DEPARTMENT OF HE			D CEDTIEI(	TATION	CENTERS FOR ME	DICARE & MEDICAID SERVICES
	-		-		TE SURVEY AGENCY	ID: W6S5 Facility ID: 00953
1. MEDICARE/MEDICAID PR (L1) <b>245184</b> 2.STATE VENDOR OR MEDIC (L2) <b>690925600</b>	OVIDER NO.	3. NAME AND AI (L3) GOLDEN L (L4) 501 EIGHT (L5) ROCHESTH	DDRESS OF FAC IVINGCENTI H AVENUE SC	CILITY E <b>R - ROC</b> I	HESTER EAST	4. TYPE OF ACTION:     7       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
	<b>06/17/2015</b> (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
<ul> <li>11LTC PERIOD OF CERTIFIC From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	LATION 116 (L18) 116 (L17)	Complianc 1. A B. Not in Con	nce With equirements e Based On: .cceptable POC npliance with Prog	gram	2. Technical Personnel     3. 24 Hour RN     4. 7-Day RN (Rural St     5. Life Safety Code	7. Medical Director
13. Total Certified Beds		Requirem	ents and/or Appli	ied Waivers:	* Code: <b>A</b> *	(L12)
14. LTC CERTIFIED BED BRE	AKDOWN				15. FACILITY MEETS	
18 SNF 18/19		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L3	16 38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY	REMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Kyla Einertson, H</u>	HFE NE II	0	06/30/2015	(L19)	Kamala Fiske-Downing	, Enforcement Specialist 06/30/2015 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RH	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELI          1. Facility is Eligit          2. Facility is not E	ble to Participate		IPLIANCE WITI HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION <b>09/01/1972</b>	BEGINNINC	6 DATE	ENDING DA	TE	VOLUNTARY     0       01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	oo run to meet ig.coment
25. LTC EXTENSION DATE:	7)	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	9 32	. DETERMINATION	OF APPROVAL	L DATE	Posted 07/15/2015 Co.	
	(L32)	06/18/2015		(L33)	DETERMINATION APP	ROVAL



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

June 30, 2015

Ms. Dori Mutch, Administrator Golden Livingcenter - Rochester East 501 Eighth Avenue Southeast Rochester, Minnesota 55904

RE: Project Number S5184027

Dear Ms. Mutch:

On May 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2015. 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 June 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 29, 2015 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 standard survey, completed on May 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2015, effective June 28, 2015 and therefore remedies outlined in our letter to you dated May 22, 2015, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245184	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/17/2015
Name	e of Facility		Street Address, City, State, Zip Code	
GC	DLDEN LIVINGCENTER - ROCHES	TER EAST	501 EIGHTH AVENUE SOUTHE BOCHESTER, MN 55904	AST

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	(	Correction Completed 06/13/2015	ID Prefix	F0225	(	Correction Completed 06/13/2015		ID Prefix	F0226		Correction Completed 06/13/2015
	483.10(b)(11)					(1)(ii)-(iii), (c)(2	) -		Reg. # LSC	483.13(c)		
ID Prefix Reg. # LSC	F0241 483.15(a)	(	Correction Completed 06/13/2015	ID Prefix Reg. # LSC		(	Correction Completed 06/13/2015 )		ID Prefix Reg. # LSC	F0281 483.20(k)(3)	)(i)	Correction Completed 06/13/2015
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	(	Correction Completed 06/13/2015	ID Prefix Reg. # LSC	F0309 483.25	(	Correction Completed 06/13/2015		ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 06/13/2015
ID Prefix Reg. # LSC	F0315 483.25(d)	(	Correction Completed 06/13/2015	ID Prefix Reg. # LSC	F0323 483.25(h)	(	Correction Completed <b>06/13/2015</b>		ID Prefix Reg. # LSC	F0329 483.25(l)		Correction Completed 06/13/2015
ID Prefix Reg. # LSC	F0334 483.25(n)	(	Correction Completed 06/13/2015	ID Prefix Reg. # LSC	F0425 483.60(a),	(	Correction Completed <b>06/13/2015</b>		ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 06/13/2015
Reviewed		eviewed		Date:	_	nature of Surv	-	221			Date:	/17/2015
State Agen Reviewed I CMS RO		<u>GPN/kf</u> eviewed		06/30/20 Date:		nature of Surv		<i>44</i> 1			Date:	, 17 / 2013

#### **Post-Certification Revisit Report**

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(Y1)	Provider / Supplier / CLIA / Identification Number 245184	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/17/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
G	OLDEN LIVINGCENTER - ROCHEST	TER EAST	501 EIGHTH AVENUE SOUTHE ROCHESTER, MN 55904	AST

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).

Correction Completed 06/13/2015       Correction Completed 06/13/2015       Correction Completed 06/13/2015       Correction Completed 06/13/2015         Reg. # 433.60(b). (d). (e) LSC       Eq. # 433.65       Eq. # 433.75(o)(1)       Eq. # 433.75(o)(1)         Reg. # 1.SC       LSC       LSC       LSC       Eq. # 433.75(o)(1)         Reg. # 403.00(b). (d). (e)       LSC       LSC       Eq. # 433.75(o)(1)         Reg. # 403.00(b). (d). (e)       LSC       LSC       Eq. # 433.75(o)(1)         Reg. # 403.00(b). (d). (e)       LSC       LSC       Eq. # 433.75(o)(1)         Reg. # 40.00(b). (d). (e)       LSC       LSC       Eq. # 433.75(o)(1)         Reg. # 40.00(b). (d). (e)       LSC       LSC       Eq. # 433.75(o)(1)         Reviewed By       DS       Signature of Surveyor:       Date:         State Agency       GPN/kfd       06/30/2015       Signature of Surveyor:       Date:         Followup to Survey Completed on:       Signature of Surveyor:       Date:       Date:       Signature of Surveyor:       Date:         Followup to Survey Completed on:       Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?       YES       NO	(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
LSC       LSC       LSC         Reviewed By       Reviewed By       Date:       Signature of Surveyor:         State Agency       GPN/kfd       06/30/2015       31221       Date:         Reviewed By       Reviewed By       Date:       Signature of Surveyor:       Date:         State Agency       GPN/kfd       06/30/2015       31221       Date:         Reviewed By       Reviewed By       Date:       Signature of Surveyor:       Date:         Followup to Survey Completed on:       Check for any Uncorrected Deficiencies. Was a Summary of	ID Prefix	F0431		Completed	ID Prefix	F0441		Completed		ID Prefix	F0520		Completed
Reviewed By       Reviewed By       Date:       Signature of Surveyor:       Date:         State Agency       GPN/kfd       06/30/2015       31221       06/17/2015         Reviewed By       Date:       Signature of Surveyor:       Date:       06/17/2015         Reviewed By       Date:       Signature of Surveyor:       Date:       06/17/2015         Followup to Survey Completed on:       Check for any Uncorrected Deficiencies. Was a Summary of       Check for any Uncorrected Deficiencies. Was a Summary of	Reg. #	483.60(b), (d), (e)			Reg. #	483.65				Reg. #	483.75(o)(1)		
State Agency       GPN/kfd       06/30/2015       31221       06/17/2015         Reviewed By	LSC				LSC					LSC			_
State Agency       GPN/kfd       06/30/2015       31221       06/17/2015         Reviewed By													
Reviewed By     Reviewed By     Date:     Signature of Surveyor:     Date:       CMS RO     Date:     Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies.	Reviewed I	By Revi	ewed	Ву	Date:	Sig	nature of Sur	veyor:					
CMS RO       Followup to Survey Completed on:       Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies.	State Agen	cy GPN	V/kfc	1	06/30/20	015		31	221			0	6/17/2015
Linear and Definition (CMS 2567) Sont to the Equility?		3y Revi	ewed	Ву	Date:	Sig	nature of Su	veyor:				Date:	
	Followup t		ed on	:		Check f	for any Unco prrected Defic	rrected Defic ciencies (CM	ienci S-256	es. Was a 67) Sent to	Summary of the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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(Y1) Provider / Supplier / CLIA / Identification Number 245184	( <b>Y2) Multiple Cons</b> A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 6/29/2015
Name of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - ROCHEST	ER EAST	501 EIGHTH AVENUE SOUTHE ROCHESTER, MN 55904	AST

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)	ltem		(Y5)	Date
ID Prefix		(	Correction Completed <b>06/13/2015</b>	ID Prefix			Correction Completed 06/13/2015		ID Prefix			Correction Completed 06/13/2015
-	NFPA 101			•	NFPA 101				-	NFPA 101		
LSC	K0054			LSC	K0062				LSC	K0069		
		(	Correction				Correction					Correction
ID Profix			Completed 06/28/2015	ID Brofiv			Completed 06/13/2015		ID Brofiv			Completed 06/13/2015
	NFPA 101	(	JO/20/2015		NFPA 101		00/13/2015			NFPA 101		00/13/2015
-	K0143			-	K0144				-	K0147		
Reg. #			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
Reg. #			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
		(	Correction Completed						D //			
Reviewed I	By Rev	viewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen	су											
Reviewed E CMS RO	By Rev	viewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
	o Survey Comple 4/28/201				Check for any Uncorrected					Summary of the Facility?		NO

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION	AND TRANSMITTAL	ID: W685
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00953
1. MEDICARE/MEDICAID PROVID           (L1)         245184           2.STATE VENDOR OR MEDICAID I           (L2)         690925600		3. NAME AND AL (L3) <b>GOLDEN L</b> (L4) <b>501 EIGHTI</b> (L5) <b>ROCHESTE</b>	IVINGCENTI H AVENUE SC	ER - ROC		4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 05/12/2006		7. PROVIDER/SU 01 Hospital	PPLIER CATEG	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 05/( 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>)4/2015</b> (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>
<ul> <li>11LTC PERIOD OF CERTIFICATIO</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> </ul>	<b>116</b> (L18)	Complianc	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	<b>116</b> (L17)		ents and/or Appli		* Code: <b>B</b>	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 116	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Marietta Lee, HFE NE II		0	6/08/2015	(L19)	Kamala Fiske-Downing.	Enforcement Specialist 06/16/2015 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBID</li> <li>1. Facility is Eligible to I</li> <li>2. Facility is not Eligible</li> </ol>	Participate		IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION <b>09/01/1972</b>	BEGINNINC	6 DATE	ENDING DA	ГЕ	VOLUNTARY     00       01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	oo run to meet igreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 06/18/2015 Co	
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7008 1830 0003 8091 4721

May 22, 2015

Ms. Dori Mutch, Administrator Golden Livingcenter - Rochester East 501 Eighth Avenue Southeast Rochester, Minnesota 55904

RE: Project Number S5184027

Dear Mr. Kallstrom:

On May 4, 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.

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.

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:

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring gary.nederhoff@state.mn.us Telephone: (507) 206-2731 Fax: (507) 206-2711

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 13, 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 June 13, 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

Golden Livingcenter - Rochester East May 21, 2015 Page 4

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 August 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Golden Livingcenter - Rochester East May 21, 2015 Page 5

### **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

		& MEDICAID SERVICES	0.00 1.00 1.77	1413 4 7015	B NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		WN Dept of Health	(3) DATE SURVEY COMPLETED
				Rochester	
		245184	B. WING	14ND 2011	05/04/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST	
GOLDEN	LIVINGCENTER - RC	CHESTER EAST		ROCHESTER, MN 55904	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	as your allegation o	f correction (POC) will serve f compliance upon the	F 00	Plan of Correction is not a leg admission that a deficiency exists of that this Statement of Deficience was correctly cited, and is also no	al or Cy ot
	bottom of the first p be used as verificat	otance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site		to be construed as an admission of fault by the facility, the Executiv Director or any employees, agent or other individuals who draft or ma	ve ts ay
	revisit of your facility validate that substa regulations has bee your verification.	y may be conducted to ntial compliance with the in attained in accordance with	5.45		n, is ot or
SS=D			F 15	agreement of any kind by the facilit of the truth of any facts alleged of the correctness of any conclusion set forth in the allegations.	or
	known, notify the re or an interested fam accident involving th injury and has the p intervention; a signit	sident's legal representative hily member when there is an he resident which results in otential for requiring physician ficant change in the resident's	1 hal	Accordingly, the Facility ha prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be file solely because of the requirement	of of d
	deterioration in heal status in either life to clinical complication significantly (i.e., a r existing form of trea consequences, or to treatment); or a dec	psychosocial status (i.e., a th, mental, or psychosocial hreatening conditions or is); a need to alter treatment need to discontinue an tment due to adverse o commence a new form of ision to transfer or discharge e facility as specified in	6/8/1 GPN	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.	at of o 9 s
	and, if known, the re or interested family change in room or re	o promptly notify the resident esident's legal representative member when there is a commate assignment as 5(e)(2); or a change in			

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.

2

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM MB NO	: 05/21/201 APPROVEI . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245184	B. WING		×	05/	/04/2015
	PROVIDER OR SUPPLIER	DCHESTER EAST		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST IOCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	regulations as spect this section. The facility must react the address and philegal representative This REQUIREMEN by: Based on document facility failed to notifigain for 1 of 1 resid dialysis treatments Findings include: R205 was admitted listed on the admissis stage renal disease mellitus. Review of physician revealed that reside and the nurse pract (NP/MD) should be weight increase of ti in a 24 hour period, increase of five (5) and When the admission assessment dated and documentation was admission weight weight increase	er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. NT is not met as evidenced Int review and interview the ty the physician of the weight ent (R205) reviewed who had three times weekly. on 4/20/15, with diagnosis sion record which included end (ESRD) and diabetes orders dated 4/20/15, ent weight was to be done daily itioner/medical doctor notified if the resident had a wo (2) to three (3) pounds (#) or if resident had weight	F1	157	-MD has been updated regard weight changes for R205. -All residents with a weight I condition change have the poter to be affected by the identi practice. -Licensed staff have been educa on Physician Notification for char of condition. Education do 5/21/15 -Random bi-weekly audits will conducted to ensure MD notificat is made timely. Audits will reviewed at QAPI and ac planned as needed.	oss ntial fied ated nge one be tion be tion the	6/13/13

Facility ID: 00953

If continuation sheet Page 2 of 86

		AND HUMAN SERVICES			FORM	: 05/21/201 APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY
		245184	B. WING		05/	/04/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTH ROCHESTER, MN 55904	IEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 157	Review of daily weige either the weights a and/or the treatmen revealed the followi 4/20/15-no weight r 4/21/15-108.2 # 4/22/15-108 # 4/22/15-109 # 4/22/15-109 # 4/26/15116.8 # (no 4/27/15-116.8 # (no 4/28/15- no weight i 4/28/15- no weight i 4/29/15-117 # (agai 4/30/15-no weight i 4/29/15-117 # (agai 4/30/15-no weight i 109#) to 4/26/15 (1 been notified of the 7.8 # (109#) to 4/26/15 (1 been notified of the hour period nor the baseline on 4/21/15 per the admission o During interview on director of nursing ( a renal diet and their available for staff re on the temporary ca assistant care guide During interview on DON verified the weight	ghts for R205 documented on and vitals summary printout at administration record (TAR) ng: ecorded recorded-Saturday of reported to physician) of reported to physician) recorded-Tuesday n not reported to physician) recorded ence the NP/MD had been weight increase from 4/24/15 16.8#). The NP/MD had not weight increase of 2-3 #'s/24 5# weight increase over (108.2#) to 4/26/15 (116.8#) orders. 4/29/15, at 3:00 p.m. the DON) verified R205 received re were no written instructions lated to dialysis care included are plan nor the nursing 3. 4/30/15, at 10:30 a.m. the eights as noted above and		57		
F 225		(c)(2) - (4)	F 22	25		
	7(02-99) Previous Versions			Facility ID: 00953	If continuation sheet	Dama 0 afr

		AND HUMAN SERVICES	_		FO	ED: 05/21/2015 RM APPROVED NO. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		245184	B. WING	à		05/04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/04/2010
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			01 EIGHTH AVENUE SOUTHEAST	
					OCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	ALLEGATIONS/INE The facility must no been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must ensi involving mistreatmo including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must hav violations are thoroup prevent further poter investigation is in pro- The results of all inv to the administrator representative and t with State law (inclu- certification agency) incident, and if the a	DIVIDUALS t employ individuals who have abusing, neglecting, or is by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment ppropriation of their property; vledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and ccordance with State law procedures (including to the rtification agency). ve evidence that all alleged ighly investigated, and must ntial abuse while the ogress.	F2	225	F225 Investigation has been completed into resident incidents for R4, R51, and R135. -All residents have the potential to be affected by the identified practice. -All staff will be educated of the requirement to report incidents of potential abuse/neglect immediately to the ED or designee and all reports of abuse/neglect will be reported to the appropriate state agency in a timely manner. The ED or designee will conduct all investigations to include interviews with employees, visitors, or residents who may have knowledge of the alleged incident. Education provided 5/21.6/2,6/4,6/9 -Random bi-weekly audits will be conducted of incident reports to ensure any allegations of abuse or neglect have been reported to the ED or designee in a timely manner, reported to the appropriate state agency and have been thoroughly investigated. Any required re- education will be conducted at that time. Audits will be reviewed at QAPI and action planned as needed. -ED/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

Facility ID: 00953

If continuation sheet Page 4 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245184	B. WING	·		05	/04/2015
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(7/5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ne 4		225			
	pa	VT is not met as evidenced	Γ4	220			
	by:						
		and document review, the ediately report allegations of					
	physical abuse to th	e administrator and					
		ency for 2 of 2 residents (R4 for resident to resident					
	altercations; and fai	led to report and initiate an					
		itential self abuse for 1 of 1 to had been identified as					
		ig to cause self-harm.			· · · · · ·		
	Findings include:						
		nge Minimum Data Set (MDS) ied R4 had no cognitive behaviors.					
	resident utilized an e mobility, and staff w	d 4/16/15, indicated the electric wheelchair for as instructed to remove the tially dangerous situations and who disturb her.					
	R51 had no cognitiv experienced behavior	6 dated 2/17/15, identified e impairment but had ors of screaming or cursing at during the 7 day look back					
	resident utilized an e	ed 4/29/15, indicated the electric wheelchair for mobility difficulty operating the ving it aggressively."					
	that R4 reported R5 wheelchair so he did	s notes dated 4/26/15, read 1 had push by her with his In't miss the elevator, and in t or jammed," R4's right					

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 5	F2	206	5		
		ediately complained of pain	.  .	220	5		
	and injury to her rig	ht hand and wrist, and R4 was					
		ncy Department (ED) for X-ray					
		nd no fracture was found. The er indicated, "Four letter					
		changed amongst the two					
		voices were heard "					
	During interview on	4/27/15 at 5:20 p.m. D4					
	stated recently she	4/27/15, at 5:30 p.m., R4 had tried to get off the					
	elevator with her ele	ectric wheelchair when					
		entified to be R51) was					
		vator in an electric wheelchair. d R51 to back up, and R51					
		sed verbal abuse toward R4					
	as R51 continued to	try to enter the elevator in his					
		R4 stated R51's wheelchair					
		stated she now has no feeling s of her right hand. R4 stated					
	she reported the inc						
	immediately, and we	ent to the emergency room					
	due to swelling in he	er the right hand. R4 stated					
	she is now wearing	oones in her hand, however, a splint and continues to have					
	pain in her right han	d and wrist.					
	Document review of	the Incident Submission					
		he state agency on 4/26/15,					
		verbal Abuse between R4					
		nt description read, "Resident ther resident [R4] in electric					
		o the elevator quickly; alleged					
	verbal altercation be	tween residents." The					
	Incident report indica	ated the incident occurred on					
		was not reported to the state wing day. Although the					
		ent to resident altercation					
	which resulted in inju						
		nt only referring to a verbal					

