, apply Betadine to wound base, apply foam dressing, measure wound and document with each dressing change, change every two days or as needed. NN and weekly nursing summary notes reiterated the hospice nurse's observations and only generally noted the right heel wound, red buttocks, and daily treatments. However, weekly wound measurements, staging, and descriptions of the skin was not specifically documented. When interviewed on 11/4/15, at 8:30 a.m. the hospice nurse verified R43 developed a PU on the heel which had worsened. She was unaware of wound measurements, or the current treatment plan and interventions for the PU. She was also unaware of the PUs on the resident's coccyx, and wound information had not been provided by facility staff. The hospice nurse reported she had	F 314		

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F 314	Continued From page 53 only worked with R46 for the past couple months, and another hospice nurse worked with the resident prior to this. LPN-C reported on 11/6/15, at 7:40 a.m. that the NAs were supposed to follow the resident's care sheets. She said R46 had refused to wear the protective boots at times, so they stopped offering them as an intervention, although was unsure the date they were discontinued. LPN-C said instead, he was currently wearing gripper socks, and some new boots had been ordered. R46's current NA assignment sheet instructed the staff to turn and reposition the resident every two hours side to side, to ensure he was only up for ½ hour after meals due to wounds, and ensure he was wearing the blue Prevalon boots on "both feet at all times." On 11/5/15 at 7:30 a.m. NA-B explained that the facility nurse took care of R46's PUs. NA-B said the only interventions she provided for R46 was to make sure he was wearing socks and offload the resident at times. NA-B said R46 did not utilize heel protectors and had refused to wear protective boots. The hospice care plan included weekly skin monitoring by facility staff, and then contacting the hospice nurse with any change in skin condition and/or the status of the PUs. On 11/5/15, at 9:02 a.m. the DON verified the weekly wound measurements had not been completed, stated the resident just saw a hospice wound nurse "yesterday" and it was determined the heel ulcer was now unstageable. The facility's undated Skin Integrity Guideline's	F 314		

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F 314	Continued From page 54 purpose was, "To provide a comprehensive approach for monitoring skin conditions. To decrease pressure ulcer and wound formation by identifying those patients/residents who are at risk, and implementing appropriate interventions; To promote healing of any wounds of any etiology, whether admitted or acquired." The policy directed the DON to implement and monitor the skin integrity program, develop a routine schedule to review wounds or persons at risk weekly, utilize IDT approaches such as addressing problems, goals, and interventions directed toward prevention of skin concerns, notifying persons such as therapy and the registered dietitian for nutritional interventions. The licensed nurse was to perform weekly skin evaluations and identity wounds on the Wound Evaluation Flow Sheet. The care plan was to be implemented evaluated and revised based on the needs of the resident. "If patient/resident is refusing or choosing not to receive treatment, review risks, benefits, and alternatives. Re-evaluate and attempt other interventions." The undated Wound Evaluation Flow Sheet was to be completed for "each pressure and non pressure wound. The accuracy and thoroughness of the Flow Sheet will assist in identifying risks and appropriately establishing a Plan of Care...It is updated at least weekly, reviewing status/changes in wound from the previous week, updating MD and family." The assessment was to include staging, measurements and a description of the wound as specified in the policy.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 55 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to minimize the risk of injury for 2 of 4 residents (R6, R51, R76, R86) reviewed for accident hazards. Findings include: R6 was heard calling out from the adjoining hallway on 11/3/15, at 9:08 a.m. When the surveyor entered her room, she was found in her bathroom waving a clean incontinent product and asking for help. Although her wheelchair was in close proximity, it was placed at an angle she would have been unable to self-transfer. The bathroom call light was activated by the surveyor. Three facility staff walked past but failed to stop and assist R6. At 9:11 a.m. the surveyor observed a nursing assistant (NA)-B in the hallway and asked her to assist R6. Although NA-B was not her primary NA, she did not think R6 was to have been left alone in the bathroom. She proceeded to assist R6 with toileting. At 9:46 a.m. a licensed practical nurse (LPN)-C stated she was uncertain if R6 was safe to be left in her bathroom unattended. The Care Assessment Are (CAA) for falls dated	F 323	F323 E -R51, 6, 76, and 86 are provided with supervision and assistance to prevent falls/accidents. R76 has not had a fall since 5/1/15. R86 has not had a fall since 7/5/15. -Residents identified as at risk for falls have the potential to be affected. -Nursing staff will be educated to provide falls/accident interventions, as identified in the care plan. -Random weekly audits, of residents identified as falls risks, will be conducted to ensure appropriate falls interventions are in place. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 323	Continued From page 56 3/4/15 described R6 as a fall risk, required assist of one staff for transfers and ambulation, was legally blind and hard of hearing. It directed staff to place call light within reach. Upon review of R6's Fall Scene Investigation and Incident Reports, a fall occurred on 4/29/15 in her bathroom. An intervention was initiated, "Have NAR [nursing assistant registered] stay with patient while she is toileting." On 7/18/15, R6 had an unwitnessed fall and was found sitting behind her bathroom floor. Although a neurological assessment was initiated and vital signs were taken, no fall interventions or recommendations were not put in place. R6's Admission Record diagnoses include: low vision, hearing loss and anxiety. A Brief Interview for Mental Status score dated 8/5/14 is 3 of 15 indicating severe cognitive impairment. A Clinical Health Status--Risk for Falls score, dated 8/5/15, was 20 of 23 indicating R6 was not at risk for falls. On 8/6/15 R6 had an unwitnessed fall without injury in her room. The Post Fall Analysis Plan to place anti-roll brakes on her wheelchair was initiated. On 8/10/15, the Interdisciplinary Team (IDT) Review and Recommendations was for therapy to assess for anti-roll brakes. Physical Therapy (PT) and occupational therapy notes (7/24/15 through 8/24/15) lacked assessment for anti-rollback brakes. On 8/18/15, R6 had another fall without injury. The IDT's recommendation was to "Adjust anti-roll brakes." R6's care plan was revised that	F 323		