Facility ID: 00953

If continuation sheet Page 6 of 86

TAG     REGULATORY OR LISC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 225     Continued From page 6 altercation.     F 225       During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately.       An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report indicated no injury had been noted to the resident's neck. The report (unsigned by who had completed it) had also documented that the resident's neck. The report had intended to harm herself, but the resident had not responded. There was no documentation on the report, or in the resident's chart of any further investigation as to the issue of whether or not the resident was attempting to cause herself harm.       During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long.       The current care plan was reviewed 4/29/15.			AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GOLDEN LIVINGCENTER - ROCHESTER EAST       STREET ADDRESS, CITY, STATE, ZIP CODE         OW ID PREERX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OPRICENCY MUST BE PRECEDED BY FULL REACH OPRICENCY MUST BE PRECEDED BY FULL TAG       D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REPERENCE TO THE APPROPRIATE DEFICIENCY)       0(0)         F 225       Continued From page 6 aftercation.       F 225       F 225         During interview on 4/28/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident to 4/26/15, The administrator verified the resident to resident altercation was not reported to the state agency immediately.       F 225         An incident report for F135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report indicated on injury had been noted to the resident had been questioned as to whether she had intended to harm herself, but the resident had not responded. There was no documentation on the resident shat the was the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident shat the sas the base of whether or not the resident was attempting to cause herself harm.       During an observation of F135's room on 43/30/15, at 10:15 a.m. it was observed the call light cord avai								
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CLY, STATE, ZP CODE         GOLDEN LIVINGCENTER - ROCHESTER EAST       STREET ADDRESS, CLY, STATE, ZP CODE         YM ID PRETX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OPENEOV WIST BE PROCEDED BY FULL PEGULATORY OR LSC IDENTIFYING INFORMATION)       D PRETX TAG       PROVIDER OF COMPRETIVE ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       OWN DEFICIENCY         F 225       Continued From page 6 altercation.       F 225         During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between H4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately.       F 225         An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report incident on injury had been noted to the resident had been questioned as to whether she had intended to harm herself, but the resident had also nocumented that the resident was attempting to cause herself harm.         During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long.			245184	B. WING			05/	04/2015
GOLDEN LIVINGCENTER - ROCHESTER EAST       POCHESTER, MN 55904         (xq) iD PREFIX TAG       ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D ID PREFIX TAG       PREFIX PREFIX TAG       PREFIX PREFIX PREFIX       PROCHESTER, MN 55904       Open (EACH CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Open CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       Open CROSS-REFERENCED TO THE APPROPRIATE DEFI	NAME OF F	PROVIDER OR SUPPLIER						
(M) ID PREPX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTION SHOULD BE IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     PROVIDEN'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     comments comments output       F 225     Continued From page 6 altercation.     F 225     F 225       During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15. The administrator verified the resident to resident altercation was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately.     An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tiphen it. The incident report indicated no injury had been noted to the resident's neck. The report (but the resident had not responded. There was no documentation on the resident was attempting to cause herself harm.       During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long.	GOLDEN	I LIVINGCENTER - RO	CHESTER EAST					
altercation.       During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately.         An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report indicated no injury had been noted to the resident's neck. The report (unsigned by who had completed it) had also documented that the resident had been questioned as to whether she had intended to harm herself, but the resident had not responded. There was no documentation on the report, or in the resident's chart of any further investigation as to the issue of whether or not the resident was attempting to cause herself harm.         During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long.         The current care plan was reviewed 4/29/15.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION DATE
administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately. An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report indicated no injury had been noted to the resident's neck. The report (unsigned by who had completed it) had also documented that the resident had been questioned as to whether she had intended to harm herself, but the resident had not responded. There was no documentation on the report, or in the resident's chart of any further investigation as to the issue of whether or not the resident was attempting to cause herself harm. During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long. The current care plan was reviewed 4/29/15.	F 225		ge 6	F 2	225	5		
a diagnosis of dementia without behavioral disturbance, there was no reference to the resident's potential for self-harm nor interventions to minimize the resident's risk for self-harm. A quarterly Minimum Data Set (MDS) dated		During interview on administrator stated notification of the im- p.m., and was not ir incident between R4 administrator verifie altercation was not i immediately. An incident report for 10:31 p.m. indicated reported the resider ace-wrap wound arc pulling on to tighten indicated no injury h resident's neck. The completed it) had al- resident had been q had intended to harr had not responded. on the report, or in th further investigation not the resident was harm. During an observatio 4/30/15, at 10:15 a.r light cord availble was The current care pla Although the care pl a diagnosis of deme disturbance, there w resident's potential fit to minimize the resident	I he received telephone cident on 4/26/15, at 7:30 nmediately notified of the 4 and R51 on 4/25/15. The d the resident to resident reported to the state agency or R135 dated 3/14/15, at d a nursing assistant (NA) had ht had been found with an bund her neck that she was it. The incident report ad been noted to the e report (unsigned by who had so documented that the uestioned as to whether she m herself, but the resident There was no documentation he resident's chart of any as to the issue of whether or attempting to cause herself on of R135's room on m. it was observed the call as long. In was reviewed 4/29/15. an identified the resident had intia without behavioral was no reference to the or self-harm nor interventions dent's risk for self-harm.					

Event ID:W6S511

Facility ID: 00953

If continuation sheet Page 7 of 86

		AND HUMAN SERVICES				FORM	05/21/2015 APPROVED 0938-0391
	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	LE CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				PLETED
		245184	B. WING			05/	04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05/0	14/2013
				5	501 EIGHTH AVENUE SOUTHEAST		
GOLDE	N LIVINGCENTER - RO	CHESTER EAST		F	ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	2/5/15, identified the who presented with week. The MDS im pleasure, felt depre about herself or tha down, and nearly ev little energy. A subs reflected R135 cont depressed, and hop no thoughts of deat Licensed social wor regarding the incide LSW-B stated she w but said she should she could perform r verified care plannin developed for R135 The administrator w 9:53 a.m. and state incident, and verifie immediately notified investigation could I The facility policy tit Investigation of Alle State laws involving Abuse, Injuries of U Misappropriation of 12/18/14, instructed are reported immedi (administrator), and in accordance with identified abuse inci abuse, regardless of resulted.	e resident as cognitively intact, mood symptoms 2-6 days a dicated the resident felt little ssed or hopeless, felt badly t she had let herself or others very day felt tired and/or had sequent Medicare MDS 4/7/15 tinued feeling down, beless, but indicated R135 had h. ever (LSW)-B was interviewed ent on 4/30/15, at 9:20 a.m. was unaware of the incident, have been made aware so mentation testing. LSW-B ng approaches had not been d's depressive symptoms. vas interviewed on 4/30/15, at d he was also unaware of the d he should have been d of the situation so an have followed.	F2	225			

Facility ID: 00953

If continuation sheet Page 8 of 86

TATEMENT	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	0. 0938-0391 TE SURVEY MPLETED	
		245184	B. WING			05/04/2015		
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COL				0 1/2010	
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST		-	01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225 F 226 SS=D	Regarding Investiga Violation of Federal Maltreatment, or Inj Accordance with Fe Vulnerable Adult Ac indicated reportable the state agency im indicated immediate as possible, but no time initial knowledg was received." 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle	Ation and Reporting of Alleged or State laws Involving uries of Unknown Source in aderal and Minnesota State t Requirements dated 9/2011, incidents must be reported to mediately. The policy ely was defined as, "as soon longer than 24 hours from the ge that the incident occurred P/IMPLMENT ETC POLICIES velop and implement written		225	F226 Investigation has been complet into resident incidents for R4, F and R135. -All residents have the potentiat be affected by the identit practice. -All staff will be educated of requirement to report incidents potential abuse/neglect immediat to the ED or designee and reports of abuse/neglect will reported to the appropriate st agency in a timely manner. The or designee will conduct. investigations to include interviet with employees, visitors, residents who may have knowled	R51, if to fied the a of tely all be tate ED all ews or		
	by: Based on interview facility failed to imple immediately reportir abuse to the admini agency for 2 of 2 res reviewed for resider for reporting and init potential self abuse who had been identit to cause self-harm. Findings include: The facility policy titl	IT is not met as evidenced and document review, the ement their abuse policy for by of allegations of physical strator and designated State sidents (R4 and R51) to resident altercations; and iation of an investigation into for 1 of 1 (R135) reviewed fied as potentially attempting ed Reporting and ged Violations of Federal and			of the alleged incident. -Random bi-weekly audits will conducted of incident reports ensure any allegations of abuse neglect have been reported to ED or designee in a timely mann reported to the appropriate st agency and have been thoroug investigated. Any required education will be conducted at t time. Audits will be reviewed	be to or the her, ate hly re- hat as on ble	6/13/15	

Facility ID: 00953

If continuation sheet Page 9 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DAT	E SURVEY
		245184	B. WING			05/	04/2015
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST		5	501 EIGHTH AVENUE SOUTHEAST		
				F	ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ae 9	F 2	26			
		Mistreatment, Neglect,		-0			
		Inknown Source, and					
		Residents property dated allegations of mistreatment					
		liately to the executive director					
		reported to the state agency					
		existing state laws. The policy luded resident-to-resident					
		of whether serious harm					
	resulted.						
	Regarding Investigation of Federal	led Policies and Procedures ation and Reporting of Alleged or State laws Involving uries of Unknown Source in					
	Accordance with Fe Vulnerable Adult Act indicated reportable	deral and Minnesota State t Requirements dated 9/2011, incidents must be reported to mediately. The policy					
		ely was defined as, "as soon					
		longer than 24 hours from the					
	was received."	ge that the incident occurred					
		nge Minimum Data Set (MDS) ied R4 had no cognitive behaviors.					
	resident utilized an e mobility, and staff w	d 4/16/15, indicated the electric wheelchair for as instructed to remove the tially dangerous situations and s who disturb her.					
	R51 had no cognitiv	6 dated 2/17/15, identified e impairment and had ning or cursing at others 1-3 ok back period.					

Facility ID: 00953

If continuation sheet Page 10 of 86

		AND HUMAN SERVICES				FORM	05/21/2015 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	GOLDEN LIVINGCENTER - ROCHESTER EAST				501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECT		(ME)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	ae 10	F2	226	6		
		ed 4/29/15, indicated the		220	8		
	resident utilized an	electric wheelchair for mobility					
		f difficulty operating the iving it aggressively."					
		s notes dated 4/26/15, read					
	wheelchair so he did	i1 had push by her with his dn't miss the elevator, and in					
	the process R51 "H	it or jammed," R4's right					
		ediately complained of pain ht hand and wrist, and R4 was					
	sent to the Emerger	ncy Department (ED) for X-ray					
		d no fracture was found. The er indicated, "Four letter					
	explicative were exc	changed amongst the two					
	residents and loud v	voices were heard"					
		4/27/15, at 5:30 p.m., R4					
	stated recently she l	had tried to get off the ctric wheelchair when					
	another resident (ide	entified to be R51) was					
		vator in an electric wheelchair. d R51 to back up, and R51					
	refused and again u	sed verbal abuse toward R4					
	as R51 continued to	try to enter the elevator in his					
		R4 stated R51's wheelchair stated she now has no feeling					
	in the last two finger	s of her right hand. R4 stated					
	she reported the inci immediately, and we	ident to the nurse ant to the emergency room					
	due to swelling in he	r the right hand. R4 stated					
		oones in her hand, however, a splint and continues to have					
	pain in her right hand						
		the Incident Submission					
	report submitted to the	he state agency on 4/26/15, verbal Abuse between R4					
		nt description read, "Resident					

Facility ID: 00953

If continuation sheet Page 11 of 86

		AND HUMAN SERVICES				FORM	): 05/21/2015 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	CHESTER FAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
	[R51] rushed by and wheelchair to get in verbal altercation be Incident report indic 4/25/15, however, it agency until the follo incident was a resid which resulted in inj submitted the incide altercation. During interview on administrator stated notification of the ind p.m., and was not in incident between R4 administrator verifie altercation was not r immediately. R135's incident report p.m. noted a nursing resident was discover around her neck and wrap to tighten it. N resident's neck. The questioned the resid intended to harm he answer. No investigar regarding the potent the resident's record On 4/30/15, at 10:15 attending an activity resident participated	other resident [R4] in electric to the elevator quickly; alleged etween residents." The ated the incident occurred on was not reported to the state owing day. Although the eent to resident altercation ury to R4, the facility ent only referring to a verbal 4/29/15, at 12:08 p.m., the he received telephone cident on 4/26/15, at 7:30 nmediately notified of the 4 and R51 on 4/25/15. The d the resident to resident reported to the state agency ort dated 3/14/15, at 10:31 g assistant (NA) reported the ered with an ace-wrap wound d was found pulling on the o injury was noted to the function or further information ial for self-harm was found in the game, she initiated no hers present. R135's room	F2	220			
	The care plan provid	ed 4/29/15, identified the					

Facility ID: 00953

If continuation sheet Page 12 of 86

		AND HUMAN SERVICES				FORM	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245184	B. WING			05/	04/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226 F 241 SS=D	behavioral disturba- included related to self-harm and nor w minimize the reside A quarterly Minimur 2/5/15 identified the She presented with week where she fel or hopeless and ba had let herself or of day she felt tired ar subsequent Medica continued feeling d hopeless, but had r plan provided 4/29/ related to depression interventions had b A licensed social w interviewed regardi 9:20 a.m. LSW-B s incident, but felt she aware so she could LSW-B verified car not been developed The administrator w 9:53 a.m. and state incident, but said he immediately notified investigation should 483.15(a) DIGNITY INDIVIDUALITY The facility must pro-	nosis of dementia without nce. Information was not the resident's potential for vas a plan developed to ent's risk for self-harm. In Data Set (MDS) dated e resident as cognitively intact. I mood symptoms 2-6 days a it little pleasure, felt depressed dly about herself or that she thers down, and nearly every nd/or had little energy. A are MDS 4/7/15 reflected R135 own, depressed, and no thoughts of death. The care 15, did not identify a problem on or the incident and no een developed. orker (LSW)-B was ing the incident on 4/30/15, at tated she was unaware of the e should have been made I perform mentation testing. e planning approaches had		226			
	L						

Facility ID: 00953

If continuation sheet Page 13 of 86

STATEMEN	T OF DEFICIENCIES OF CORRECTION	KANNERSPECTION     KANNERSPECTION     KANNERSPECTION     KANNERSPECTION     KANNERSPECTION     KANNERSPECTION     KANNERSPECTION     KANNERSPECTION				(X3) DAT	. 0938-039 E SURVEY
		245184				05/	04/2015
	PROVIDER OR SUPPLIER		iD	50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
F 241	enhances each res full recognition of h This REQUIREME by: Based on observa review, the facility f answered in dignific resident whose call off. Findings include: R81 was lying in be 4/29/15, at 7:21 a.m want to get up soor activated his call lig were then conducte observed: At 7:37 a.m. an unk entered room and of around the room, tu the room without ac to talk loudly as he something to eat. I light on. Come on, on. Are you going to call light on. Can't y Although R81 had r roommate's televisi the room and inform had requested the t NA-D then tuned of room. Later, when f been turned off, he	sident's dignity and respect in is or her individuality. NT is not met as evidenced tion, interview and document cailed to ensure call lights were ed manner for 1 of 1 (R81) I light was repeatedly turned ed during an observation on n. R81 stated very loudly, "I n" at which time he also ght. Continuous observations ed and the following was known nursing assistant (NA) donned gloves. She looked urned the light off, and then left ddressing R81. R81 continued lay in bed stating, "I want need to get up. I have my call can't you help me? Oh come o starve me too? I have my	F2	241	F241 -R81 call light is being answere a timely manner and R81 needs being met before call light is tur- off. -All residents have the potential be affected. -Staff will be educated on call response, need to answer call timely, and meeting resident nee -Random bi-weekly audits will performed on call light response include meeting resident nee Audit results will be reviewed QAPI and action planned needed. -DNS/Designee is the response party. -Education provided 5/21,6/2,6/4,6/9 -Corrective action will be comple by 6-13-2015.	are rned al to light ds. be e to eds. l at as sible	6/13/13

Facility ID: 00953

STATEMENT OF DEFICIENCIES       (X1) PROVIDERSUPPLERCLAN       (X2) DEVIFICITION NUMBER:       (X2) DE			AND HUMAN SERVICES				FORM	): 05/21/2015 APPROVED ). 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       GOLDEN LIVINGCENTER - ROCHESTER EAST     STREET ADDRESS, CITY, STATE, 2P CODE       ON JD PREFX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE REACEDED BY FULL RECULATORY OF LSC DENTFYING INFORMATION)     D PROVESS FERENCED TO THE APPROPRIATE DEFICIENCY       F 241     Continued From page 14 nervous lying here."     PROVESS FERENCED TO THE APPROPRIATE DEFICIENCY       At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, 11 am working on the other side. I told them to come help you." R81 continued to loudly request to get up."     F 241       At 8:01 a.m. R81 repeated loudly, "I want to get up."     F 241       At 8:01 a.m. R81 repeated loudly, "I want to get up."     F 241       At 8:07 a.m. R81 continued taking to himself about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and if the room. When asked why the resident'. NA-D then told the resident, "I will them you want to get up," and again turned off the call light was to get, "I and working to the outs to det up." and again activated. The resident that again turned off the call light was to the get, "I am orking to get up. when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.						IPLE CONSTRUCTION	(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STREET, ZIP CODE         GOLDEN LIVINGCENTER - ROCHESTER EAST       SOTEGHTA WARK SOUTHEAST ROCHESTER, MN 55904         (%) ID PHEEK TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST RE PRECEDED BY FULL REGULATIONY ON LGC DENTIFYING INFORMATION)       PROVIDERS PLAY MO F CORRECTION (EACH CORRECTIVE ACTION SHOLDS BE CHOOSE-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 241       Continued From page 14 nervous lying here.*       F 241         At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, '1 am working on the other side. I told them to come help you.*       F 241         At 8:01 a.m. R81 continued to loudly request to get up.*       F         At 8:01 a.m. R81 repeated loudly, 'I want to get up.'       F and they always do. They aren't supposed to turn it off until they help me, but they just come in and turn it off.*         At 8:07 a.m. R81 continued taiking to himself about wanting to get up, when NA-D entered the room and said, 'They will get you up,' as as he turned off the call light mat log they and again turned off. NA-D then told the resident, 'I will them you want to get up,'' and again turned off the call light mat the resident had again activated. The resident the light back on.         At 8:12 a.m. R81 continued lying in bet taiking loudy about wanting to get up when NA-E entered the room. NAE lift ontinued stating he wanted to get up and put his call light back on five minutes later.			245184	B. WING	i		05	/04/2015
OUDER LUNRCENT FN - ROCHESTER EAST       POCHESTER, MN 55904         (%) ID PHETK TK3       SUMARY STATEMENT OF DEFICIENCES (EACORRECTIVE ACTION NOF CORRECTION REGULATION ON LSC DEXTIFYING INFORMATION)       ID PROVIDERS FLAND OF CORRECTION (EACORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY)         F 241       Continued From page 14 nervous lying here.*       F 241         At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, '1 am working on the other side. I told them to come help you.*       F 241         At 8:01 a.m. R81 repeated loudly, 'I want to get up.'       That is what they always do. They aren is supposed to turn it off until they help me, but they just come in and turn it off.*       F 241         At 8:07 a.m. R81 continued taiking to himself about wanting to get up, when NA-D entered the room and said, 'They will get you up,' as she turned off the call light mat light was turned off NA-D responded, 'I am working on the west side. He lives on the cast side.' NA-D then told the resident, '' will them you want to get up,'' and again turned off the call light mat to get up,'' and again activated. The resident that again activated. The resident that again activated. The resident the NA-D responded, 'I am working on the west side. He lives on the cast side.' NA-D then told the resident, '' will them you when NA-E entered the room. NA-E informed the resident that again turned off the call light mat to get up,'' and again turned off the call light was turned off NA-D responded, '' am working on the west side. He intered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, 'I will come and help you.'' R81 continued stating he wanted to get u	NAME OF	PROVIDER OR SUPPLIER						
Wold Dependence         SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST REPRECEDED BY PLU, EACH DEFICIENCY MUST REPRECEDED BY PLU, EACH DEFICIENCY MISSING REPRECEDED BY PLU, EACH DEFICIENCY MISSING REPRECEDED BY PLU, EACH DEFICIENCY)         Deficience         Deficience <thdeficience< th=""></thdeficience<>	GOLDEN	LIVINGCENTER - RO	CHESTER EAST					
Prefex Txg       read/conserved actions works and the preceded by Full Reductored of the call light of and to the resident, "I am working on the other side. I told them to come help you." R81 continued to loudly request to get up."       F 241       Continued From page 14 nervous lying here."       F 241         At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, "I am working on the other side. I told them to come help you." R81 continued to loudly request to get up."       F 241         At 8:01 a.m. R81 repeated loudly, "I want to get up."       At 8:01 a.m. R81 repeated loudly, "I want to get up."       F 241         At 8:07 a.m. R81 continued to liscull tight had again been turned off, he activated lit and stated, "That is what they always do. They aren't supposed to turn it off until they help me, but they just come in and turn it off."       At 8:07 a.m. R81 continued talking to himself about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and light was turned off NA-D responded, "I am working on the west side. He lives on the east side." NA-D then told the resident," I will tell them you want to get up," and again turned off the call light that the resident had again activated. The resident then turned the call light back on.         At 8:12 a.m. R81 continued lying in bed talking loudy about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L		N	(VE)
At 8:05 a.m. NA-C entered R81's room, turned the call light off and told the resident, "I am working on the other side. I told them to come help you." R81 continued to loudy request to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:01 a.m. R81 repeated loudy, "I want to get up."         At 8:07 a.m. R81 continued talking to himself about wanting to get up, when NA-D entered the room and said. "They will get you up," as she turned off.         At 8:07 a.m. R81 continued talking to himself about wanting to get up. when NA-D entered the room. When asked why the resident's call light was turned off.         NA-D responded. "I am working on the west side. He lives on the east side." NA-D then told the resident. "I will tell them you want to get up." and again turned off the call light that the resident had again activated. The resident the call light back on.         At 8:12 a.m. R81 continued lying in bed talking loudly about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROS	DBE	COMPLETION
<ul> <li>nervous lying here."</li> <li>At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, "I am working on the other side. I told them to come help you." R81 continued to loudly request to get up."</li> <li>At 8:01 a.m. R81 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. R81 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. R81 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. R81 continuously requested to get up and talked about eating breakfast. When he realized his call light had again been turned off, he activated it and stated, "That is what they always do. They aren't supposed to turn it off until they help me, but they just come in and turn it off."</li> <li>At 8:07 a.m. R81 continued talking to himself about wanting to get up, when NA-D entered the room and said. "They will get you up." as she turned off the call light and left the room. When asked why the resident's call light was turned off NA-D responded. "I am working on the west side. He lives on the east side." NA-D then told the resident, "I will tell them you want to get up." and again autivated. The resident then turned the call light back on.</li> <li>At 8:12 a.m. R81 continued lying in bed talking loudly about wanting to get up when NA-E entered the room. Not hen assisting another resident who needed oxygen, "I will come and help you." R81 continued the resident if NA-F did not come soon, when she was tinished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.</li> </ul>	F 241	Continued From pa	ae 14	F	24.	1		
<ul> <li>the call light off and told the resident, "I am working on the other side. I told them to come help you." RB1 continued to loudly request to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:01 a.m. RB1 repeated loudly, "I want to get up."</li> <li>At 8:07 a.m. RB1 continued stated, "That is what they always do. They aren't supposed to turn it off."</li> <li>At 8:07 a.m. RB1 continued talking to himself about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and left the room. When asked why the resident's call light was turned off NA-D responded, "I am working on the west side. He lives on the east side. "NA-D then told the resident," I will tell them you want to get up," and again activated. The resident the toget up," and again activated. The resident the toget up and page in the set off the call light was the sinshed assisting another resident the R81 continued by up. "R81 continued the resident if NA-F fid not come soon, when she was finished assisting another resident who needed stating he wanted to get up and put his call light back on five minutes later.</li> </ul>			•					
<ul> <li>up! I want to get up!" R81 continuously requested to get up and talked about eating breakfast.</li> <li>When he realized his call light had again been turned off, he activated it and stated, "That is what they always do. They aren't supposed to turn it off until they help me, but they just come in and turn it off."</li> <li>At 8:07 a.m. R81 continued talking to himself about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and left the room. When asked why the resident's call light was turned off NA-D responded, "I am working on the west side. He lives on the east side." NA-D then told the resident, "I will tell them you want to get up," and again turned off the call light that the resident had again activated. The resident then turned the call light back on.</li> <li>At 8:12 a.m. R81 continued lying in bed talking loudly about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.</li> </ul>		the call light off and working on the othe help you." R81 con	told the resident, "I am r side. I told them to come					
about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and left the room. When asked why the resident's call light was turned off NA-D responded, "I am working on the west side. He lives on the east side." NA-D then told the resident, "I will tell them you want to get up," and again turned off the call light that the resident had again activated. The resident then turned the call light back on. At 8:12 a.m. R81 continued lying in bed talking loudly about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.		up! I want to get up! to get up and talked When he realized hi turned off, he activa what they always do turn it off until they h	" R81 continuously requested about eating breakfast. is call light had again been ted it and stated, "That is b. They aren't supposed to					
loudly about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later.		about wanting to get room and said, "The turned off the call lig asked why the resid NA-D responded, "I He lives on the east resident, "I will tell th again turned off the again activated. The	t up, when NA-D entered the ey will get you up," as she iht and left the room. When ent's call light was turned off am working on the west side. side." NA-D then told the tem you want to get up," and call light that the resident had					
NA-C stated in an interview on 4/29/15 at 8:18		loudly about wanting entered the room. N NA-F did not come s assisting another res will come and help y he wanted to get up five minutes later.	to get up when NA-E IA-E informed the resident if soon, when she was finished sident who needed oxygen, "I ou." R81 continued stating and put his call light back on					

Facility ID: 00953

If continuation sheet Page 15 of 86

		AND HUMAN SERVICES				FORM	0: 05/21/2015 APPROVED 0: 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN	LIVINGCENTER - RO	CHESTER FAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	Continued From pa	-	F2	241	1		
	wants. We are done	off when I ask him what he e with our work on the other e to help on this side." NA-E 1, as well.					
	During an interview explained on 4/30/1 expect that when the need to give the res	with registered nurse (RN)-A 5, at 8:50 a.m. "I would ey answer the call light, they ident a time someone will be m. I don't want the staff to just					
	at 9:08 a.m. "If they call light, they are ex	ing (DON) stated on 4/30/15, are a NA and they answer the spected to meet his needs. In his light off with out helping sue."					
	1/29/15, revealed the cognitively impaired, problems, and requi	mum Data Set (MDS) dated e resident was moderately , displayed no behavioral red extensive assistance for ng, dressing, transfers and	•				
	and mobility impairm revealed on 4/29/15,	ed 9/30/14, indicated self-care nents. Progress notes , "Resident is alert & oriented s able to communicate his ble to use call light					
	directed staff as follo must be aware of ca ALL call lights promp assigned to the resid resident feel you are	all lights dated 1/26/15, bws: All facility personnel Il lights at all timeAnswer btly whether or not you are dent Never make the too busy to give assistance; ice before you leave the					

Facility ID: 00953

If continuation sheet Page 16 of 86

		AND HUMAN SERVICES			FORM	05/21/2015 APPROVED 0.0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		245184	B. WING	i	05	/04/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - RO	CHESTER EAST		501 EIGHTH AVENUE SOUTHEAST			
040.15	SUMMARY STA			ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 241	Continued From pa	ge 16	F 2	241			
	A dignity policy date residents will be treat environment that more resident's dignity and his or her individual and respect maintai resident's self-worth psychosocial well-bu- 483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or othe incapacitated under participate in plannin changes in care and A comprehensive cas within 7 days after the comprehensive associated interdisciplinary tear physician, a register for the resident, and disciplines as detern and, to the extent pr the resident, the res legal representative; and revised by a tea each assessment.	NNING CARE-REVISE CP e right, unless adjudged wwise found to be the laws of the State, to ng care and treatment or d treatment. are plan must be developed	F 2	<ul> <li>F280</li> <li>-R113 and R135 have had their of plans revised to address cur conditions.</li> <li>-All residents have the potential be affected if care plans are updated with changes.</li> <li>-Licensed staff have been educated to update care plans as the n arises on 5/21, and 6/2. Licen staff have also been educated review resident care plans as scheduled care conferent annually, quarterly, and wisgnificant changes and update needed.</li> <li>-Random bi-weekly audits will conducted in conjunction weekly care conferences to ensign are updated to addr current conditions. Any required education and/or updates will conducted at that time Audits be reviewed at QAPI and ac planned as needed.</li> <li>-DNS/Designee is the respons party.</li> <li>-Corrective action will be completed by 6-13-201.5</li> </ul>	rent I to not ited eed sed to with ees, with as be with ure ess re- be will tion	6/13/15	

Facility ID: 00953

If continuation sheet Page 17 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245184	B. WING			05/	04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	ILIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	1 of 1 resident (R11 ambulation assistive care plan for 1 of 3 with a Foley cathete Findings include: R113 was admitted according to the face diagnoses that inclu- dementia, Alzheime depression, pain in osteoporosis, perso loss, and difficulty in R113's quarterly Mit 4/10/15 indicated se with a Brief Intervier was independent w after set up, balance transitions and walk and had sustained to the previous assess R113's care plan las risk for falls related Remeron. "Interven limited to: encourag antianxiety medicat walker when ambul- times." The care pl cane for ambulation A nursing progress "Resident was walk cane and then he g on the floor of the e	<ul> <li>iled to revise the care plan for 3) in the sample with e devices; failed to revise the residents (R135) reviewed er.</li> <li>to the facility on 1/30/12 cility admission record with uded but was not limited to er's disease, anxiety, joint pelvic region and thigh, anal history of fall, hearing in walking.</li> <li>nimum Data Set (MDS) dated evere cognitive impairment w for Mental Status score of 6, ith ambulation and transfers e was steady during ting, used a cane or crutch, two falls without injury since sment date.</li> <li>st reviewed on 3/10/15 read at to hx [history] of falls, use of tions included but was not e use of walker, give ion per nurse practitioner, use ating as he is unsteady at an also indicated R113 used a</li> </ul>	F2	280			

Facility ID: 00953

If continuation sheet Page 18 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		245184	B. WING	i		05/	/04/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - ROCHESTER EAST					501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ao 19		200			
1 200	pushing him in a wh	-	F 2	280			
	4/29/15 at 8:29 a.m	l walking with a cane on ., at 10:52 a.m., and at 11:32 /as not observed to walk with survey.					
	registered nurse (R use the cane, it's the walker or not. RN-A be updated to reflect assistive device. R135 was admitted noted on the care pl which included: uns	on 04/30/15, 2:19 p.m. N)-A stated, resident chose to e resident's choice to use the stated the care plan should at the choice of using either on 11/1/14, with diagnoses lan last reviewed on 3/18/15, specified debility, abnormality sis, osteoarthritis, retention of ney failure.					
	2/19/15, indicated m	nimum Data Set (MDS) dated noderate cognitive impairment and was frequently incontinent er.					
	reviewed 3/29/15, st frequency and timin due to R135's occas incontinence. The c include information	R135's care plan, last taff were directed to evaluate g of incontinence episodes sional bowel and bladder current care plan did not regarding R135's indwelling reflect R135's current needs.					
	R135 was seated in	on on 4/18/15, at 7:19 a.m. the wheelchair in the room attached to the wheelchair.					
	dated 4/17/15, R135	ne nursing progress notes, i returned from the facility with a "Foley in place, not					

Facility ID: 00953

If continuation sheet Page 19 of 86

		AND HUMAN SERVICES					FORM	): 05/21/2015 APPROVED ), 0938-0391	)
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) D/				X3) DA	TE SURVEY	]
		245184	B. WING				05	/04/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CO	DE			1
	LIVINGCENTER - RO			501 EIGHTH A	VENUE SOUTHEAST				
GOLDEN		CHESTER EAST		ROCHESTE	R, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	OVIDER'S PLAN OF CORF H CORRECTIVE ACTION S -REFERENCED TO THE AI DEFICIENCY)	HOULD B		(X5) COMPLETION DATE	
F 280 F 281 SS=D	Continued From pa ordered to take out UTI's" (urinary tract During a review of r 4/21/15, for R135, " catheter for urinary During an interview director of nursing ( plans should be upo care changes. This catheter for R135. A facility policy rega care plans was requ 483.20(k)(3)(i) SER PROFESSIONAL S The services provide must meet profession This REQUIREMEN by: Based on observati review the facility fai care plan was devel (R203 & R205) in th within the past two w Findings include:	ge 19 at this time d/t [due to] chronic infections). mursing progress noted, dated has an indwelling Foley needs" on 4/30/15, at 1:39 a.m. the DON) indicated resident care lated when a resident plan of is in regards to the Foley rding updating of resident vices PROVIDED MEET TANDARDS ed or arranged by the facility onal standards of quality. IT is not met as evidenced on, interview and document led to ensure a temporary oped for 2 of 3 residents e sample who were admitted veeks.	F 2	F281 -R203 r facility. develope -Newly a potential are not c -Licensed on deve care plan -Random complete insure tel developed be reviewe	DEFICIENCY) no longer resides R205 has had a ca admitted residents h to be affected if card are planned on adm d staff have been ed lopment of the ter n upon admission. b bi-weekly audits ad on admitted resid mporary care plan t timely. Audit resu ed at QAPI.	in the are plar ave the e needs ission. ducated mporary will be dents to s are its will			
	admission diagnose dated 4/19/15 active including rheumatoid inflammatory disorde	on 4/17/15, at 3:25 p.m. with s (Order Summary Report orders as of 4/17/15) d arthritis [chronic, systemic er that primarily affects joints], b, abscess of anal and rectal		party. -Corrective	-DNS/Designee is the responsible			6/13/15	_

Facility ID: 00953

If continuation sheet Page 20 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245184	B. WING			05/	04/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		0.12010	
GOLDEN	LIVINGCENTER - RO	CHESTER EAST		1	501 EIGHTH AVENUE SOUTHEAST			
					ROCHESTER, MN 55904			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281	Continued From pa	ae 20	F2	221	1			
	regions, pain in ank	le and foot joint and		201				
	generalized pain.							
		iated 4/17/2015 includes a						
		lcer actual or at risk due to: ent under cast. Has three						
		ent under cast. Has three yx area." Lacked goals or						
	interventions for pre	essure ulcer or open areas						
		ped interventions to minimize ng additional pressure ulcers.						
	In addition the care							
	management proble	em, goal, and interventions.						
	completed by RN-B	Flow Sheet dated 4/17/15 listed the following areas						
		cyx 1 cm length x .2 cm width.						
		cer. Current treatment, Mepiborder (self-adhesive						
	absorbent dressing)	. No interventions listed.						
	2. Abscess coccyx	2 cm length x 1 cm width x atment listed. Current						
		ntions include wheelchair						
	cushion and turn rep	position. No time frame listed						
	for repositioning.	2 cm length x 1 cm width.						
	Current treatment m	epiborder. Current						
		ntions wheelchair cushion,						
	repositioning.	No times frames listed for						
	Resident Status and	Care Plan, undated,						
	indicated skin that in	cluded non-healing ulcers						
	three on the rectum, foot.	one left leg, and one left						
	Resident Status and	Care Plan, undated,						
		where but elbows with a n. No interventions listed.						

Facility ID: 00953

If continuation sheet Page 21 of 86

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		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245184	B. WING			05/	04/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - ROCHESTER EAST				501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 21	F 2	281	1		
	On 4/27/15 at 3:03	p.m. R203 reported, "I have					
	ulcerations on my b	ottom that are supposed to be					
		v my bottom is a lot sorer. I've I came in. They never cleared					
	up the meds with th	e doctor for what I am					
		The ambulance came and they [facility] wouldn't give me					
	pain meds. They tol	d me I couldn't go but I was in					
	pain." B205 admitted on 4	/20/15, with diagnosis listed					
	on the admission re	cord which included end					
	stage renal disease mellitus.	(ESRD) and diabetes					
	4/20/15, revealed or	f physician orders dated ders for daily weights one					
	time a day, notify N	P/MD (nurse doctor) if resident had weight					
		ree pounds in one 24 hour					
	period, or if resident pounds over baselin	had weight increase of five le.					
		the admission clinical health 5, lacked any indication R205					
	received dialysis ser	vices; no mention of access					
		r thrill. The assessment weight. The clinical health					
		ompleted on 4/20/15.					
		the resident status, an initial					
		, identified R205 received a ursing assistant care guide,					
	not titled and not dat	ted, revealed instructions that					
		al diabetic diet. There were					
	to dialysis care.	in the initial care plan related					
	During interview on 4	4/29/15, at 7:19 a.m. a					

If continuation sheet Page 22 of 86

		AND HUMAN SERVICES			FORM	05/21/2015 APPROVED 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245184	B. WING _		05/04/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - ROCHESTER EAST				501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 281	Continued From pa	-	F 28	11			
		assistant (TMA)-A indicated sight to be the right lower rib					
	TMA-A entered R20 the access site was	s on 4/29/15, at 8:28 a.m., 05's room, asked R205 where located, observed the site est, and stated, "guess I new today."					
	assistant (NA)-I stat on the right chest.	4/29/15, at 8:35 a.m., nursing ted R205's access sight was NA-I stated R205 was on fluid icated not aware of the fluid					
	of nursing stated sh instructions to be in nursing assistant ca administration recor administration recor	rd.					
	483.20(k)(3)(ii) SEF PERSONS/PER CA	IVICES BY QUALIFIED RE PLAN	F 28	2 F282			
	must be provided by	ed or arranged by the facility y qualified persons in ch resident's written plan of		-R147 no longer resides in facility. R113 receives assistan from staff based on individualiz assessed needs per the care plan -All residents have the potential be affected by the identif	nce zed n. I to		
	by: Based on observati review the facility fai accordance with the residents (R113, R1	IT is not met as evidenced on, interview, and document iled to provide services in plan of care for 2 of 34 47) assessed to need activities of daily living.		practice. -CNA's will be educated to prov cares as directed on the C assignment sheets. Licensed s have been educated to update CNA assignment sheets as need	ride NA taff the		