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F 323	Continued From page 57 date to indicate the resident was at risk for falls due to poor safety awareness, required assistance to transfer/ambulate, and received daily anti-depressant medication. The care plan directed staff to stay with resident in the bathroom to prevent falls and to keep the call light within reach of resident. In addition, the NA Assignment Sheet directed staff to stay with the resident while toileting to prevent falls. R6 had an unwitnessed fall on 10/14/15 in her room. The Post Fall Analysis interventions were to anticipate resident's needs and assist with transfers as resident allowed. A review of R6's Minnesota Incident Reports indicated R6 experienced two falls within the last 30 days on 10/12/15 and 10/14/15. No injury was reported. On 11/5/15, at 1:47 p.m. the assistant director of nursing (ADON) explained, "When a fall occurs, interventions are put into place. I expect all interventions to be carried through." An interview with the maintenance staff on 11/5/14, at 1:23 p.m. revealed a work order to apply anti-lock brakes on the wheelchair used by R6 was not received and therefore was not completed. At 1:25 p.m. R6 was observed in the common area near the main entrance. R6's wheel chair did not have anti-roll brakes. The director of nursing verified the resident's wheelchair did not have anti-roll brakes at 1:47 p.m.. The ADON said, "When a fall occurs, interventions are put into place. I expect all interventions to be carried through."	F 323		

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F 323	Continued From page 58 On 11/6/15, at 10:10 a.m. R6 was observed in her bed with the telephone in her hand. Her call light was on the floor behind the headboard. She stated, "Are you here to take me to the hospital? I need to go to the hospital." LPN-C came to assist R6 and explained she was not "really" capable of using her call light. R51 was observed participating in physical therapy (PT) on 11/5/15, at 8:04 a.m. She was assisted by one staff to ambulate and complete sit to stand exercise. At 8:39 a.m. R51 was observed sitting in her room. She was in her wheelchair and held a large basin in her hands. R51 was diaphoretic (perspiring) and vomiting into the basin. Her call light was wrapped around the rail on her bed. The bedside table was in front of the rail. When asked, R51 stated she could not reach her call light. At 8:41 a.m. the surveyor called the NA-A into the room. NA-A verified the call light was not within R51's reach "especially with the table in the way." NA-A explained that she believed a PT staff brought R51 to her room. At 8:43 a.m. the ADON also verified the call light was not within reach for R51. She stated, that all staff, including therapy, was required to place a call light within reach of a resident when in their room. The (undated) Admission Record revealed diagnoses including fractures, macular degeneration (poor vision), osteoarthritis (brittle bones) and dizziness. The CAA for falls, dated 1/10/15, indicated R51 is at risk for falls, required	F 323		