Facility ID: 00953

If continuation sheet Page 23 of 86

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM	: 05/21/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY IPLETED
		245184		à		05/	04/2015
NAME OF	PROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - ROCHESTER EAST			L (				
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Findings include: R113 care plan incl monitoring of skin of purple bruise had n nor monitored per of During an observati R113 had a dark pu with approximate m (cm) in diameter that Identification of the medical record. The R113's care plan wa demonstrated by, la lack of reporting of directed by the care R113 was admitted according to the fac diagnoses that inclu- dementia, Alzheimed depression, anemia and osteoporosis, p loss, and difficulty in R113's quarterly Mii 4/10/15 indicated se with a Brief Interview was independent w after set up. R113's care plan las risk for bruising due aspirin with an indiv shall have bruising a placed to prevent fut care plan included i equipment that may notify MD/NP [medit to review med regin any new bruises not	uded the reporting and concerns, however, a dark ot been reported to the nurse care plan: ion on 4/28/15, at 1:21 p.m. irple bruise on his left forearm reasurements of 3 centimeters at was not identified by staff. bruise was not evident in the e facility failed to ensure as being followed ack of skin surveillance and/or injury of unknown origin as e plan. to the facility on 1/30/12 cility admission record with uded but was not limited to er's disease, anxiety, and macular degeneration, rersonal history of fall, hearing	F	282	conducted to ensure CI assignment sheets are current w resident comprehensive care plan Any required re-education and updates will be conducted at th time Audits will be reviewed	NA hith hs. /or hat at as nd	6/13/15

Facility ID: 00953

If continuation sheet Page 24 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015	)
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI A. BUILD		IPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED	
		245184	B. WING	i		05/04/2015		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			1
GOLDEN LIVINGCENTER - ROCHESTER EAST					501 EIGHTH AVENUE SOUTHEAST			
					ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 24	F 2	282	2			
	-	ded the instruction to "inspect			-			l
	skin with care. Repo	ort reddened areas, rashes,						
		eas to charge nurse."						l
		the month of April 2015 did not tion of the identification of the						l
		earm. Furthermore, an						l
	incident report was	not found in the medical						
	record pertaining to	the bruise. The identification						
	the medical record.	ne bruise was not evident in						
		on 4/29/15, at 11:52 a.m.						
	LPN-C verified the t	pruise on R11's forearm.						
		mentation related to the						
		bruise in the nursing progress n incident report had not been						
		en indicated she needed to						
	document and invest	stigate.						
		not followed in regards to						
		cers were to have daily skin						
	monitoring, weekly s	completed in accordance with						
	the care plan.							
		on 4/30/15, at 12:16 p.m.						
	weakness and pain.	not get out of bed because of R147 stated he had sores on						
	his bottom that had	been there for a long time.						
	R147 stated staff ha	d not assisted or reminded						
	him to reposition at a							
		on on 4/30/15, at 1:06 p.m. A)-E rolled R147 onto right						
	side. Bottom reveale	ed chafing of bilateral upper						
	buttocks, and entire	upper portion of the sacrum						
	and upper gluteals w	vere red in color with areas						
	that were slow to bla	nch. The right buttock						
	showed two open wo	ounds one covered by slough.						
	R147 was admitted to the facility on hospice on 4/2/15 according to the facility admission record							

Facility ID: 00953

If continuation sheet Page 25 of 86

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		CONSTRUCTION		0. 0938-03 TE SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245184	B. WING			05	/04/2015
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			EIGHTH AVENUE SOUTHEAST CHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ge 25	F 2	282			
		included but not limited to:					
	malignant neoplasm	n of the kidney, bone, and					
	lungs, hypercalcem	ia (high calcium), malaise and					
	fatigue, history of ve	enous thrombosis (blood clot),					
	and rheumatoid arth	and cerebrovascular disease,					
		linimum Data Set (MDS)					
		ed no cognitive impairment					
	with a Brief Interview	w for Mental Status (BIMS)					
		d extensive assistance of two					
	staff members for a	ctivities of daily living of bed					
		Iressing, and toileting. The 7 did not ambulate and					
		mities had range of motion					
		DS further revealed a formal					
		essment were used, did not					
		s, and no topical applications	. 1				
	of ointments were up						
		nission Physical/Clinical locumentation dated 4/2/15					
		jical wound and read, "see					
		ment: Not applicable" The					
		ed description, location, and					
	measurements. The						
	indicated a stage I p	ressure ulcer on buttocks, it					1
	The assessment fur	he area was not measured. ther indicated the wounds					
		dressing was not changed, "					
		ge summary: Mepilex					
	dressing to bilateral	gluteals".					
		sical Clinical Monitoring					
	nursing documentati	on dated 4/7/15 again					
	and a detailed skin a	ce of a non-surgical wound					
		imentation reflected the					
		er on buttocks had healed.					
	R147's Hospice Phys	sical/Clinical Monitoring					
	nursing documentati	on dated 4/21/15 indicated					
	intact skin. However,						

If continuation sheet Page 26 of 86

STATEMENT	RS FOR MEDICARE	KI PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
	or connection	DENTIFICATION NOMBER.	A. BUILDI	NG		MPLETED
		245184	B. WING		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 26	F 28	32		
		4/21/15 read, "pt has irritated		-		
		on. RN [registered nurse]				
		Im to this area and wrote order D [three times per day] and prn				
		rding to the documentation on				
		ent was not provided on four				
		4/21/15 and 4/28/15				
	according to the hose	spice order. sive Skin Assessment that				
		erance Observation (a skin				
	assessment used to	o determine skin tolerance to				
		prominences; used to				
		ning schedule) dated 4/2/15 The assessment was blank.				
		plan dated 4/10/15 indicated				
	R147 was non-weig	ht bearing and required the				
		I Hoyer lift for transfers. The I staff to "inspect skin with				
		ned areas, rashes, bruising, or				
		ge nurse" The care plan also				
		ulcer actual or risk due to;		F309		
		in bed mobility, Braden score esity, dx [diagnoses] of			as been	
		psychotropic medications."		assessed, care planned	d, and is	
	R147's individualize	d goal was "skin will remain		being provided and		
		n further instructed staff to		Dialysis care has been care planned, and is bein		
		cale per living center policy, n inspectionprovide		for R205.	g provided	
		after each incontinent episode		-All residents have the p	otential to	
	and apply barrier cre	eam, and skin assessment to		be affected by the	identified	
F 000	be completed per liv			-Licensed staff have been	educated	
F 309	483.25 PROVIDE C HIGHEST WELL BE	ARE/SERVICES FOR	F 30	on proper assessing and		
SS-D				necessary care for resider	nt needs.	
SS=D			1	<ul> <li>Audits will be conducted</li> </ul>	bi-weekly	1
SS=D		receive and the facility must				
SS=D	provide the necessa	ary care and services to attain		to ensure cares are being	g provided	
SS=D	provide the necessa	ary care and services to attain est practicable physical,			g provided cable well-	

Facility ID: 00953

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245184	B. WING			05	/04/2015
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	05	04/2015
GOLDEN	I LIVINGCENTER - RC	CHESTER EAST		5	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	and plan of care. This REQUIREMEN by: Based on observati review the facility factor coordinated for 1 of sample who receive to ensure resident's treatment done time reviewed for wounds Findings include: R205 Lacked initial for staff to care for relack of daily weights physician ordered: R205 was admitted to and on dialysis. How temporary care plan meet fluid restriction bleeding at access so daily weights and also more pounds in one R205 was admitted to and on dialysis. How temporary care plan meet fluid restriction bleeding at access so daily weights and also more pounds in one	IT is not met as evidenced ion, interview, and document iled to ensure care was 1 resident (R205) in the id dialysis services and failed wound was monitored and ely for 1 of 2 residents (R96) s. care planning interventions esident receiving dialysis and and reporting weight gain as with orders for renal failure vever, there was not developed for facility staff to , what to do in case of ite, lack of physician ordered so reporting weights of two or	F	309			6/13/1
	health status, an ass revealed no indicatio	the facility admission clinical essment dated 4/20/15, n R205 received dialysis location, bruit, or thrill. The					

Facility ID: 00953

If continuation sheet Page 28 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DAT	E SURVEY
		245184	B. WING			05/	04/2015
NAME OF	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ae 28	E 2	309			
		an admission weight. The		000			
	clinical health status 4/20/15.	s was signed completed on					
		s on 4/28/15, at 4:11 p.m.,					
		ess sight was observed on the overed with a clear dressing.					
	The area was clean	and dry. During interview at					
		ed was on a special diet that ium and fluid restriction,					
	although was unawa	are of fluid limit. R205 stated					
		her to have too many fluids. ked with facility dietician					
	regarding diet, fluids	s, and likes and dislikes.					
		ed dialysis on Mondays, Fridays and would leave the					
	facility at 11:00 a.m.	, on those days. R205 stated					
		end a sack lunch along to esn't happen." Stated goes					
	without eating or bu	ys something to eat at dialysis					
		facility in time for supper. t time, revealed 1/2 cup					
	coffee, 4 ounce glas	ss of water, and a small gray					
		raw (water), on the over the ch R205 ordered and had					
	delivered.						
		4/28/15, at 4:24 p.m.,					
		urse-E (LPN-E) stated R205 on of 1.5 liters and the access					
	sight was upper righ						
		4/29/15, at 7:19 a.m., trained					
		t (TMA)-A indicated the t to be the right lower rib area.					
		entered R205's room, asked					
	R205 where the acc	ess sight was located,					
		ocated on right chest, and rned something new today."					

Facility ID: 00953

If continuation sheet Page 29 of 86

		AND HUMAN SERVICES				FORM	0: 05/21/2015 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245184	B. WING			05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 29	F3	309	9		
	assistant-I (NA-I) st on the right chest.	4/29/15, at 8:35 a.m., nursing ated R205's access sight was NA-I stated R205 was on fluid icated not aware of the fluid					
	breakfast tray was o room. Breakfast co juice, 8 ounces milk waster, scrambled e	s on 4/29/15, at 8:47 a.m., delivered to R205 in resident insisted of 4 ounces apple a, cup of coffee, 12 ounces eggs, 1 slice dry toast, and 5 immediately began to eat.					
	R205 sat in a wheel waiting for van ride	s on 4/29/15, at 10:58 a.m., chair in the facility lobby to dialysis and had a sack d a meat sandwich and sprite					
	and care plan, an in identified R205 rece no other instructions to dialysis care. Rev assistant care guide give care to R205 in	the facility resident status itial care plan not dated, vived a renal diet. There were is in the initial care plan related view of facility nursing used by nursing assistant to cluded renal diabetic diet and are and what to do in case bleed.					
	4/20/15, included da notify nurse practitio if resident had weigh pounds in one 24 ho	physician orders dated hily weights one time a day, ner/medical doctor (NP/MD) nt increase of two to three bur period, or if resident had we pounds over baseline.					
		d for R205 for a period from 0 4/30/15 even though					

If continuation sheet Page 30 of 86

		AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		245184	B. WING			05	5/04/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	0/61
PREFIX TAG	(EACH DEFICIENCY	WUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From page	ae 30	F3				
	physician ordered d	-		000	, 		
	4/21/15-108.2 poun						
	4/22/15-108 pounds 4/23/15-109 pounds						
	4/24/15-109 pounds						
	gain in past two day	nds (had over 7 pound weight and no indication physician					
	was notified of weig	ht gain)					
	4/27/15- 116.8 poun 4/29/15-117 pounds	as (again no indication of 8					
		n past 5 days to the physician)					
	director of nursing v above and no others physician orders dat weights and to notify	4/30/15, at 10:30 a.m., erified the weights as noted s provided. She verified the ted 4/20/15, directed daily y NP/MD of weight increase of					
	above baseline. Dire facility lacked evider	in 24 hours or five pounds actor of nursing verified the ace of baseline weight and th would be the first weight					
	of nursing said R205 not contain dialysis i emergency procedu bleed. Also verified t	4/29/15, at 3:00 p.m., director 5's temporary care plan did nformation for care and re in case of access site there were no written dialysis nursing assistants on the re guide.					
	of dietary services ve diet which included le diet, and did not have restriction. Director became aware on 4/ lack of sack lunches	4/29/15, at 3:10 p.m., director erified R205 received dialysis ow potassium and low salt e physician orders for fluid of dietary services stated she 28/15, of R205's complaint of sent to dialysis and now ack lunch directly to resident					

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DAT	E SURVEY
		245184	B. WING			05/	04/2015
NAME OF I	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	I LIVINGCENTER - RO	CHESTER FAST		ŧ	501 EIGHTH AVENUE SOUTHEAST		
GOLDEN	SEDEN EIVINGCENTER - NOCHESTER EAST				ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ne 31	F3	200	0		
		iving for dialysis appointments.		009	9		
		n tear and ongoing monitoring					
		essing to promote healing was					
	R96's significant ch	ange Minimum Data Set					
	(MDS) dated 3/31/1	5, indicated R96 was					
		behaviors, needs extensive					
	daily living and toile	fers, bed mobility, activities of ting.					
	diagnosis of paralys disease), acquired t involuntary movement	ed 2/18/15, indicated a sis agitans (Parkinson ' s corsion dystonia (an ent disorder). The care plan or an assistive device					
	in her room where the engaging in an active shin, front side of here	4/28/15, at 4:08 p.m. R96 was he resident was independently rity. A bandage on her right er leg about 4 inches above dage had old blood on it. R96 and it did not hurt.					
	assistant (NA)-G tole a nurse look at her of said she was not sur she wiggles her legs wheelchair. NA-G w licensed practical nu check her skin. LPN her right shin and sa about 3 inches (estir didn't know how it ha said the bandage sh days. LPN-B verified	Algorithms and the second states of the second s					

Facility ID: 00953

If continuation sheet Page 32 of 86

		AND HUMAN SERVICES				FORM	): 05/21/2015 APPROVED ). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING	ì		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	ILIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	when it was last cha bandage and dated An interview on 4/30 wound rounds were today. It measured front of her leg. A progress note dat "Resident alert and to staff, dressing ch tonight. pain with rei 4/19/15, at 1:18 p.m skin tear in her lowe 0.1 NA reported that resident Wheel chai and stopped her in t answer the call light coming out the resident back the event was wither resident backed his notified at 1820 [6:21 1828 [6:28 p.m.] and services] was notifie note addressing the An incident reported indicates right leg ski	anged. She applied a new it. D/15, at 8:56 a.m. RN-B said started and I measured it 4 cm x 0.6 cm tear on the ed 4/22/15, at 01:53 indicated able to communicate needs anged on Rt [right] shin moval" Another note dated indicated "Resident have a er right leg, measures 3.2 by t, NA was pushing the r [chair] to the dining room he middle of the hall way to of another resident when NA lent room, finds out that ck his chair against her leg. ssed by the resident itself and chair. DR. [doctor] was 0 p.m.], family was notified at d DNS [director of nursing d" No further progress open area on lower right leg. for R96 dated 4/18/15, in tear 3.2 x. 1 cm. This	FS	30			
	the hall way. Treatment record for monitoring, cleansing started on April 29th.	ther resident back into R96 in April 2015, indicated g and changing dressing Which was the day surveyor he care and treatment for lines, undated read,					

Facility ID: 00953

If continuation sheet Page 33 of 86

		AND HUMAN SERVICES	_		F	TED: 05/21/20 ORM APPROVE NO. 0938-03		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:	) DATE SURVEY COMPLETED		
		245184	B. WING			05/04/2015		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/04/2010		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			D1 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIO		
F 309	"licensed nurse will	be responsible for performing	F3	309	F314			
	Weekly Skin Review 483.25(c) TREATM PREVENT/HEAL P	ENT/SVCS TO	F3	314	-R147 and R203 no longer reside in the facility. R51 has been assessed for pressure ulcer risk with interventions implemented and care			
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f				planned to prevent further skin breakdown. -All residents at risk for pressure ulcer development have the potential to be affected by the identified practice. -Nursing staff have been educated on assessing risk for pressure ulcer development, weekly skin observations, and care planning interventions to prevent further breakdown.			
	by: Based on observative review, the facility fare reassessment after ulcer/s and develop interventions to pro- pressure ulcers from residents (R51, R14	IT is not met as evidenced ion, interview and document ailed to complete a skin development of pressure treatments and services note healing and prevent new in developing for 3 of 3 7, R203) reviewed with s resulted in harm for R51.			Educated 5/21, and 6/2 -Random bi-weekly audits will be conducted to ensure those residents determined at risk for skin breakdown have the necessary interventions in place to prevent further breakdown. Any required re- education will be conducted at that time Audits will be reviewed at QAPI and action planned as			
	and was observed to extending to buttock powder. On 4/21/15 open red areas on b and covered with dro	he hospital on April 7, 2015 o have a redden groin area s area which was treated with progress notes identified two uttocks which were treated essings. However, was no completed after finding these			needed. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/1.		

Facility ID: 00953

If continuation sheet Page 34 of 86

1

		AND HUMAN SERVICES				FORM	): 05/21/2018 APPROVED ). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING			05	/04/2015
	PROVIDER OR SUPPLIER	OCHESTER EAST		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	interventions put in wounds heal and pr developing. On Apri two stage II pressur again there had not interventions based completed from 4/2 aware of the open w 21/15. After survey attention a compreh was completed, the presence of the two care plan intervention Also R51 had not be a.m. to 12:00 p.m. a 2015. The lack of sk development of skin development of skin development of two resulted in harm to R R51 was admitted to according to the phy report dated 4/8/15. diagnosis as Obesity manifests type II (ad control even with the chronic bronchitis wi respiratory failure. R51 admission Minin 11/18/14 noted R51 needed extensive as daily living except su wheelchair for all mo with one assist. Also developing pressure reducing device for t	place to help the open revent new ones from II 29, 2015 surveyors observed re ulcers on buttocks and been a skin reassessment or on the skin reassessment 1/15 when the facility was first wounds on buttock area. Ors brought this to the facility's nensive skin reassessment doctor was notified of the stage II pressure ulcers and ons were being developed. Seen repositioned from 7:00 a total of 5 hours on April 29, kin reassessment and ninterventions and stage II pressure ulcers R51. O the facility on 11/7/14 visician's order summary Also the report included y, diabetes with neuro lult onset) and not under e use of insulin, obstructive ith exacerbation and acute mum Data Set (MDS) dated was cognitively intact and sistance with activities of opervision with eating. Used a ovement as only able to stand o indicated he was at risk for ulcers, and had pressure	F3	:14			

Facility ID: 00953

If continuation sheet Page 35 of 86

		AND HUMAN SERVICES				FORM	0: 05/21/2015 APPROVED 0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	/01/2010
	LIVINGCENTER - RO	CHESTED FAST			501 EIGHTH AVENUE SOUTHEAST		
GOLDEN	LIVINGCENTER - RU	CHESTER EAST			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 214	Our line of F	0.5	_				
F 314	e entanded i reni pu	-	FS	314	4		
	repositioning progra	ım.					
	cognitive impairmer Mental Status score assistance from one extensive assistance and used an indwell addition, the MDS in ulcers and a clinical determination of pre- ulcer risk assessme medical record durin time frame). During an interview p.m. he said, "I've b [nursing assistants- stand me up one tim observation at 2:15 used a mechanical I two brown dressings Licensed practical n the two brown adhes and left buttock. The drip from the dressin wounds to the floor. at this time with left centimeters (cm) by measured 0.1 x .0.0 bilateral wounds was excoriation present. grimaces during the up that hurts and I c was then lowered to that was soiled with sheet with the undre contact with the soile	S dated 2/17/15 indicated no it with a Brief Interview for e of 15, required extensive e staff for bed mobility, e from two staff for transfers, ling urinary catheter. In indicated a risk for pressure assessment was used in the essure ulcer risk (a pressure and the assessment was used in the assure ulcer risk (a pressure and the assessment with R51 on 4/29/15 at 2:04 een sitting here all day, they NAs] have only come in to the all day long!" During p.m. nursing assistant (NA)-K ift to stand R51 and observed s on each buttock cheek. urse (LPN)-A then removed sive dressing from R51's right are was red blood noted to the all from the buttock LPN-A took measurements wound measured 0.75 (x) 0.2 cm and right wound 01 cm. Surrounding skin of a deep red colored with some R51 displayed facial procedure and stated, "hurry an't breathe." The resident the recliner that had a pad body secretions and wrinkled ssed wounds coming in ad pad. LPN-A came back a applied dressings to the open					

If continuation sheet Page 36 of 86

		AND HUMAN SERVICES				FORM	D: 05/21/2015 APPROVED D: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	GOLDEN LIVINGCENTER - ROCHESTER EAST				501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	wounds. The lack o ulcers and the soile concern. Progress note dated redness but has ded get bleedy. Residen caused more bleedi pressure. Cleansed groin and buttock ar [non-adherent band R51's care plan that 11/12/14 indicated F deficit related to self mobility impairment; transfers. The care skin with care and re and bruises to charg included, Pressure to assistance required of diabetes, presence interventions to dece pressure ulcers inclu- complete Braden sc conduct weekly skin over bony prominent completed per living as ordered. The cur any repositioning sc R51's Treatment Add April 2015 included to skin checks with vita evening. Documenta check was performe documentation of the	f barrier between the open d pad was an infection d 4/21/15 read, "Continued creased, two areas noted that t had extra large stool and ng from wounds d/t [do to] area, applied zgard all over rea, applied two telfas age] to areas that bled." t had a last review date of R51 had a physical functioning f-care impairment, and required a mechanical lift for plan directed staff to inspect eport reddened areas, rashes, ge nurse. The care plan ulcer actual or at risk due to; in recliner mobility, diagnoses be of edema. The rease the risk or prevent uded but was not limited to ale per living center policy, inspection, do not massage ce, skin assessment to be center policy, and treatments trent care plan did not contain hedule. ministration Record (TAR) for the order to perform weekly al signs every Wednesday attion reflected the last skin d on 4/1/15, however e skin evaluation was not	F	314			
	found in the medical	e skin evaluation was not record. The order for skin as was discontinued on					

Facility ID: 00953

If continuation sheet Page 37 of 86

DEPAR	FORM	: 05/21/2015 APPROVED							
	TOF DEFICIENCIES	& MEDICAID SERVICES					MB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245184	B. WING			05	/04/2015		
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2010		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST				
040.15				_	ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE		
F 314	Continued From no	ao 07							
1 1 314		ge 37 or nursing order to discontinue	F 3	14	+				
		s not found in the medical							
	Documentation on t	he TAR indicated Z-Guard							
		d as ordered by the physician							
	seven times betwee	en 4/14/15 through 4/29/15.							
		reflected Gold Bond Powder d as ordered by the physician							
	4 times between 4/2	23/15 through 4/29/15. The							
	Gold Bond powder v scrotum rash.	was used to treat the redden							
	During an interview	on 4/29/15, at 2:04 p.m. R51							
	explained he could r	not sleep in a bed related to							
		and had the bed removed so chair. R51 stated he was							
	unable to come to a	standing position							
	independently and d	lepended on staff for mobility.							
		on 4/29/15, at 2:36 p.m.							
		N)-C explained R51 was given							
		ssure ulcers prevention and efused to use the bed and							
	R51 did not want the	e bed. Progress notes dated							
		staes bed was tried the week only three days then							
		as removed from the room to							
	save space. RN-C s	tated R51 did not tolerate							
	laying down. RN-C s	tated R51's usual routine ad down during the day. RN-C							
		he last time R51 was							
	repositioned today.								
	During an interview of	on 4/29/15, at 3:04 p.m.							
	director of nursing (D	DON) confirmed wound							
	tracking for R51 had	not been completed well, er system was needed. DON							
	further said the resid	ent's red perineal area							

Facility ID: 00953

If continuation sheet Page 38 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
245184 B. WING	05/04/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN LIVINGCENTER - ROCHESTER EAST 501 EIGHTH AVENUE SOUTHEAST	
ROCHESTER, MN 55904	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECT           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHO TAG         CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 314 Continued From page 38 F 314	
should have been tracked on the blue sheets so	
we could make sure it was healing and not	
getting worse. Also if the wounds do get worse	
we would notify the physician and get new orders for a different treatment.	
ior a different treatment.	
On 4/29/15, at 4:01 p.m. a nursing progress note	
authored by RN-A, wounds were referred to as "excoriation" and "some bleeding" was noted.	
The progress note indicated the current treatment	
ordered was Z-guard ointment [not consistent	
with physician's order to apply Z-guard to the	
perirectal area, not the buttocks], the nurse practitioner (NP) had been notified and a new	
order was given for Bourdreaux's Butt Paste	
topically to area three times a day.	
During an interview on 4/29/15, at 4:32 p.m. RN-A confirmed she had contacted nurse practitioner (NP).	
During an interview on 4/29/15, at 5:08 p.m. DON	
indicated she had completed an assessment of	
the buttocks wounds. DON then stated, "I am staging those wounds at stage II pressure ulcers	
they are both located over the ischium where	
there would be pressure." DON stated a foam	
dressing had been applied and explained the Bourdreaux's Butt Paste was not appropriate for	
those wounds. DON further explained a bed	
would be put in R51's room so that he could be	
laid down to obtain an accurate wound	
assessment and an appropriate dressing would be applied. The DON further explained the NP	
would look at the wound on 4/30/15. The	
corresponding nursing progress note authored by	
the DON at 5:22 p.m. read, "Resident has a dark	
red bottom with an open area on lower right ischium and left lower ischiumright wound	

Facility ID: 00953

If continuation sheet Page 39 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - RO	OCHESTER EAST			01 EIGHTH AVENUE SOUTHEAST OCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	measures 1.1 x .75 x .3 [cm]. Areas are exacerbated by mod During an interview LPN-A stated at 2:0 area with normal sa Mepilex. LPN-A con the wound findings During an interview stated she had work she had provided m a.m. for R51 (R51 w day shift for cares) care and a partial be dressings had come she stood R51 at no on sheet that covere looked raw. NA-B st hurt. NA explained a the wounds after sh NA-B stated she had repositioned him be p.m. the next time R around noon and blo the chair pad. During an interview confirmed the currer initiated and revised changes have been further explained the updated to reflect the and skin condition. T be on repositioning p care plan. The DON	[cm] left wound measures 1.2 e stage II from pressure and isture association" on 4/29/15, at 5:40 p.m. 0 p.m. she had cleaned the line and applied another firmed she did not document nor treatment given. on 4/29/15, at 5:57 p.m. NA-B ked the day shift. NA-B stated iorning cares around 7:00 vas assigned to NA-B for the that had included perineal ed bath; during cares the e off the wounds. NA-B stated iorn and there had been blood ed the chair and bottom a nurse applied dressings to e had reported his bottom a nurse applied dressings to e had reported it to the nurse. d not stood him or tween 7:00 a.m. and 12:00 IS1 stood up again was bod had been observed on on 5/1/15, at 8:24 a.m. DON int care plan for R51 was on 11/12/2015 and no made since then. DON e care plan would be now e two stage II pressure ulcers The DON stated R51 should program and included in the also explained wound were identified in the past	F3	14			

Facility ID: 00953

If continuation sheet Page 40 of 86

		AND HUMAN SERVICES				FOR	D: 05/21/2015 APPROVED		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	1 11	IPLE CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:					COMPLETED		
		245184	B. WING						
NAME OF I	PROVIDER OR SUPPLIER	240104	0. 11110		STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2015		
GOLDEN	I LIVINGCENTER - RC	CHESTER FAST			501 EIGHTH AVENUE SOUTHEAST				
					ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 314	Continued From page	ge 40	FS	314	4				
	hours) when assess and lacked a compr	repositioning (went over 6 sed as having two pressure ehensive skin reassessment interventions to promote							
	R147 stated he did r weakness and pain. his bottom that had	on 4/30/15, at 12:16 p.m. not get out of bed because of R147 stated he had sores on been there for a long time. Id not assisted or reminded all today.							
-	nursing assistant (N, side. Bottom reveale buttocks, and entire and upper gluteal's w that were slow to bla	on on 4/30/15, at 1:06 p.m. A)-E rolled R147 onto right ed chafing of bilateral upper upper portion of the sacrum vere red in color with areas unch. The right buttock ands one covered by slough.							
	at 1:16 p.m. RN-B ro measured the wound buttock is 0.3 centim RN-B explained wou ulcer. RN-B then me reported the measure RN-B stated that this pressure ulcer becau	on and interview on $4/30/15$ , illed R147 to right side. RN-B is and stated the right upper eters (cm) x (by) 0.7 cm. nd was a stage II pressure asured the wound below and ements of 0.4 x 0.4 cm. wound was an unstageable use the base cannot be seen. would dress the wounds an.							
	4/2/15 according to th with diagnoses that ir malignant neoplasm	o the facility on hospice on he facility admission record included but not limited to: of the kidney, bone, and heral and cerebrovascular							

Facility ID: 00953

If continuation sheet Page 41 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245184	B. WING	i		05/04/2015				
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST					
(XA) ID	SUMMA DV STA				ROCHESTER, MN 55904					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 314	Continued From pa	ne 41	F3	24	4					
	disease and rheuma	-		514	<b>64</b>					
		linimum Data Set (MDS) ed no cognitive impairment								
	with a Brief Interview	w for Mental Status (BIMS)								
	score of 14, require	d extensive assistance of two								
	mobility, transfers, o	ctivities of daily living of bed dressing, and toileting. The								
	MDS indicated R14	7 did not ambulate and				Í				
		mities had range of motion IDS further revealed a formal								
	and clinical skin ass	essment were used, did not								
	have pressure ulcer of ointments were u	s, and no topical applications sed.								
		harge summary dated								
		a gluteal skin alteration /thema and the wound bed								
		nmary indicated the wound								
	was covered with a	Mepilex (type of bandage).								
	R147's Admission C									
		/2/15 indicated no skin ms. The Braden Scale for								
	Predicting Pressure	Ulcers score indicated								
	moderate risk for pre	essure ulcers with a score of								
	generalized weaknes	t further indicated R147 had ss.								
	R147's Hospice adm	nission Physical/Clinical								
	Monitoring nursing d	ocumentation dated 4/2/15								
	indicated a non-surg	ical wound and read, "See ment: Not applicable" The								
	documentation lacke	ed description, location, and								
	measurements of the	e wounds. The								
	ulcer on buttocks. it v	indicated a stage I pressure was protected, and the area								
	was not measured.	protociou, and the area								

Facility ID: 00953

If continuation sheet Page 42 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	i		05/	04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From no	ao 10					
		ge 42 ysical Clinical Monitoring	FS	314	4		
	nursing documentat	tion dated 4/7/15 again					
	indicated the preser	nce of a non-surgical wound					
		assessment was not					
		cumentation reflected the cer on buttocks had healed.					
	olago i presedire die	or on buttoeks had healed.					
		ysical/Clinical Monitoring					
		tion dated 4/21/15 indicated r, the corresponding skilled					
	nursing note dated	4/21/15 read, "pt has irritated					
	skin on coccyx regio	on. RN [registered nurse]					
		m to this area and wrote order					
	for staff to apply TIL	D [three times per day] and prn ding to the documentation on					
		ent was not provided on four					
	occasions between	4/21/15 and 4/28/15.					
	R147's Comprehens	sive Skin Assessment that					
	included Tissue Tole	erance Observation (a skin					
		determine skin tolerance to					
		prominences; used to hing schedule) dated 4/2/15					
	was not completed.	ing solicidale, dated 4/2/15					
	Dragman and a						
	concerns" and indic	ed 4/5/15 read, "No new skin cated to treatments or					
		note dated 4/9/15 read, "					
	no apparent skin iss	ues were noted at this time."					
	These were the only	two progress notes that					
	mentioned R147 's	SKIN CONDITIONS.					
		ted 4/10/15 indicated R147					
		ring and required the use of a					
	instructed staff to ins	t for transfers. The care plan spect skin with care. Report					
		hes, bruising, or open areas					
	to charge nurse. The	e care plan also included					
	under pressure ulcer	r actual or risk due to;					

If continuation sheet Page 43 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245184	B. WING			05	/04/2015	
NAME OF I	PROVIDER OR SUPPLIER			ş	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0.1/2010	
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST			
				F	ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 314	Continued From an							
F 314	pa	•	F S	314	+			
		l in bed mobility, Braden score esity, dx [diagnoses] of						
	cancer, pain, use of	f psychotropic medications.						
		ed goal was skin will remain						
		n further instructed staff to cale per living center policy						
		skin inspection and provide						
		e after each incontinent						
		parrier cream. However, the urning and/or repositioning						
		a comprehensive skin						
	assessment.							
		on 4/30/15, at 1:31 p.m. NA-E						
		cked on R147 a number of			-			
		not reposition him since						
	arriving to work at 7	:00 a.m.						
	During an interview	on 5/1/15, at 8:24 a.m. DON						
		plan had not been updated to						
		ent open pressure ulcers nor terventions based on the						
		n reassessment. The DON						
	stated R51 should b	e on a consistent						
	repositioning schedu	ule.						
		cal Guideline: Skin Integrity						
		0 read All resident will be						
		for risk of skin breakdown dmission, quarterly and as						
		nge in condition. Living						
	Center develops a re	outine to review residents with						
		a weekly basis. Director of						
		NS) will be responsible to itor the skin integrity program.						
		nitored on a weekly basis.						
	Assessment/observa	ation is to be completed						
	within the first twenty							
	aumission/quarterly/	significant change of						

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	ì	05	/04/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
GOEDEN	EMINGOENTER-HO	Jonesten EAST			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	condition using the identified risk prese documented in the comprehensive care satisfactory complia evaluation flow shee designee evaluates Residents will be ob assistant (CAN) dai Changes will be rep and documented, in meet individual resid concentrated press for weekly observati resident's and print Administration Reco document weekly or evaluation glow she R203 was admitted three current press not completed a terr treatments and serv services on a consis and prevent further R203 was asked by p.m. if they had any stated she had oper today located on left nobody would wrap Ulcerations on my b treated daily. " Trea ago Friday when I ca change since then. T	Clinical Health Status Tool, If nt the interventions will be immediate plan of care or e plan. To demonstrate ance with guideline wound et is being used, DNS or wounds on a weekly basis. oserved by certified nursing ly for reddened/open areas. orted to the licensed nurse itiate positioning schedule to dent needs and minimize ure to skin. The nursing order ion will be entered on all out on the Treatment ord and licensed nurse to n all wounds using the wound	F	314			
		minutes to get cleaned up." sitting in her wheelchair, ositions while being					

Facility ID: 00953

If continuation sheet Page 45 of 86

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	i		05/	04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	pa	ge 45	F	314	4		
	interviewed.						
	(DON) was unable	a.m. the director of nursing to find treatment sheets for but would continue to look.					
	treatment record do changes. RN-A prov	p.m. RN-A stated, the bes not list wound dressing vided a copy of the treatment ted no charting exists for					
	the facility with adm Summary Report da of 4/17/15) including systemic inflammat affects joints], ulcer	25 p.m. R203 was admitted to ission diagnoses (Order ated 4/19/15 active orders as g rheumatoid arthritis [chronic, ory disorder that primarily of the lower limb, abscess of ons, pain in ankle and foot ed pain.					
	indicates the followi	Summary dated 4/17/15 ng skin alterations: skle Type: ulcer Treatment:					
	Treatment: cast 3. Location: Anal	Type: ulcer Treatment:					
	saline 4. Location: Anal Xeroform (petrolatu with normal saline of (self-adhesive abso	soaked & cleaned with normal Type: ulcer Treatment: m dressing gauze) cleansed covered with Mepilite rbent dressing). ower extremity Type:					
	puncture Treatment to a wound to prome	ent: Kerlix (compress applied ote healing)					
	Wound Evaluation F	Flow Sheet dated 4/17/15					

Facility ID: 00953

If continuation sheet Page 46 of 86

		AND HUMAN SERVICES					FORM	): 05/21/2015 APPROVED	)
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	0	(X3) DA	). 0938-0391 TE SURVEY MPLETED	
		245184	B. WING	i			05	/04/2015	
NAME OF I	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZI	P CODE	00	/04/2010	1
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEA	ST			
040.15	SUMMARY OTA				ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD	BE	(X5) COMPLETION DATE	
F 314	Continued From page	ae 46	F3	21/	4				
		lists the following areas							
		cyx 1 cm length x 0.2 cm							
	width. Stage 1 press	sure ulcer. Current treatment,							l
		Mepiborder (self-adhesive . No interventions listed.							
	2. Abscess coccyx	2 cm length x 1 cm width x							
	.3 cm depth. No trea	atment listed. Current ntions include wheelchair							l
		position. No time frame listed							
	for repositioning. No	ulcer stage/type listed.							
	Current treatment m	2 cm length x 1 cm width.							
	preventative interver	ntions wheelchair cushion,							
	turn and reposition. repositioning. No ulc	No times frames listed for er stage/type listed.							
		low Sheet dated 4/23/15							
	assessed:	lists the following areas				11			
	1. Abscess of cocc	eyx 1 cm length x 0.2 cm			1				
	Width. Current treatm Meniborder (self-adh	nent, cleanse cover with nesive absorbent dressing).							
	No interventions liste	ed.							
	2. Abscess coccyx	1 cm length x 0.3 cm width x atment listed. Current							
	preventative interven	atment listed. Current							
	cushion and turn rep	osition. No time frame listed							
	for repositioning. 3. Abscess coccvx	1.5 cm length x 0.7 cm							
	width. Current treatm	ent mepiborder. Current							
	preventative interven	tions wheelchair cushion, No times frames listed for							
	repositioning.								
	Clinical Health Status	s dated 4/17/15 3:25 p.m.							
(	completed by RN-B s	section B, skin conditions,							
	abscess and two per	concern areas; one a coccyx ianal abscesses along with a							

Facility ID: 00953

If continuation sheet Page 47 of 86

		AND HUMAN SERVICES				FORM	D: 05/21/2015		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245184	B. WING						
NAME OF F	PROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2015		
					501 EIGHTH AVENUE SOUTHEAST				
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST	ROCHESTER, MN 55904						
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 314	Continued From par note stating "others included was Brade Pressure Sore Risk indicating at risk for Care plan dated initi focus of "pressure up pressure ulcer press open areas on cocc related to the manage pressure ulcers to p to minimize the risk pressure ulcers was plan. No comprehensive at included clinical, phy factors. Clinical Guideline: S read, " page 1 Docu Interventions for Ski present the intervent the immediate plan of care plan, initiate po the individual resider concentrated pressure dietary of any newly pressure ulcers, nutr determines need for documentation comp occurs on initial notif ulcer." Treatment pr guidelines to care for	ge 47 unable to visualize." Also n Scale for Predicting with a total score 16 developing pressure ulcers. iated 4/17/2015 includes a ulcer actual or at risk due to: ent under cast. Has three yx area." No information gement of the current romote healing or inventions of development of new found on the temporary care assessments provided that ysical, and environmental risk kin Integrity dated 2/25/10 umentation and Care n Integrity: If identified risk tions will be documented in of care or comprehensive sitioning schedule to meet nt needs and minimize re to skin, nursing notifies admitted or acquired itional assessment nutritional interventions, oleted by registered dietician ication of a new pressure otocol on page 3 provides r stage 2, 3, 4, and does not give the guidelines	F 3		DEFICIENCY)	11AT E			
	Skin and Wound Car	e Guidelines, undated, was o the clinical guideline.							