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F 323	Continued From page 59 extensive assistance to complete cares and despite memory issues her cognition was intact and verified by a BIMS score of 15/15 (10/1/15 was 11/15 indicating R51 mild cognitive impairment). Upon review of R51's Fall Scene Investigation and Incident Reports, an unwitnessed fall in her bathroom occurred on 7/17/15. The IDT Review and Recommendations dated 7/22/15 was to "assess for toileting plan." Another unwitnessed in R51's room occurred on 8/26/15. Although neurological assessments were completed, the fall recommendations lacked implementation of new or useful interventions to minimize reoccurrence of falls. The care plan for R51 revised 10/12/15, noted the resident was at risk for fall related to fall history and daily use of anti-depressant medication. She had a fall with hip fracture 10/13/15. The care plan directed staff to keep call light available and in easy reach. The Golden Living NA/R Assignment sheet also noted R51 was at risk for falls. The Clinical Health Status--Risk for Falls score, dated 10/18/15, was 16 of 23 indicating R51 was at risk for falls. On 11/5/15, at 1:47 p.m. the ADON explained, "When a fall occurs, interventions are put into place. I expect all interventions to be carried through." She that Neither a Bowel and Bladder or Toileting assessment had been initiated. The ADON further acknowledged that an appropriate intervention was not put into place stating to assist resident as she allowed and to keep	F 323		

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F 323	Continued From page 60 environment clean were standards of practice. During an interview on 11/6/15, at 9:12 a.m. the administrator stated she would have expected a resident never to be left alone without easy access to a call light unless it was an emergency situation, especially if the resident was at risk to fall. She expected staff to follow the care plan and carry out all interventions for each resident. The Falls Management Guideline, indicated following a resident's fall: the licensed nurse would assess resident for injuries, provide necessary treatment, and to initiate a "Change of Condition Report-Post Fall/Trauma, notify representative, implement appropriate interventions and update the care plan. The IDT reviews the Change of Condition Report and makes additional recommendations within 72 hours." R86's room was observed on 11/2/15, at 3:33 p.m. Two grab bars were attached to the bed; one on each side. Both grab bars were very loose and swayed back and forth at least one and half inches to two inches when the bars were touched. R86 stated that she used the grab bars for repositioning and transfer and acknowledged they were loose. R76's room was observed on 11/3/15, at 9:07 a.m. Two half side rails were attached to the bed, one on each side. The right side rail was very loose and swayed back and forth at least one and half inches to two inches when the rail was touched. During a follow-up observation on 11/4/15, at 9:57	F 323		

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F 323	Continued From page 61 a.m. R76 was observed lying on her bed eyes open. Side rail was checked and was still loose. R76 stated that she used the side rail when in bed for repositioning and described the rail as "weak." During an interview on 11/4/15, at 10:32 a.m. licensed practical nurse (LPN)-H verified that both R86's grab bars and R76's right side rail were not fitting properly on the beds. LPN-H stated NAs were supposed to be reporting any loose rails to the nurses or start a maintenance order electronically if they observe any issues. LPN-H stated, "I should also check but I haven't been to these rooms lately, and I usually don't get residents up." During an interview on 11/4/15, at 10:44 a.m. LPN-C stated that her expectation was nurses and NAs should have been reporting loose side rails and making sure work orders were placed. LPN-C stated, "Side rails are safety concerns, and having them loose is a major issue. I will call maintenance to come and fix it right away." Later at 10:48 a.m. house keeping supervisor who was on the floor reported that he would fix the side rails as "The maintenance director is not here yet." During an interview on 11/4/15, at 12:27 p.m. NA-D stated that it was everyone's responsibility to check on the side rails. NA-D stated that if side rails are loose, "We are supposed to put an order in the computer and maintenance is responsible to fix it." Later that afternoon at 1:20 p.m. facility maintenance director (FMD) was interviewed.	F 323		