Facility ID: 00953

If continuation sheet Page 48 of 86

		AND HUMAN SERVICES		FOR	D: 05/21/2015 MAPPROVED D. 0938-0391						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING (X3) COMPLE								
		245184	B. WING		5/04/2015						
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST		501 EIGHTH AVENUE SOUTHEAST							
				ROCHESTER, MN 55904							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE						
F 314		-	F 31	14							
SS=D	"Reddened Area sta include evaluate pre- for moisture cleanse episode with cleans Dimethicone Barrier 483.25(d) NO CATH RESTORE BLADDE Based on the reside assessment, the fac resident who enters indwelling catheter i resident's clinical co- catheterization was who is incontinent o treatment and service infections and to res function as possible This REQUIREMEN by: Based on observati review the facility fai assess the need for for bladder control for reviewed for indwelli Findings include: R141's admission re diagnoses which inc	r or Paste PRN." HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the endition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder IT is not met as evidenced on, interview, and document led to comprehensively an indwelling Foley catheter or 1 of 3 residents (R141)	F 31	<ul> <li>F315</li> <li>-R141 no longer resides in the facility.</li> <li>-All residents with an indwelling catheter have the potential to be affected by the identified practice.</li> <li>-Nursing staff have been educated on assessing residents with an indwelling urinary catheter for continued need.</li> <li>-Random bi-weekly audits will be conducted to residents with an indwelling catheter have a medical need for ongoing use of same. Any required re-education will be conducted at that time Audits will be reviewed at QAPI and action planned as needed.</li> <li>-Education provided on 5/21, and 621.</li> <li>-DNS/Designee is the responsible party.</li> <li>-Corrective action will be completed by 6-13-2015</li> </ul>	6/13/15						
		num Data Set (MDS) /27/15, indicated R141 was									

Facility ID: 00953

If continuation sheet Page 49 of 86

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			STRUCTION	0	X3) DATE	SURVEY LETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			COMP	LETED
		245184	B. WING				05/0	4/2015
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO	DE		
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			ESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETIO DATE
F 315	Status (BIMS) score urinary catheter. R141's care plan las the diagnosis of urin instructions for routi and directed staff to needed. The care p a 14 French Foley of catheter monthly. R141's hospital disr 1/21/14, indicated h related to diagnoses urinary tract infection infection secondary summary read, "fa her urinary tract infection infection secondary summary read, "fa her urina	ge 49 th a Brief Interview for Mental e of 13 and used an indwelling st revised on 10/2/14 included hary retention, included ine indwelling catheter care, o provide a urology consult as lan also instructed staff to use catheter, and to change the missal summary dated ospitalization had been s of clostridium difficile colitis, in, and recurrent urinary tract to self-catheterizations. The amily expressed concerns that ections are the result of when self-catheterizingit n indwelling catheter, despite would be the best option. option compared to having assist her with catheterization The summary indicated bladder was discovered on /06, and confirmed by an ompleted on 3/9/06; at which theterization started. visit progress notes dated 2/14, 2/2/15 and 4/10/15 s of atonic bladder and read, cystoscopy on 2/17/06. ndary to urinary retention."		15				

Facility ID: 00953

If continuation sheet Page 50 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	D: 05/21/2019 MAPPROVED D: 0938-039	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
	245184		B. WING	i		05	5/04/2015	
NAME OF PROVIDER OR SUPPLIER				1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	,04,2010	
GOLDEN LIVINGCENTER - ROCHESTER EAST					501 EIGHTH AVENUE SOUTHEAST			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		ROCHESTER, MN 55904	211		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 315	Continued From page	ge 50	FS	315	5			
	date of 2/2/14 identi urinary Foley cathet identification of the id determination the in catheter was the be- in the nursing home lacked identification and/or medical cond risk or cause urinary. The Evaluation for mo- Catheters section to indwelling catheter hassessment was las 1/30/15. During an observation R141 was noted to happropriately anchor During an interview of acknowledged the us R141 stated, "I used years, and then I car permanent thing. It's have in all the time! I and out, that I could During an interview of DON stated the cath removed when R141 trial attempted and/o the indwelling catheter	on 4/29/15, at 7:53 a.m. R41 se of an indwelling catheter. to catheterize myself for me here and it became a not something I wanted to I would prefer to do the in						
	reviewed on 1/5/15 re	lling Catheter Review last ead, "If the resident is with an indwelling catheter,						

Facility ID: 00953

If continuation sheet Page 51 of 86

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		245184	B. WING		05/0	4/2015
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	100/0	1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 315	ensure that resident diagnosis: urinary re medical or surgical contamination of sta care of terminally	t has an appropriate etention that cannot be y corrected, urine ate III or IV pressure ulcer. ill or severely impaired ed a clothing changes are	F 315			
F 323 SS=D	Justification/Decisio obtain a physician's for the justification of not met. The diagram monitor and assess determine toileting p diagram directed sta	n Diagram instructed staff to order for removal if criteria of an indwelling catheter was m further instructed staff to output for 72 hours to olan. In addition the decision aff to review quarterly for he indwelling catheter. ACCIDENT	F 323	F323 -Causal factors for falls have bee		
	environment remain as is possible; and e	sure that the resident s as free of accident hazards ach resident receives n and assistance devices to		identified for R113. R96 has had a assessment completed for safe us of a medical device for transfers. -All residents at risk for falls hav the potential to be affected by the identified practice. -Nursing staff have been educate on identifying causal factors for	an Se Ve he ed or	
	by: Based on observation review the facility fail a mechanical device (R96) reviewed for the thoroughly investigat	T is not met as evidenced on, interview, and document ed to assess the safe use of (EZ) for 1 of 1 resident ansfers; and failed to e falls to determine causal dents (R113) who had falls.		residents with falls. Nursing sta have been educated on neede assessments for safe use of medica devices for transfers. -Education provided on 5/21 an 6/2.	ed al	

Facility ID: 00953

If continuation sheet Page 52 of 86

		AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245184	B. WING	i		05	5/04/2015
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	/04/2015
GOLDEN	LIVINGCENTER - RC	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Findings include: R96's significant cha (MDS) dated 3/31/1 cognitively intact, no assistance for trans- daily living and toilet R96's care plan date diagnosis of paralys which literally means disease is another to acquired torsion dys disorder in which a p uncontrollably). The for an assistive device When observed on 4 assistant (NA)-G put assisted with her shi lift in front of her, wh shower chair. The w opposite side of the feet onto the lift and legs and the lift. NA standing position on her trunk. NA-G inst handles. NA-G had R96's legs and the left instructed R96 to pus started falling, NA-G again to bring her hip not in the proper pos the pillow being in be R96's pants and rolled wheelchair. R96 was	ange Minimum Data Set 5, indicated R96 was b behaviors, needs extensive fers, bed mobility, activities of ing. ed 2/18/15 indicated a is agitans (paralysis agitans, s shaking palsy, Parkinson erm for this disease), tonia (is a movement berson's muscles contract e care plan also listed a need	F 3	323	-Random bi-weekly audits will conducted of incident reports a Post Fall investigations, to ensi- causal factors have been identif and proper transfer devices a being used for residents with fa Audits will be reviewed at QAP1 a action planned as needed. -DNS/Designee is the responsi- party. -Corrective action will be comple- by 6-13-2015.	and ure ied are ills. and ble	6/13/15

Facility ID: 00953

If continuation sheet Page 53 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	: 05/21/2015 APPROVED . 0938-0391	)
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245184	B. WING	_		05/	/04/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			7
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST			
040.15					ROCHESTER, MN 55904			_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From page	ge 53	F3	323	3			1
		A-G on 4/29/15, at 9:05 a.m.			-			
		when she is pushing her legs						
		ork as well." "Some people of medical reasons but I think it						
		ervous." NA-G indicated R96						
	has gotten bruises f	rom the lift, so we put the						
	pillow in between the	e lift and her legs.						
	An interview with NA	A-H on 4/29/15, at 2:03 p.m.						
	indicated R96 is tran	nsferred with one staff and the						
		tted a pillow is placed in front						I
	of her legs to protec	t her legs.						l
	When interviewed o	n 4/29/15, at 2:43 p.m. R96						I
	said sometimes my	legs get scratched on the lift						l
	machine.							
	When interviewed o	n 4/30/15, at 8:42 a.m. unit						
	manager/registered	nurse (RN)-A indicated R96						l
	doesn't want to utiliz	e the Hoyer lift and the facility						
	is a "no lift" facility so	o staff place a pillow between he leg holders. When						l
	auestioned whether	a pillow was the best choice,						l
	RN-A indicated the in	ntervention was to pad it but						
	the direction to use a	a pillow was never stated. It						
	is the persons interp	retation of padding when a						
		I-A was unable to determine was safe as she had not						
		nt transfer in this manner.						
	RN-A also said thera	apy discussed this and the						
	use of padding was	discussed at morning stand						
	pillow.	vas no direction to use a						
		n 4/30/15, at 9:22 a.m. the						
	therapist (PT)-D indi	st (OT)-C and physical cated they were not entirely						
	sure how the skin tea	ar located on her leg						
		e told with the tremors R96						

Facility ID: 00953

If continuation sheet Page 54 of 86

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245184	B. WING			05	/04/2015
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	wheelchair. OT-C a was recommended a pillow in the mann the lift). OT-C said the EZ stand becau manufacturer recom assessment had no pillow with the EZ st During an interview director of nursing ( unaware of using th R96. The manufacturer re indicated "do not me Care plan dated 2/1 (wc,mech lift)" but d to use a pillow. A lift dated 2/5/15 indicat lift." There was no re regarding modificati R113 experienced a investigation to dete on-going appropriate fall was not evident R113 was admitted facility admission re- included but was no Alzheimer's disease joint pelvic region ar personal history of fa in walking. R113's quarterly Min	the foot peddle of the and PT-D indicated padding but never directed staff to use her used (between R96 and they can't use a pillow with se it is against the mmendations. Both agree an t occurred with the use of the rand. on 4/30/15, at 9:16 a.m. the DON) stated she was e pillow when transferring ecommendations for EZ lift bdify the lift unit." 8/15 lists "an assistive device oes not give any instructions t mobility status assessment ed R96 was safe to use a "EZ notation on the assessment	F3	323			

If continuation sheet Page 55 of 86

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245184 B. WING 05/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 323 Continued From page 55 F 323 with a Brief Interview for Mental Status (BIMS) score of 6, was independent with ambulation and transfers after set up, balance was steady during transitions and walking, used a cane or crutch, and had sustained two falls without injury since the previous assessment date. The MDS also included R113 had an indwelling urinary catheter. R113's care plan last reviewed on 3/10/15 read. "at risk for falls related to hx [history] of falls, use of Remeron." Interventions included but were not limited to encourage use of walker, give antianxiety medication per nurse practitioner (NP), use walker when ambulating as he is unsteady at times. The care plan also indicated R113 used a cane for ambulation. R113's physician orders per the electronic medical record (EMR) included the use of Oxycodone 5 milligrams (mg) two times a day as needed for headaches not relieved by Tylenol; Remeron (anti-depressant medication) 15 mg daily at bedtime; Ativan (anti-anxiety medication) 0.5 mg as needed for agitation/or anxiety two times a day as needed; and Celexa (anti-depressant medication) 20 mg daily. All of these medications could contribute to falling. R113 has experienced multiple falls between March 2015 and April 2015. R113 sustained two falls on 3/10/15 and one fall on 3/17/15 (Post Fall Analysis/plan had been completed). R113 also had a fall on 3/22/15 according to nursing progress notes but a post fall investigation was not evident in the medical record. The facility was requested to provide the most recent 3 months of fall investigations/incident reports and the investigation related to the 3/22/15, fall and/or report indicating the fall had occurred, and none

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00953

If continuation sheet Page 56 of 86

## DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245184 B. WING 05/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 EIGHTH AVENUE SOUTHEAST GOLDEN LIVINGCENTER - ROCHESTER EAST** ROCHESTER, MN 55904 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 56 F 323 was provided. A nursing progress note dated 4/16/15 read, "Resident was walking down the hall with his cane and then he got into elevator and gently sat on the floor of the elevator ... When up to 2nd floor nursing assistants assisted him to his room by pushing him in a wheelchair." R113 was observed walking with a cane on 4/29/15, at 8:29 a.m., at 10:52 a.m. and at 11:32 a.m. R113 was not observed to walk with the use of a walker during the survey. During an interview on 4/30/15, at 2:12 p.m. RN-A explained incidents were logged on a facility software system called DQI. RN-A stated the incident that occurred on 4/16/15 would be considered a fall and confirmed a follow up investigation or report had not been performed. RN-A stated a Post Fall Analysis/Plan should have been completed. Facility policy Falls Management Guidelines last reviewed 1/22/15 read, "The licensed nurse initiates the DQI Quality Control Report" and "Residents are evaluated for fall risk" and "licensed nurse completes change of condition-Post Fall Analysis following a resident fall." Facility policy Post Fall Analysis Summary and Guidelines for Completion last reviewed 11/13/14 read, "It is the policy of Living Center to complete the Post Fall Analysis Summary after every known resident fall to assess the individuals condition and to identify the reason and/or risk factor for fall in order to prepare a plan of care to reduce the potential for future falls." The policy included the definition of a fall as "A fall is a

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

Facility ID: 00953

If continuation sheet Page 57 of 86

			AND HUMAN SERVICES	_			FOF	ED: 05/21/201 MAPPROVE	
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, 2P CODE     STREET ADDRESS, CITY, STATE, 2P CODE       GOLDEN LIVINGCENTER - ROCHESTER EAST     STREET ADDRESS, CITY, STATE, 2P CODE     SOLDAL       (PA)     SUMMARY STATEMENT OF DEFICIENCIES     PREVIDENT AND SOLDADES     PROVIDER PLAN, MN S5904       (PA)     F323     SUMMARY STATEMENT OF DEFICIENCIES     PREVIDENT, STATE, 2P CODE     SOLDADES       (PA)     SUMMARY STATEMENT OF DEFICIENCIES     PREVIDENT, MN S5904     PROVIDER PLAN, AND SCHUDD BE     Consent of the Consent of the Consent of the APPROPRIATE     Deficiency       (PA)     SUMMARY STATEMENT OF DEFICIENCIES     PREVIDENT, MN S5904     F323     F323     Continued From page 57     Continued From page 57     SUMARY STATEMENT OF DEFICIENCY     PREVIDENT, STATE, 2P CODE     Deficiency       F 329     483.25(I) DRUG REGIMEN IS FREE FROM     F 329     F 329     F 329       Sudden change in position usually involving the floor or lowering/assisting a resident to the floor*     F 329     F329       each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicat therapy), or for excessive dose (including duplicat therapy) or for excessive adose.     F 329       Based on a comprehensive assessment of a resident the facility must ensure that residents who use antipsychotic drug stare have been educated inderecting start and experimentions.     -All residentified taraget behaviors and non-pharmacologic interventi			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /					
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Facility ID: 00953

If continuation sheet Page 58 of 86

AND PLAN OF CORRECTION         NAME OF PROVIDER OR SUPPLIER         GOLDEN LIVINGCENTER - ROCI         (X4) ID       SUMMARY STATEM         PREFIX       (EACH DEFICIENCY MU REGULATORY OR LSC         F 329       Continued From page medications could be continued effectiveness and R104) who were r medication use.         Findings include:       R4 was admitted to the diagnoses including de resident care plan prin         The facility identified R Minimum Data Set (MI 4/6/15, to have intact or mood symptom of poor	MENT OF DEFICIENCIES	A. BUILD	OMB NO. 0938-0391           TIPLE CONSTRUCTION         (X3) DATE SURVEY           UNG         COMPLETED           05/04/2015         05/04/2015
GOLDEN LIVINGCENTER - ROCI         (X4) ID PREFIX TAG       SUMMARY STATEM (EACH DEFICIENCY MU REGULATORY OR LSC)         F 329       Continued From page medications could be continued effectiveness and R104) who were r medication use.         Findings include:       R4 was admitted to the diagnoses including de resident care plan prin         The facility identified R Minimum Data Set (MI 4/6/15, to have intact of mood symptom of pool extensive assistance of	HESTER EAST	B. WING	03/04/2013
GOLDEN LIVINGCENTER - ROCI         (X4) ID       SUMMARY STATEM         PREFIX       (EACH DEFICIENCY MUREQULATORY OR LSC)         F 329       Continued From page medications could be a continued effectiveness and R104) who were medication use.         Findings include:       R4 was admitted to the diagnoses including de resident care plan print         The facility identified R Minimum Data Set (MI 4/6/15, to have intact or mood symptom of poor extensive assistance or extensive assistanc	MENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE
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revealed no indicators behavioral symptoms, continued use of antide During interview on 5/1 director of nursing state depression scale and o included on the facility form, although none wa R4's care plan revised area of potential for dru related to anti-depressa Interventions included t monthly pharmacy revise as ordered and monitor	gradually reduced with as for 2 of 2 residents (R4 reviewed for unnecessary e facility 9/2/13, with epression, according to ted 4/29/15. At on a significant change DS)assessment dated cognition, no behaviors, ir appetite, and required of two staff for activities of atus form dated 3/9/15, of depression, no however indicated epressant medications. 1/15, at 10:58 a.m., the ed she expected the facility cognitive exams to be Clinical Health Status as available. 10/8/14, included a focus ug related complications ant medication. to monitor for side effects, ews, provide medications r side effects, and tion plan as recommended hacist.	F3	<ul> <li>-Random bi-weekly audits will be conducted to residents with an indwelling catheter have a medical need for ongoing use of same. Any required re-education will be conducted at that time Audits will be reviewed at QAPI and action planned as needed.</li> <li>-Education provided on 5/21, and 621.</li> <li>-DNS/Designee is the responsible party.</li> <li>-Corrective action will be completed by 6-13-2015</li> </ul>

Event ID: W6S511

If continuation sheet Page 59 of 86

		AND HUMAN SERVICES			Р		: 05/21/2015 APPROVED
		& MEDICAID SERVICES					. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245184	B. WING	à		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	04/2010
GOLDE	N LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	including, 4/27/15 in during the day, R4 w about the facility in h mood symptoms we During interview on assistant (NA)-C sta of being irritable. Na that were sometimes with R4 and re-appr Document review of 4/14/15, revealed or an anti-depressant r daily. The physician for adverse reactions mouth, somnolence, diarrhea, anxiety, an Document review fro symptoms of depress Although the facility in quarterly psychosoci 1/20/15, which also re behaviors except "oo there were no record at a gradual dose red even though the resi symptoms.	n the evening, and 4/28/15 was observed in her room and her electric wheelchair. No ere observed. 4/29/15, at 7:52 a.m., nursing ated R4 had mood symptoms A-C stated interventions used s effective included to talk oach later. physician orders signed ders for citalopram (celexa) medication, 40 milligrams orders directed to observe s that included nausea, dry insomnia, sweating, tremor,	FS	329			

		AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
	245184 B. WING			05	/04/2015		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0 1/2010
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST			01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	been admitted to the diagnoses including depressive disorder disturbance. A revier revealed an order for milligrams (mg) dail related to depressiv Medication Review had been increased R104's 2/3/15, quar resident as severely displayed no mood i experienced behavio others including war assessment period. R104 was depender of daily living. A Clinical Status Her indicated the resider indicators of depress A quarterly Psychoss 2/17/15, also indicat indicators. R104's care plan dar resident had dement alteration in behavio her mood. A review of the Resid Detail Report for R10 only wandering behavior There was no docum	e facility 10/21/11 with c depressive type psychosis, and dementia with behavioral w of the Physician Orders or the use of Zoloft 75 y for "behavior dyscontrol e disorder." The Pharmacist Summary indicated the Zoloft in September of 2014. terly MDS identified the v cognitively impaired; indicators; however had oral symptoms directed at ndering 1-3 days during the The quarterly MDS indicated nt on staff to perform activities alth form dated 2/3/15, nt wandered but had no sion. ocial Progress Note dated ed R104 displayed no mood ted 2/22/15, noted the tia, was at risk for an rs, and had an alteration in dent Behavior Log & Behavior 04 from 4/1-5/1/15 revealed	F 32	29			