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F 323	Continued From page 62 The FMD explained that if a side rail was loose, That is definitely a safety issue because a resident can grab the bar and fall off." FMD stated he performed quarterly audits of rooms and checks of side rails. Nursing staff was supposed to utilize the maintenance online order form. The FMD acknowledged "Sometimes we have new staff who does not know what to report, and I have been educating them." On 11/4/15, at 1:37 p.m. R76 and R86's rooms were observed and the side rail and grab bars were observed to be fixed and fitting properly on the beds. R76's significant change Minimum Data Set (MDS) dated 7/31/15, indicated R76 had severely impaired cognitive skills. MDS also indicated R76 required one staff extensive assist with bed mobility and two staff extensive with transfers. R76's care plan dated 10/29/15, identified a physical functioning deficit related to self-care impairment, mobility impairment. Among the interventions identified were assistive devices, two half side rails, bed mobility assistance: assist of 1-2 with turning and repositioning in bed with the use of the rails. R86's significant change Minimum Data Set (MDS) dated 10/16/15, indicated R86 was cognitively intact. MDS also indicated R86 required one staff limited assist with bed mobility and transfers. R86's care plan dated 10/8/15, identified a physical functioning deficit related to self-care impairment, mobility impairment. Among the interventions identified were assistive devices,	F 323		

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F 323	Continued From page 63 two grab bars, bed mobility assistance, and it was noted the resident was able to reposition herself using the two bars and staffs' assistance as needed. A facility's undated Bed Rail Guideline directed, "Residents with bed rails have appropriate assessments completed. There is evidence of multidisciplinary approach to bed rail utilization. There is evidence that risk and benefits were explained to resident and that the 'Guidance on Bed Rails' brochure was given to and discussed with the resident."	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fluid restrictions were monitored for 1 of 1 resident (R133) reviewed for dialysis. Findings include: R133 explained during an interview on 11/4/15, at 8:53 a.m. he had dialysis at DaVita on Tuesdays, Thursdays and Saturdays at 5:30 a.m. When he returned from dialysis he ate lunch. A full pitcher of ice water was observed on R133's over the bed table. R133 explained staff filled his water pitcher each shift.	F 327	F327 D -R133s fluid restriction is monitored. -Residents on a fluid restriction have the potential to be affected. -Licensed staff will be educated to ensure residents on a fluid restriction are monitored for daily intake of fluids. -Random weekly audits will be conducted to ensure fluid restriction monitoring is completed. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 327	Continued From page 64 R133's admission Minimum Data Set (MDS) dated 10/27/15, indicated the resident was cognitively intact and had diagnoses including end stage renal failure. R133's care plan dated 10/28/15, indicated a potential for nutritional risk due to therapeutic diet, fluid restriction, end stage renal disease and dialysis. Interventions included restricting fluids to 1500 ccs, 360 ccs per meal (1080 ccs provided by dietary staff at meals and 460 ccs by nursing). The total amount, however, was 40 ccs greater than the 1500 cc restriction. R133's care plan lacked direction for staff to monitor R133's daily weight and record intake per shift. During an interview on 11/4/15, at 8:56 a.m. a licensed practical nurse (LPN)-A stated R133's meal and fluid intake were charted by nursing and recorded on the medication administration record (MAR) or the treatment administration record (TAR). When LPN-A went to R133's MAR and TAR, however, she was unable to locate the intake records. LPN-A stated, "I guess it's not on the MAR or TAR...All there is is his fluid restriction of 1500 ccs." LPN-A and a registered nurse (RN)-A both verified fluid intakes were not being monitored or recorded for R133 per shift. A phone interview was conducted on 11/4/15, at 10:18 a.m. with R133's dialysis nurse (RN)-E. RN-E explained when R133 arrived at the dialysis unit, the MAR only indicated he was on a 1500 cc fluid restriction. RN-E verified she had never actually seen evidence R133's daily fluid intake was being recorded on the records he brought to dialysis. In an interview on 11/5/15, at 7:05 a.m. LPN-E	F 327		

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F 327	Continued From page 65 verified he was assigned to care for R133 that day. LPN-E explained he was new to the floor and would need to review R133's care plan. LPN-E then verified that although staff should have been recording R133's fluid intake, it was not being completed. R133's nursing notes lacked documentation indicating fluids were being restricted, nor whether he was staying within the allotted daily amounts. In addition, R133's MAR and TAR for 10/15 and 11/15 was reviewed and lacked any indication staff was to record fluid intake. A facility policy and procedure was requested, but was not provided.	F 327		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 411	F411 D -R17 has been offered Dental services. -All residents have the potential to be affected. -SS has been educated regarding the need to offer dental services upon admission and with all care conferences. -Weekly audits will be conducted with care conferences to ensure appropriate services are offered to residents. Audit results will be presented at QA&A for review and action planned as needed. -SS Director or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 411	Continued From page 66 review, the facility failed to ensure dental services were provided for 1 of 2 residents (R17) reviewed for dental services. Findings include: R17 was observed on 11/2/15, at 3:28 p.m. and was noted to be edentulous (absent of teeth). When R17 was asked, he explained he had a full set of dentures but did not wear them "because they hurt." A Clinical Health Status report dated 5/21/15 indicated R17 was edentulous. The Apple Tree Dental MDS 3.0 (Minimum Data Set) Oral/Dental Form dated 7/2/15, noted R17 had loosely fitting full dentures without natural teeth. The Dental Care Referral Recommendations included "routine dental referral, non-urgent dental care needs to reline dentures (?)." The MDS dated 9/16/15, identified R17 had a broken or loosely fitting full or partial dental, have no natural teeth or tooth fragments, received a mechanically altered diet (soft foods), and was able to understand and be understood by others. An Admission Record diagnosis included dysphagia (difficulty swallowing), with an onset date 5/20/15. The corresponding dental Care Area Assessment, dated 9/16/15, read, "Resident is edentulous but wears an upper and lower denture. He has loose fitting dentures per oral/dental form 7-2-15. Routine dental referral recommended. Non-urgent dental care needs. Reline dentures? Nsg [nursing] brushes dentures	F 411		

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F 411	Continued From page 67 and assists with oral care. No c/o [complaints of] pain or discomfort...." R17's physician's orders included a regular diet with pureed meat texture, nectar thickened liquids (start date 9/16/15), diet upgrade to mechanical soft textures (date not noted) house supplement (start date 9/22/15), and diet order change from nectar thick to thin liquids (no start date). The care plan, revised 9/24/15, directed staff to assist with oral care, brushing upper and lower dentures. Dental exams as necessary. During an interview on 11/4/15, at 9:38 a.m. a licensed practical nurse (LPN)-C stated after the oral assessment on 7/2/15, there was no follow-up to reline R17's dentures and no further dental appointments were made. She explained the person in charge of the referrals was not working there any longer and did not know who was responsible to follow through with the referrals. LPN-C stated R17's dentures had been "missing for quite some time." She explained a dentist visited in-house twice times each year. LPN-C called R17's family, both his son and his sister denied having the dentures. R17's son stated he was "fine" with having the dentures relined if that was what his father wanted. R17 was later observed eating a meat sandwich at 10:25 a.m. When asked if he had any difficulty eating the sandwich without dentures he replied in a sarcastic tone, "No shit" and reiterated he wished he had dentures. On 11/5/15, at 10:17 a.m. a nursing assistant, (NA)-A explained R17's oral cares included	F 411		

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F 411	Continued From page 68 rinsing his mouth with mouth wash. She had started caring for R17 "sometime after July" but never witnessed the resident having dentures. On 11/6/15, at 9:30 a.m. LPN-C stated that although the dentures "have not been around for months," an investigation into their whereabouts was not initiated because she was unaware the dentures were missing. LPN-C stated the facility would look into replacing the dentures, particularly the upper dentures. On 11/6/15, at 11:11 a.m. the administrator explained that when a referral was made, the charge nurse needed to follow through to ensure services were arranged. The administrator stated, "I would expect that something would have been done by now." A policy on dental services was requested but not provided.	F 411		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		

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F 431	Continued From page 69 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medication was properly labeled with resident name and/or opened date for 1 of 1 resident (R125) reviewed for medication storage. Findings include: R125's inhalation medication Symbicort and Spiriva (to aid in breathing) were prepared for administration on 11/3/15, at 10:00 a.m. by a licensed practical nurse (LPN)-B. was observed preparing R125's inhalation medications of . LPN-B handed R125 his Spiriva inhaler and R125 inhaled the medication, followed by the Symbicort inhaler. R125 administered two puffs and handed the inhaler back to LPN-B, who then walked away	F 431	F431 D -R125's medication is properly labeled with resident name and open date. -Residents receiving medication have the potential to be affected. -Licensed Nurses will be educated to ensure that medication is properly labeled with resident name and date opened, as needed. -Random weekly audits will be conducted to ensure medication is appropriately labeled with resident name and date opened, as needed. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015	