Facility ID: 00953

If continuation sheet Page 61 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES						PI		): 05/21/2015	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0		APPROVED	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DA	TE SURVEY MPLETED	
		245184	B. WING			κ.	05	05/04/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE			
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHE	AST			
		,			ROCHESTER, MN 55904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE	
F 329	Continued From pay continued use of the During interview on of nursing stated sh appropriate monitor cognition, as well as effect monitoring. During interview on director of nursing (I lacked consistent m and target behavior word and behavior verified behavior and inconsistently docum the continued need to medications, includin current dose. On 5/4/15 at 4:40 p.1 consultant pharmaci expectation facility si monitor residents' m determine the contin medications. The facility's Mood/B read, "The social ser facilitator, will ensure Committee utilizes the monitoring the freque surrounding behavior MAR (medication ad	ge 61 e increased dose of Zoloft. 5/1/15, at 10:58 a.m. director e expected staff to complete ing for depression and a pertinent medication side 4/29/15, at 7:19 a.m., the DON) verified the facility onitoring of mood symptoms a for residents who received medications. The DON d mood monitoring was nented in order to determine for the use of psychoactive ing antidepressants, at the m. via telephone, the st reported it was his taff would consistently ood and or behaviors to ued need for the ehavior Management policy vices coordinator, as	F 3		DEFICIEN		NATE	DATE	
F 334	the following: sympto severity of the behav	ms, cause, patterns, and	F 33	4					

Facility ID: 00953

If continuation sheet Page 62 of 86

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245184	B. WING	i		0	04/2015
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	05	5/04/2015
	I LIVINGCENTER - RO				01 EIGHTH AVENUE SOUTHEAST		
GOLDEN		CHESTER EAST		F	ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	that ensure that (i) Before offering th each resident, or the representative recei- benefits and potenti- immunization; (ii) Each resident is of immunization Octob- annually, unless the contraindicated or th immunized during th (iii) The resident or the representative has the immunization; and (iv) The resident's models documentation that if following: (A) That the resident representative was per the benefits and pote- immunization; and (B) That the resident influenza immunization contraindications or re The facility must devi- that ensure that (i) Before offering the mmunization, each re egal representative re	velop policies and procedures e influenza immunization, e resident's legal ves education regarding the al side effects of the offered an influenza er 1 through March 31 immunization is medically he resident has already been is time period; he resident's legal he opportunity to refuse edical record includes ndicates, at a minimum, the nt or resident's legal provided education regarding ential side effects of influenza ant either received the on or did not receive the on due to medical refusal. elop policies and procedures	F3	334		en to ne to ew ior lits on	6/13/13
( i	mmunization, unless	ffered a pneumococcal the immunization is ated or the resident has					

Facility ID: 00953

If continuation sheet Page 63 of 86

CENTERS FOR MEDICARE & MEDICARD SERVICES     CMB PROVED       STREEMING OF PROVIDER SUPPLIER     (A) PROVIDERSUPPLIERLA. IDENTIFICATION NUMBER.     (A) BUILLIPLE CONSTRUCTION A BUILLIPLE     (A) DATE SURVEY COMPLETED       MAME OF PROVIDER ON SUPPLIER     245184     B. WING     (B) THEET ADDRESS, CITY, STATE, 2P CODE SI EIGHT AVENUE SOUTHEAST ROCHESTER, MN 5504       MAME OF PROVIDER ON SUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES RECURRENT OF DEFICIENCIES RECURRENT ON THE PRECEDED BY FLUX RECOLLIFIER OF THE SIGNAL TRA     D PREFX RECOLLIFIER ON SECONDERS OF PRECEDED BY FLUX RECOLLIFIER ON SECONDERS OF RECOL PRECEDED THE APPROPRIATE DEFICIENCY ON LSD DEFICIENCIES RECOLLIFIER ON SECONDERS OF RECEDED BY FLUX RECOLLIFIER ON SECONDERS OF RECEDED BY FLUX RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     D PREFX RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     00/04/2016 COMERTION DATE SUMMARY STATEMENT OF DEFICIENCIES RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     D PREFX RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     00/04/2016 COMERTION DATE SUMMARY STATEMENT OF DEFICIENCIES RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     D PREFX RECOLLIFIER ON SECONDERS OF RECEDED THE APPROPRIATE DEFICIENCY     D PREFX RECOLLIF			AND HUMAN SERVICES			P		D: 05/21/2015
STATEMENT OF DEFICIENCIES AND FUN OF CORRECTION     [M1] PROVIDERSUPPLIER     [D2] DATE SUPPLIER     [D3] DATE SUPPLIER       NAME OF PROVIDER OR SUPPLIER     245184     B. WING			& MEDICAID SERVICES					
NAME OF PROVIDER OR SUPPLIER     USU64/2015       GOLDEN LIVINGCENTER - ROCHESTER EAST     STREET ADDRESS, CITY, STATE, ZP CODE       0(4)     SUMMARY STATEMENT OF DEFICIENCIES     SPECINK, MS 55904       PREFIX     REGULATORY OR ISE DEPORTOR     PROVIDER DAVID ON CONRECTION PROVIDES     One of the content of	STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION				PLE CONSTRUCTION	(X3) DA	TE SURVEY
STREET ADDRESS, CITY, STATE, JP CODE         GOLDEN LIVINGCENTER - ROCHESTER EAST         STREET ADDRESS, CITY, STATE, JP CODE         STATE ADDRESS, CITY, STATE, JP CODE         STATE, JP CODE<			245184	B. WING			05	04/2015
OCHESTER, MN 55904         OWI ID. PROV TGG       SUMARY STATEMENT OF DEFICIENCIES EXCLUDENCED BY FULL REGULATORY ON USET BENEFORMATION       D PROVIDERS PLAN OF CORRECTIVA DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       OME         F 334       Continued From page 63 already been immunized; (ii) The resident or the assident's legal representative has the opportunity to refuse immunization; and (iii) The resident or the resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident or resident's legal representative, based on an assessment and practitioner recommendation, a second pneumococcal immunization, and be to medical contraindication or refusal. (i) As an alternative, based on an assessment and practitioner recommendation, a second pneumococccal immunization.       F 334         This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza aconsent prior to administering the influenza consent prior to administering the influenza aconsent prior to	NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	00	04/2015
CMULT         SUMMARY STATEMENT OF DEFICIENCIES         PREFX         RCCHESTER, MM 59304           TAG         EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         D         D         PREFX         TAG         CONDENTS FLAN OF CORRECTION (EACH OPRICENCY MUST ACTION SHOLD BE CROSS-REFERENCE ACTION SHOLD BE DEFICIENCY)         0         D<	GOLDEN	LIVINGCENTER - RO	CHESTER EAST					
PREFX       TAG       REAULTORY OR LSC IDENTIFYING INFORMATION       PREFX       TAG       CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE TO THE APPOPRIATE       COMMATION CONSTRUCT ACTION SHOULD BE CROSS-REFERENCE       COMMATION COMMATICON COM					_			
already been immunized;       If 334         (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and       If 334         (iv) The resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumcocccal immunization; and       If 304         (B) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumcocccal immunization or did not receive the pneumcocccal immunization or did not receive the pneumcocccal immunization and be given after 5 years following the first pneumcocccal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.         This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.         Findings include:       R7 lacked evidence that they had been educated regarding the risks and benefits and potential side	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization or did not receive the pneumococcal immunization or did not receive the pneumococcal immunization as econd pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side	F 334	Continued From page	ae 63	F3	24			
representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (V) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization due to medical contraindication or the resident or the resident or the resident silegal representative refuses the second immunization.		already been immur	nized;	13	04			
<ul> <li>immunization; and</li> <li>(iv) The resident's medical record includes</li> <li>documentation that indicated, at a minimum, the following:</li> <li>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</li> <li>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</li> <li>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization assessment and practitioner recommendation, a second pneumococcal immunization.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 resident's (R7) reviewed for influenza immunizations.</li> <li>Findings include:</li> <li>R7 lacked evidence that they had been educated regarding the risks and benefits and potential side</li> </ul>		(iii) The resident or t	the resident's legal					
<ul> <li>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</li> <li>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</li> <li>(B) That the resident either received the pneumococcal immunization due to medical contraindication or refusal.</li> <li>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on influenza vaccine for 1 of 5 residents (f) review of 10 rinfluenza immunizations.</li> <li>Findings include:</li> <li>R7 lacked evidence that they had been educated regarding the risks and benefits and potential side</li> </ul>		immunization: and	he opportunity to refuse					
following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization or did not receive the pneumococcal immunization on a assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		(iv) The resident's m	nedical record includes					
<ul> <li>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</li> <li>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</li> <li>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization any be given after 5 years following the first pneumococcal immunization.</li> <li>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.</li> <li>Findings include:</li> <li>R7 lacked evidence that they had been educated regarding the risks and benefits and potential side</li> </ul>		documentation that	indicated, at a minimum, the					
representative was provided education regarding the benefits and potential side effects of pneumococcal immunization, and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.         (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.         This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.         Findings include:         R7 lacked evidence that they had been educated regarding the risks and benefits and potential side			nt or resident's legal					
pneumococcal immunization; and       (B) That the resident either received the         pneumococcal immunization or or did not receive       the pneumococcal immunization due to medical         contraindication or refusal.       (v) As an alternative, based on an assessment         and practitioner recommendation, a second       pneumococcal immunization may be given after 5         years following the first pneumococcal       immunization, unless medically contraindicated or         the resident or the resident's legal representative       refuses the second immunization.         This REQUIREMENT is not met as evidenced       by;         Based on interview and document review, the       facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5         residents (R7) reviewed for influenza       immunizations.         Findings include:       R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		representative was p	provided education regarding					
<ul> <li>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</li> <li>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</li> <li>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.</li> <li>Findings include:</li> <li>R7 lacked evidence that they had been educated regarding the risks and benefits and potential side</li> </ul>		the benefits and pote	ential side effects of					
the pneumococcal immunization due to medical contraindication or refusal.       (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.         This REQUIREMENT is not met as evidenced by:       Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.         Findings include:       R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		(B) That the reside	nt either received the					
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<ul> <li>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</li> <li>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.</li> <li>Findings include:</li> <li>R7 lacked evidence that they had been educated regarding the risks and benefits and potential side</li> </ul>		contraindication or re	nmunization due to medical					
pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		(v) As an alternative,	based on an assessment					
years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		and practitioner reco	mmendation, a second					
immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.         This REQUIREMENT is not met as evidenced by:         Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations.         Findings include:         R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		years following the fi	rst pneumococcal					
refuses the second immunization.         This REQUIREMENT is not met as evidenced         by:         Based on interview and document review, the         facility failed to obtain influenza consent prior to         administering the influenza vaccine for 1 of 5         residents (R7) reviewed for influenza         immunizations.         Findings include:         R7 lacked evidence that they had been educated         regarding the risks and benefits and potential side		immunization, unless	medically contraindicated or					
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by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side								
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Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		This REQUIREMENT	T is not met as evidenced					
facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side			and document review, the					
residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side	1	facility failed to obtair	n influenza consent prior to					
immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		administering the influence (BZ) review	uenza vaccine for 1 of 5					
R7 lacked evidence that they had been educated regarding the risks and benefits and potential side		immunizations.						
regarding the risks and benefits and potential side		Findings include:						
	1	regarding the risks ar	nd benefits and potential side					

If continuation sheet Page 64 of 86

		AND HUMAN SERVICES		PF	RINTED: 05/21/2015 FORM APPROVED	
		& MEDICAID SERVICES		ON	IB NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245184	B. WING		05/04/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/04/2013	
GOLDEN	N LIVINGCENTER - RO	CHESTER EAST		501 EIGHTH AVENUE SOUTHEAST		
	1			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION	
F 334	Continued From page 10/22/14.	ge 64	F3	334		
	in the medical recor the medical chart id influenza vaccine w	ed consent, was not available d of R7. Documentation in entified that R7 received an hile in the facility on 10/22/14.				
	provided an influenz but verified the cons 10/22/14 influenza v	p.m. the administrator a consent form dated 3/26/13 ent form provided prior to the accine was not available.				
SS=D	last updated 12/1/14 Consent or Declination provided on the influ- consents that are do original copy of the in- declination form will resident's current me section as the Immu consent was given for vaccine and that edu benefits was provide 483.60(a), (b) PHARM ACCURATE PROCE	MACEUTICAL SVC - DURES, RPH vide routine and emergency to its residents, or obtain	F 42	F425 -R203 no longer resides in f facility. R63 is receiving pr medications as ordered by f physician. -All residents receiving medicati have the potential to be affected. -Licensed staff have been educat on medication errors and medicati administration to include obtaini ordered medications and time administration.	ain the ion ed on ng	
	§483.75(h) of this pa unlicensed personne law permits, but only supervision of a licen	rt. The facility may permit I to administer drugs if State under the general		-Education provided on 5/21 a 6/2. -Daily review of medication administration will be conducted f timely administration and/ potential medication error	on for for	

Event ID: W6S511

Facility ID: 00953

If continuation sheet Page 65 of 86

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		1	. 0938-0391 E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		CON	IPLETED
		245184	B. WING _			05/	04/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	CHESTER EAST		501 EIGHTH AVEN ROCHESTER, M			
(X4) ID		TEMENT OF DEFICIENCIES	ID		DER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PRRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)		COMPLÉTION DATE
F 425	Continued From page	ao 65	F 42	F			
		es that assure the accurate	Г 42	5			
	acquiring, receiving	, dispensing, and		Negative f	indings will be addres	sed	
	the needs of each r	drugs and biologicals) to meet esident.		at that t	ime. Results will	be	
	The facility must am	alou or obtain the services of		reviewed a -DNS/Desi	ignee will be respons	sible	
	a licensed pharmac	ploy or obtain the services of ist who provides consultation		party.	action will be comple		Gliptis
	on all aspects of the services in the facili	provision of pharmacy		by 6-13-20		sieu	4/15/15
	services in the lacin	ıy.					
	This REQUIREMEN by:	IT is not met as evidenced					
	Based on interview	and document review, the					
		in medications for pain mely manner for 2 of 2					
		3) reviewed for pain.					
	Findings include:						
		with R203 on 4/27/15 at 3:03					
		o the surveyor that her ations had not been received					
	by the facility on the	day of admission.					
	The Admission Reco	ord sheet indicated R203 had					
		e facility on 4/17/15 with ne 15 milligrams (mg) one					
	tablet daily by mouth	and Oxycodone 15 mg one					
	half a tablet by mout for pain.	th every four hours as needed					
		documentation including a					
	fax Transmission Ve	rification Report, the en faxed to Alixa (pharmacy)					
	on 4/17/15 at 4:16 p						

If continuation sheet Page 66 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP		MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	· · /				IPLETED
		245184	B. WING	_		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Medication adminsit notes reviews for R2 no receipt of the Ox Although MAR docu provided R203 with Ibuprofen 400 mg, c and that the residen the facility had ultime emergency room to been unable to rece According to the hos Clinical Note from 4, received her narcotic at the NH [nursing h ultimately this is what tactile temps, chills, Narcotic pain prescr given to the patient to calls [by ER nurse] w staff awareness of the were accompanying setting." On 4/28/15 at 9:00 at (DON) stated she was medication issue. Sh issue with the fax sca During a telephone in pharmacist on 5/4/15 expected the facility medications available emergency medication	tration record and nursing 203 verified there had been ycodone 4/17/15. Imentation revealed staff had Tylenol 500 mg 2 tablets, and during the evening of 4/17/15, t had received some relief; ately sent R203 to the receive the Oxycodone they'd ive from the pharmacy. Spital Emergency Record /18/15, "She [R203] had not cs for pain since she arrived ome] yesterday afternoon, at is causing her low grade flushing, and abdominal pain. iptions were rewritten and to carry back to the NH and vere placed to reinforce the ne written prescriptions that the patient back to the NH a.m. the Director of Nursing as aware of the pain ne verified it had been an ripts for Alixa pharmacy. Interview with consultant 5 at 4:40 p.m. he stated he to have emergency e in the facility and to use the ons that are in the facility.	F 4	.25			
	AdministrationPrep						

Facility ID: 00953

If continuation sheet Page 67 of 86

		AND HUMAN SERVICES				FORM	): 05/21/2015 APPROVED ). 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DAT	TE SURVEY
		245184	B. WING			05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					501 EIGHTH AVENUE SOUTHEAST		
GOLDEN	ILIVINGCENTER - RO	JCHESTER EAST			ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Continued From an	07					
F 420	pa	-	F 4	25	5		
	indicates; if a medic	cation with a current, active					
	contacted or medic	ated, the pharmacy was ation was to be removed from					
	the night box/emerg	gency kit.					
	Policy titled, Miscell	aneous Special Situations					
	Unavailable Medica	tions section 6.10 dated 5/12					
	indicates; "the facilit	ty must make every effort to					
		tions are available to meet the ent. Section B indicates					
		) notify the attending physician					
		explain the circumstances,					
	expected availability	and optional therapy(ies) that					
		tain a new order and					
		he order for the non-available y the pharmacy of the					
	replacement order.						
	R63 had chronic pai	in and physician ordered					
	Lidoderm patch (slo	w release pain medication)					
	was not available du	e to not reordering the					
	for R63.	hich decreased pain control					
	R63 had diagnosis of	of shoulder region join pain,					
	pain in soft tissues in	n limb, backache, difficulty					
		orosis, and osteoarthrosis ility admission record.					
	according to the lact	inty aumission record.					
	R63's quarterly Minir	mum Data Set (MDS) dated					
	3/3/15 indicated mod	derate cognitive impairment					
		v for Mental Status (BIMS)					
		R63 frequently had pain ent period and received					
	scheduled pain med						
	Cigned - burlet						
	Lidoderm patch 5%	ders dated 2/23/15 included					
	neck/shoulder/rib tor	bically every 12 hours for					
		iouny overy remound for					

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA , IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245184	B. WING	i		05	5/04/2015
NAME OF P	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RC	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST		
					ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 425	Continued From no	00	_		_		
F 420	Continued From pa	-	F4	42	5		
	then remove.	2 hours in a 24 hour period					
	During an observati	on of a medication pass on					
		n. LPN-Z stated R63 did not					
		patches left in his supply and contact pharmacy to order					
	more.	contact pharmacy to order					
	During an interview	on 4/29/15, at 12:00 p.m.					
		narmacy had been contacted					
	and would be delive that evening.	ered the Lidoderm patch later					
	D62's Mediaction A	dministration Decard (MAD)					
		dministration Record (MAR) oply the Lidoderm patch at					
	8:00 a.m. and remo	ve the patch at 8:00 p.m. The					
	MAR further indicate	ed Lidoderm patch was not					
		and referred to a nursing					
	progress note.	ote dated 4/29/15 read,					
		ilable will be delivered tonight					
	per pharmacy."						
		on 4/29/15, at 5:19 p.m. R63					
		had an increase in pain and the pain patch was for,					
		patch was for his shoulders.					
	R63 stated the patch	h was on (with the resident's					
	consent, the patch v	vas observed not to be on by					
	this writer). R63 did	not recall being informed by es were not available.					
	During an interview	on $4/30/15$ , at 8:26 a.m.					
	registered nurse (RN	N)-A stated a medication error					
	report had not been	filled out for the omission of					
		RN-A stated a medication					
	reported to the physic	nave been filled out and ician.					
		on of a medication pass on					
	4/30/15, at 8:26 a.m	. licensed practical nurse					
	(LPN)-C was asked	if the Lidoderm had been					