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F 431	Continued From page 70 and placed both inhalers into the medication cart. Neither the Symbicort nor the Spirvia inhaler were labeled with R125's name and the Symbicort inhaler lacked an opened date. LPN-B verified the inhalers lacked R125's name and a opened date on the Symbicort. LPN-B explained that R125's inhalers were stored in the same place, but she did not know when the Symbicort inhaler would have been considered expired once opened. When asked how it would be determined whether the inhaler should have been considered expired if the opened date was not recorded LPN-B shrugged his shoulders and said, "I don't." LPN-B explained that the facility had not offered annual training related to medication administration nor were random audits conducted of medication passe. Instruction was, however, offered when a new medication was put into the medication cart for administration. R125's admission Minimum Data Set dated 9/30/15, indicated diagnoses including dementia and chronic obstructive pulmonary disease (COPD). R125's care plan dated 10/6/15, indicated an alteration in respiratory status due to COPD, with a goal to remain free of worsening symptoms. Interventions were to administer medications as ordered. Also noted was impaired communication and cognition. R125 required verbal cues from staff to completed activities of daily living, and staff was to anticipate his needs and provide assistance with oral care. R125's 11/15, medication administration record (MAR) directed staff to administer Spiriva inhaler a capsule of 18 micrograms (mcg) once daily and	F 431		

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F 431	Continued From page 71 Symbicort aerosol inhaler of 160-4.5 mcg 2 puff orally twice daily. Staff was also to offer a glass of water to rinse out the mouth after using the inhaler device. During an interview on 11/3/15, at approximately 10:30 a.m. LPN-C verified R125's Symbicort and Spiriva inhaler was not labeled with his name nor was there an opened date on the Symbicort. LPN-C stated she could not remember but believed Symbicort would have been viable for 32 days once opened. LPN-C stated she would removed R125's Symbicort from the cart and disposed of it, since it did not contain and opened date. She would ensure the Spiriva was labeled with R125's name. On 11/5/15, at 7:42 a.m. the surveyor inspected the medication cart again where R125's medications were stored. When asked to see R125's Symbicort and Spiriva inhalers, both lacked the resident's name on the container. LPN-F stated he was the nurse assigned to care for R125 and pass medications that day. LPN-F verified both of R125's inhalers should have been labeled with his name, but were not. That same day at 7:54 a.m. LPN-C verified R125's Symbicort and Spiriva inhalers lacked R125's name. LPN-C stated it was the expectation nurses labeled new medication with the resident's names and record the opened date when the medication was put into use. The 2012, Symbicort manufacturer's instructions directed the user to "Throw away Symbicort when the counter reaches zero or 3 months after you take it out of its foil pouch, whichever comes	F 431		

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F 431	Continued From page 72 first." The facility's 1/6/15, Storage of Medication policy indicated "Medications and biologicals are stored properly, following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administrations."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F441 E -The glucometer is disinfected to acceptable standards for R75 and, 80 to minimize the potential spread of infection. R114 and R93 are no longer residents at this facility. -Residents requiring the use of a glucometer or the performance of wound care have the potential to be affected. -Licensed staff will be educated on the acceptable standard of disinfection of the glucometer and the appropriate washing of hands before, during and after the provision of wound cares. -Random weekly audits will be completed to ensure compliance with appropriate infection control procedures during the use of the glucometer and the performance of wound cares. Audit results will be presented at QA&A for review and action planned as needed. -DNS or Designee is the responsible party. -Corrective action will be completed by 12/16/2015.	

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F 441	Continued From page 73 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate hand washing by staff during a dressing change to minimize the risk of spreading infection. This had the potential to affect 1 of 3 (R93) residents reviewed for pressure ulcers. In addition, a multi-use glucometer (used to measure blood glucose) was disinfected according to acceptable standards to minimize the potential spread of infection for 3 of 8 residents (R75, R80, R114) who utilized a shared glucometer, and potentially affecting the 8 residents who shared the glucometer. Findings include: R93's pressure ulcer dressing changes were observed on 11/2/15, at 3:11 p.m. by a licensed practical nurse (LPN)-H. One of these wounds was located near the resident's rectum, and its dressing was soiled with stool as well as wound drainage. After entering the room, LPN-H did not wash her hands prior to starting the bedside preparation step of the dressing change procedure. She appropriately placed a clean field for the clean dressing supplies, and laid out those	F 441		

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F 441	Continued From page 74	F 441		

unopened packages. She then put on clean gloves to open the packages of dressing supplies, but without first washing her hands.

LPN-H next removed the old, stool and drainage-soiled dressing and discarded it appropriately (considered "dirty" part of a dressing change because of the possibility of contamination of clean surfaces and supplies by the bacteria in wound drainage). She then removed her used gloves and without performing either soap-and-water or alcohol gel hand washing, and put on another pair of clean gloves.

She cleaned the wounds with a spray and protected the surrounding skin with a skin prep pad. LPN-H then changed gloves again without hand washing between used and clean gloves. She placed the new dressing. She removed the used gloves, and repeated the whole process to change a soiled dressing at the gastric tube site on R93's abdomen. She again changed gloves at the appropriate times during the second dressing change, but without the appropriate hand washing between used glove removal and new glove placement.

At 3:18 p.m. on 11/2/15, LPN-H finally was observed performing soap/water hand washing at the resident's sink. She admitted, "I washed before and after the dressing change. I usually wash in between steps, but today I forgot."

A review of the facility's policy, Handwashing/Hand Hygiene indicated routine hand hygiene was to include using alcohol-based hand rub or soap and water for the following situations: before handling clean or soiled dressings, before moving from a contaminated

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F 441	Continued From page 75 body site to a clean body site during resident care, after handling used dressings, and after removing gloves. The policy further directed hand washing as the final step after removing and disposing of [gloves], and warned: "The use of gloves does not replace hand washing/hand hygiene." The director of nursing stated, on 11/6/15, at 8:45 a.m. "I would have expected to see soap and water hand washing before the start of the dressing, and re-washing with soap and water afterward," as well, he indicated, as use of alcohol hand wash between discarding dirty gloves and re-gloving with clean ones. During an observation on 11/5/15, at 7:12 a.m. a licensed practical nurse (LPN)-E went into R114's room to perform his blood glucose check with a glucometer. LPN-E washed his hands, applied gloves, obtained a blood sample via a fingerstick from R114's finger and touched the end of the glucometer strip to the blood sample. After obtaining the numerical results, LPN-E took the glucometer back to the nursing station, removed one antimicrobial bleach wipes from it's container and wiped off the glucometer for 20 seconds. When asked how long do you clean the glucometer with the bleach wipe? LPN-E replied for 2 minutes, the surveyor asked LPN-E was that 2 minutes? He said "No, I just leave it here to dry, once it's dry then I [LPN-E] can use if for another resident." LPN-E explained the 300 wing has only one glucometer that is shared among the diabetic residents. LPN-E stated he is not sure what the facility's policy is on cleaning glucometers, but believes you have to let the glucometer soak for 2 minutes.	F 441		

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F 441	Continued From page 76 The same day at 11:51 a.m. during an continuous observation LPN-D was observed performing a blood glucose check on R75. LPN-D washed her hands, applied gloves, obtained a blood sample via a fingerstick from R75's finger and touched the end of the glucometer strip to the blood sample. After obtaining the numerical results, LPN-D took the glucometer back to the nursing cart locked it up without disinfecting the glucometer. Then at 11:58 a.m. the same day during the continuous observation, LPN-D removed the same glucometer and performed a blood glucose check on R80. LPN-D brought the glucometer back to the medication cart and locked it away without disinfecting it before or after it was used. LPN-D said, "I'm done with all the blood glucose for today." When asked about the proper cleaning of the glucometer, LPN-D said, "oh ya, I did not clean it after use," and verifier their is only one glucometer that is used for all the diabetic resident on the 100 wing. During an interview on 11/5/15, at approximately 12:20 p.m. the director of nursing (DON) stated his expectation for staff is to follow the facility's policy and procedures on how to clean glucometers. The DON explained the meters should be clean with alcohol for 1 minutes then wrapped up for 1 minute. A review of facility's training on blood glucose meters on 11/6/15, at 9:27 a.m. indicated both LPN-D and LPN-E attended the inservice on 10/16/15. An interview on 11/6/15, at 9:27 a.m. with the director of clinical education stated she is the person who does the staff training for blood glucose meters. The director of clinical education verified both LPN-D and LPN-E were trained on the blood glucose meter from her and she would	F 441		

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F 441	Continued From page 77 expected them both to follow the facility's cleaning policy and procedure. The 6/13, Professional Blood Glucose Monitoring System (EvenCare G3) User's Guide under the Cleaning and Disinfection Procedure for the Meter section indicated "The EvenCare G3 Meter should be cleaned an disinfected between each patient. Wipe all external areas of the meter including the front and back surfaces until visibly wet. Allow the surface of the meter to remain wet at room temperature for at least 1 minute and allow to air dry." A facility policy and procedure for glucose disinfecting was requested, but was not provided. However, the facility's undated EvenCare G3 Meter Skills Checklist was provided. The checklist instructed staff to clean the meter between each resident, wipe thoroughly with the antimicrobial wipe and allow the surface of the meter to stay damp and then dry for at least one minute to disinfect the meter.	F 441		
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an	F 496		

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F 496	Continued From page 78 individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 newly hired nursing assistants reviewed, were active on the state nursing assistant registry. This had a potential to impact all 62 residents residing in the facility. Findings include: During the abuse prohibition investigation, a review of newly hired employee (E) files was completed and revealed the following: 1) E1 was NA-E who had a hire date of 10/29/15. There was no documentation of NA certification verification and no evidence of abuse training prior to working directly with residents. 2) E2 was NA-F who had a hire dated of 9/1/15.	F 496	F496 -All facility employed nursing assistants have documentation of NA certification, documentation of completed background checks, and have completed abuse training. -All residents have the potential to be affected by the alleged practice. -Facility management has been educated on the requirements for completed background check, Vulnerable adult abuse training, and NA certification prior to serving as a nurse aide. -Audits of new CNA hires will be completed prior to working with residents to ensure all necessary paperwork is completed and included in CNA personnel file. -ED, Staffing, and Business Office Manager, or Designee is the responsible party. -Corrective action will be completed by 12/16/2015.	

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F 496	Continued From page 79 There was no documentation of a back ground check being completed, no NA certification verification and no evidence of abuse training prior to working directly with residents. During an interview on 11/6/15, at 8:15 a.m. the ED stated that the company was utilizing a new hiring system which has caused "some things to be missed out." ED verified the screening documentation was missing from the employees' files and abuse training was missed due to "changes." The ED explained that the hiring managers were responsible for making sure all paper work is in place but, "Unfortunately we do not have any human resource on site." An interview with the state nursing assistant registry representative on 11/20/15, at 12:00 p.m. revealed NA-E and NA-F were both active on the nursing assistant registry. However, the interview revealed that the facility requested the letters from the state registry on 11/5/15. Even though NA-E and NA-F were enlisted on the nursing assistant registry, the facility did not ensure that they were listed before hiring them. NA-E was hired on 10/29/15 and NA-F was hired on 9/1/15 but the facility did not request letters from the state agency until 11/5/15 after the state surveyor had pointed it out.	F 496		

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	245324	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on November 04, 2015. At the time of this survey, Golden Livingcenter-Bloomington was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC OK 12-29-15 Conduct PCR with FMS PCR. Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with the facts or conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. RECEIVED DEC 29 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	12/29/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/04/2015

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter-Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. In 1999, an addition was constructed and was determined to be Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 61 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 99 and NFPA 70 The National Electric Code. This deficient practice could affect the resident. Findings include: On facility tour between 9:30 AM and 12:30 PM on 11/04/2015, observation revealed that resident room 300 had a medical device (tube feeding pump) that was plugged into a powerstrip and not directly plugged into a wall outlet. This deficient practice was verified by the Administrator at the time of the inspection.	K 147	**K 147** Facility has ensured that no medical devices are plugged into power strips, and are plugged directly into a wall unit to meet code requirements. Random visual inspections will be completed. Date of compliance 11/4/15. Emily Jenkins, Executive Director and Tim Graber, Director of Maintenance are responsible for correction and monitoring to prevent reoccurrence.	