Facility ID: 00953

If continuation sheet Page 69 of 86

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245184	B. WING		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 69	F 4	25		
	delivered for R63. L Lidoderm patches, t was not for R63. Th that contained 4 Lid the bag was not for the last few patches the bag and stated t and explained they original packages at	PN-C took out a box of the pharmacy label on the box e box also had a plastic bag oderm patches, the label on R63. Then LPN-C took out in the box that were behind the patches belonged to R63, had been taken out of the nd put with the other ones. ad put a new Lidocain patch				
	director of nursing ( practice to remove r packaging with the p the medication should	on 4/30/15, at 9:42 a.m. DON) stated it was not good nedication from the original oharmacy label. DON stated Id have been re-ordered at ays prior to the medication				
F 428 SS=D	medication) doses; a prescribed by the ph medication error rep physician notification evident.	dditional Ativan (anti-anxiety and did not follow the order sysician. In addition a ort was not completed, and of medication error was not GIMEN REVIEW, REPORT DN	F 42	28 F428		
	reviewed at least on pharmacist. The pharmacist mus the attending physici	e each resident must be ce a month by a licensed at report any irregularities to an, and the director of eports must be acted upon.		-Consultant pharmacist reviewed medication regimen for and R104. Recommendations I been addressed by primary MD. -All residents receiving medica have the potential to be affected -Consultant pharmacist has I educated on reviewing medica regimen for unneces medications.	ation been ation	

Event ID: W6S511

Facility ID: 00953

If continuation sheet Page 70 of 86

NAME OF PROV GOLDEN LIV (X4) ID PREFIX TAG F 428 Col	F DEFICIENCIES CORRECTION DVIDER OR SUPPLIER IVINGCENTER - RO SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS ontinued From pag	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	A. BUILDIN	PLE CONSTRUCTION G STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X3) DA COI 05	0. 0938-0391 TE SURVEY MPLETED /04/2015 /04/2015 COMPLETION DATE
GOLDEN LIV	SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS	CHESTER EAST TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	N BE	(X5) COMPLETION
GOLDEN LIV	SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	N BE	(X5) COMPLETION
(X4) ID PREFIX TAG F 428 Col	SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	ROCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
F 428 Col	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
Thi		ge 70	F 42			
I .				8		
faci idea revi unr Find On con exp mod deta the The inclu faci Con mor surr MAI repo the seve Acc bee diag depu distu	y: Based on interview ucility failed to ensu- entified irregularitie view 2 of 5 resider necessary medica ndings include: n 5/4/15 at 4:40 p.1 onsultant pharmaci (pectation facility s onitor residents' m etermine the contin e medications. ne facility's Mood/B cluded: "The socia cilitator, will ensure ommittee utilizes th onitoring the freque trounding behavio AR (medication ad port, Incident Repor e following: sympto verity of the behav ecording to the Adm en admitted to the agnoses including: pressive disorder a sturbance. A review	m. via telephone, the st reported it was his taff would consistently ood and or behaviors to ued need/effectiveness of ehavior Management policy al services coordinator, as that the Behavior be existing systems of ency and circumstances rs, including Care Tracker, ministration record), 24 hour orts to assist in determining oms, cause, patterns, and		<ul> <li>Monthly audit will be conduct after pharmacist medication revie Negative findings will be reviewed QAPI.</li> <li>DNS/Designee is the responsil party.</li> <li>-Corrective action will be complet by 6-13-2015</li> </ul>	ew. I at ble	6/3/15

Event ID: W6S511

Facility ID: 00953

If continuation sheet Page 71 of 86

DEPARTMENT OF HEALTH AND HUI CENTERS FOR MEDICARE & MEDIC					FOR	D: 05/21/2015 MAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVI	DER/SUPPLIER/CLIA FICATION NUMBER:				X3) DATE SURVEY COMPLETED	
	245184	B. WING			0	5/04/2015
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	,04,2010
GOLDEN LIVINGCENTER - ROCHESTER	REAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PI TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>F 428 Continued From page 71 Medication Review Summary had been increased in Septer</li> <li>R104's 2/3/15, quarterly MDS resident as severely cognitive displayed no mood indicators; experienced behavioral symptothers including wandering 1- assessment period. The quar R104 was dependent on staff of daily living.</li> <li>A Clinical Status Health form of indicated the resident wander indicators of depression.</li> <li>A quarterly Psychosocial Prog 2/17/15, also indicated R104 of indicators.</li> <li>R104's care plan dated 2/22/1 resident had dementia, was at alteration in behaviors, and ha her mood.</li> <li>A review of the Resident Beha Detail Report for R104 from 4/ only wandering behaviors had</li> <li>There was no documentation i indicate whether the resident of depressive symptoms which we continued use of the increased</li> <li>During interview on 5/1/15, at 1 of nursing stated she expected appropriate monitoring for depic cognition, as well as pertinent re effect monitoring.</li> </ul>	nber of 2014. identified the ly impaired; however had toms directed at 3 days during the rterly MDS indicated to perform activities dated 2/3/15, ed but had no ress Note dated displayed no mood 5, noted the risk for an d an alteration in vior Log & Behavior 1-5/1/15 revealed occurred. n the record to continued to have rould require the d dose of Zoloft. 10:58 a.m. director I staff to complete ression and	F 4	28			

Event ID: W6S511

Facility ID: 00953

If continuation sheet Page 72 of 86

		AND HUMAN SERVICES				FORM	): 05/21/2015 APPROVED
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		245184	B. WING	i		05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	/04/2015
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ON	0.0
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Continued From page	ge 72	F4	128	3		
	During interview on	4/29/15, at 7:19 a.m., the					
		DON) verified the facility onitoring of mood symptoms					
	and target behaviors	s for residents who received					
		medications. The DON d mood monitoring was					
	inconsistently docur	nented in order to determine					
	medications, includi	for the use of psychoactive ng antidepressants, at the					
	current dose.	0					
	P4 was admitted to						
	diagnoses including resident care plan p	the facility 9/2/13, with depression, according to rinted 4/29/15.					
	The facility identified	R4 on a significant change					
	4/6/15, to have intac	MDS)assessment dated t cognition, no behaviors,					
	mood symptom of p	oor appetite, and required					
	daily living.	or two starr for activities of					
		Status form dated 3/9/15,					
	revealed no indicato	rs of depression, no s, however indicated					
	continued use of ant	idepressant medications.					
	During interview on 5	5/1/15, at 10:58 a.m., the					
	director of nursing st	ated she expected the facility					
	included on the facili	d cognitive exams to be ty Clinical Health Status					
	form, although none	was available.					
	R4's care plan revise	ed 10/8/14, included a focus					
	area of potential for or related to anti-depres	drug related complications					
	Interventions include	d to monitor for side effects,					

If continuation sheet Page 73 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED . 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245184	B. WING			05/	04/2015	
NAME OF	PROVIDER OR SUPPLIER							
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			01 EIGHTH AVENUE SOUTHEAST			
				R	OCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CTION SHOULD BE COMPL D THE APPROPRIATE DAT		
F 428	Continued From pa	From page 73		28				
		reviews, provide medications	F4	20				
	as ordered and mor	nitor side effects, and						
	risk/benefit and re by physician and ph	duction plan as recommended narmacist.						
	During interview on	4/29/15, at 7:52 a.m., nursing						
	assistant (NA)-C sta	ated R4 had mood symptoms						
		A-C stated interventions used as effective included to talk						
	with R4 and re-appr							
	4/14/15, revealed or	f physician orders signed rders for citalopram (celexa) medication, 40 milligrams						
	daily. The physiciar	n orders directed to observe						
		ns that included nausea, dry e, insomnia, sweating, tremor, ad nervousness.						
		om 4/1-4/30/15 revealed no ssion had been exhibited.						
		had documentation of ial progress note dated						
	1/20/15, which also behaviors except "o	revealed no moods and no ccasionally feels down",						
-		nt notes regarding the use of the antidepressant.			F431			
	There were no record	mmendations for an attempt			-R36 no longer resides in the fac			
		duction of the antidepressant			R4 insulin has been repla Expired medication has I	aced. been		
	even though the res symptoms.	ident was not exhibiting			removed from the medication of	carts		
F 431	483.60(b), (d), (e) D	RUG RECORDS,	F 43	31	and medication rooms. Medicat			
		JGS & BIOLOGIĆALS	F 431		are being disposed of prop Controlled medications are b			
		ploy or obtain the services of			documented when dispensed. -All residents receiving medicat	tions		
		st who establishes a system and disposition of all			have the potential to be affected this deficient practice.			

Facility ID: 00953

If continuation sheet Page 74 of 86

	RS FOR MEDICARE T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	FORM APPROV OMB NO. 0938-03 MULTIPLE CONSTRUCTION (X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING
		245184	B. WING	05/04/2015
	PROVIDER OR SUPPLIER	OCHESTER EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIN
F 431	accurate reconciliat records are in order controlled drugs is r reconciled. Drugs and biological labeled in accordance professional principl appropriate accesso instructions, and the applicable. In accordance with S facility must store al locked compartment controls, and permit have access to the k The facility must pro- permanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 a abuse, except when package drug distrib quantity stored is mit be readily detected. This REQUIREMENT by: Based on observation review the facility fail that were expired for receiving insulin on the control section of the facility fail that were expired for receiving insulin on the facility fail that were expired for	sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the bry and cautionary e expiration date when State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to ceys. vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced on, interview, and record ed to remove insulin pens 2 of 9 residents (R36, R4) he 2nd floor; failed to k medications from potential	F4	<ul> <li>-Licensed staff have been educated on checking expiration dates prior to dispensing, proper disposition of medications, and documentation of administration.</li> <li>-Random audits will be performed on medication carts weekly to check for expired medications, proper disposition of medications, and documentation of administration. Negative findings will be reviewed at QAPI.</li> <li>-DNS/Designee is the responsible party.</li> <li>-Corrective action will be completed by 6-13-2015.</li> </ul>

If continuation sheet Page 75 of 86

		AND HUMAN SERVICES				FORM	: 05/21/2015 APPROVED	
STATEMENT	OF DEFICIENCIES	FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	. 0938-0391 E SURVEY	
AND FLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMPLETED		
		245184	B. WING	_		05/	04/2015	
					STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST			
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST			ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	Continued From page 75			101				
	e en la carron pa	room located on the 2nd floor	F 4	131				
		dication storage room located on reviewed during medication						
	storage observation	. In addition, the facility staff						
		contaminated medication dication storage observation						
	on 1 of 3 facility floo	ors. In addition, the facility						
		trolled medications were dispensed from 1 of 2						
	medication carts loc	ated on the 2nd floor when						
	reviewed. This had t residents who reside floors.	the potential to affect all 86 e on the second and third						
	Findings include:							
	During the medication review of the 3rd floor medication storage room on 4/28/15, at 10:00 a.m. an opened stock bottle of Bisacodyl (medication to treat constipation) was noted with an expiration date of 12/2014. It was currently available for use.							
	During the medication storage review of the 2nd floor East medication cart on 4/29/15, at 7:40 a.m. with trained medication assistant (TMA)-A, the following was noted:							
	(1) A Novolog (insulin used to treat diabetes) multidose pen for R36 had a dispensed date from the pharmacy of 2/20/15 and was labeled with an opened date of 3/7/15. R36's physician orders directed staff to give Novolog solution 100 unit/milliliter (ml) per sliding scale, before meals and at bedtime.							
	dispensed date from	nultidose pen for R4 had a the pharmacy of 3/10/15 an opened date of 3/21/15.						

Facility ID: 00953

If continuation sheet Page 76 of 86

		AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED	)
STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES         ATEMENT OF DEFICIENCIES         ID PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         245184					X3) DATE SURVEY COMPLETED		
		245184	B. WING			05	04/2015	
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	00	04/2013	1
GOLDE	N LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST			
	1	TEMENT OF DEFICIENCIES		F	ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	Continued From page 76		-	~				
	R4's physician orders directed staff to give		F 4	31				l
	Novolog PenFill solution cartridge 100 unit/ml per sliding scale, before meals.							
	When interviewed o	n 4/29/15, at 7:40 a.m.						
	TMA-A indicated mu	Iltidose insulin pens were						
	TMA-A verified the in	30 days after being opened." Insulin pens were past the 30						
	days and were expir	ed and indicated the nurses						
	insulin. A review of	taking care of and giving the R36's medication						
	administration record	d (MAR), revealed R36						
	day, for 25 days, after	n the insulin pen, four times a er the insulin pen was						
	expired. A review of	R4's MAR, revealed R4						
	a day, for 11 days, a	the insulin pen, three times fter the insulin pen was						
	expired.							
	(3) A stock bottle of	One Daily multivitamins had						
	as opened on 4/23/1	3/15. The bottle was labeled 5. TMA-A verified although						
	the multivitamins we	re expired, the bottle						
	indicated all staff who	ready for use. TMA-A administered medications						
	were responsible for	checking expiration dates						
	and removing expire	d medications from the cart.						
	During an observatio	n on 4/29/15, at 8:07 a.m.,						
	licensed practical nur location of the 2nd fir	se (LPN)-C moved the or West medication cart, to						
	retrieve an unidentifie	ed pill on the floor, located						
	underneath the cart.	LPN-C retrieved the pill						
	crushed it and threw	it inside a plastic bag, the small plastic bag with the						
	crushed pill into the tr	ash bin located on the side						
	of the medication car immediately after the	t. When interviewed incident, LPN-C stated she						
	dropped the pill on the	e floor so she, "Crushed it						

Facility ID: 00953

If continuation sheet Page 77 of 86

STATEMENT OF DEPROCENCIES AND PLAND PLANDERS       (M) PROVEDBRUPPLERLAL DEMTIFICIANT NUMBER:       (M) PUTCHE CONSTRUCTION A BULDING       (M) OUT BURNEY A BULDING         MARE OF PROVIDER OR SUPPLIER       245184       8 WING STREET ADDRESS, GTY, STATE, ZIP CODE 50 EIGHTH AYENUE SOUTHEAST ROCHESTER, MI SEGON       05(04/2015         MARE OF PROVIDER OR SUPPLIER       STREET ADDRESS, GTY, STATE, ZIP CODE 50 EIGHTH AYENUE SOUTHEAST ROCHESTER, MI SEGON       05(04/2015         Image: Comparison of the Compariso			AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED D. 0938-0391
NAME OF PROVIDER OR SUPPLIER     USUA42015       GOLDEN LIVINGCENTER - ROCHESTER EAST     STREET ADDRESS, CITY, STATE, ZP CODE SO EGRITH AVENUE SOUTHEAST ROCHESTER, MN 55904       MAIN PREFIX TAG     SUMAARY STATEMENT OF DEPICIENCES (EACH DEPICIENCEDED BY PLUL REGULATORY OR LSC DENTIFYING INFORMATION)     D PROVIDERS PLAN OF COMPECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       F 431     Continued From page 77 and put it in the trash." When asked about the process for disposing contaminated medications, LPN-C strugged her shoulders, and indicated she didn't know. LPN-C stated, "I'm just a tempI had one day of orientation. I don't know what their policy is."     F 431       During the medication storage review, on 4/29/15, at 2:11 p.m. of the 2nd floor West medication cart, urbit LPN-C the following was noted: (1) A stock bottle of One Daily multivitamins with an expiration date of 3/15. LPN-C verified, although the marcotics book, flipped the pages one by one and signed her name to some of the pages. When asked about the practice, LPN-C stated she signed all of the narcotics has had given throughout the day, at the end of her shift. LPN-C stated, "That's what do." When reconciling R82's Morphine Sulfate 30 mg, there were 80 in the punch pack, although the marcotic book revealed there were 88 pills. LPN-C stated, That's because I gave one and haven't signed it out yet." When reconciling R82's Morphine Sulfate 30 mg, there were 80 in the punch pack, although the marcotic book revealed there were 88 pills. LPN-C stated, That's because I gave in the numb pack, although the narcotic book revealed there were 83 pills. LPN-C stated, "That's because I gave him three today, and I haven't signed them out yt." When asked how she knows the narcotic book revealed there were 80 in the punch pack, although the narcotic book revealed there w		ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	(X3) DA	TE SURVEY
IMAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CTV, STATE, JP CODE         GOLDEN LIVINGCENTER - ROCHESTER EAST       SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS, CTV, STATE, JP CODE         Mail D       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER DFLWAR OF CORRECTIVE ACTION ADDRESTIVE ACTION ADDRESTING ADDRESTING ADDRESTING ADDRESTING ADDRESTING ADDRESTING ADDREST			245184	B. WING	à_		0;	5/04/2015
ROCHESTER, MN 55904         Provided       Summary Structure of concensions: EACH DERIVENCY MIST BE PRECEDENDED IN LIL RECULORING ON FORMETING INFORMATION       D PRECULORING ACTION SHOLD BE EACH DERIVENCY MIST BE PRECEDENDED IN LIL RECULORING ACTION FORMATION       D PRECULORING ACTION BADLE DE EACH DERIVENCY MIST BE PRECEDENDED IN LIL PRECULORING ACTION FORMATION       D PRECULORING ACTION BADLE DE EACH DERIVENCY MIST BE PRECEDENDED IN LIL RECULORING ACTION FORMATION       D PRECULORING ACTION EACH DERIVENCY TAG       D PRECULORING ACTION BADLE DE EACH DERIVENCY MIST DE EACH DERIVENCY MIST BE PRECEDENDED IN LIL PRECULATION ACTION EACH DERIVENCY DEFICIENCY       COMMATTION BECH CONFECTIVE ACTION BADLE DE EACH DERIVENCY DEFICIENCY       COMMATTION BECH CONFECTIVE ACTION BECH CONFECTIVE ACTI	NAME OF I	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
Description         Description           PHEFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION)         D         PREFX TAG         CONVERTS FUN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECEDENCY)         D         PREFX TAG         CONVERTS FUN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECEDENCY)         D         D         PREFX TAG         CONVERTS FUN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         D	GOLDEN	LIVINGCENTER - RO	CHESTER EAST					
PHERX TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTIONY OR LSC DENTIFYING INFORMATION)       PRETX TAG       CEACH CORPECTIVE ACTION SHOULDS BE CROSS-REFERENCE OT THE APPROPRIATE       COMBATE         F 431       Continued From page 77 and put it in the trash." When asked about the process for disposing contaminated medications, LPN-C shrugged her shoulders, and indicated she didn't know. LPN-C stated, "I'm just a tempI had one day of orientation. I don't know what their policy is."       F 431         During the medication storage review, on 4/29/15, at 2:11 p.m. of the 2nd floor West medication cart with LPN-C the following was noted: (1) A stock bottle of 01/5 LPN-C verified, atthough the multivitamins were expired, the bottle remained in the cart, ready for use. (2) When reviewing and reconciling narcotics located on the 2nd floor West medication cart, LPN-C took the narcotic book, flipped the pages one by one and signed her name to some of the pages. When asked about her practice, LPN-C stated she signed all of the narcotics bash had given throughon the day, at the end of her shift. LPN-C stated, "That's what 1 do." When reconciling R82's Morphine Sulfate 30 mg, there were 80 in the punch pack, atthough the narcotic book revealed there were 88 pills. LPN-C stated, That's because I gave one and havent signed thout yet." When asked how she knows the narcotic counts accurate, LPN-C stated, "I like to count the bay, at loor, then accound book revealed there were 83 pills. LPN-C stated, "That's because I gave him three today, and I havent signed them outy et." When asked how she knows the acroutic count is accurate, LPN-C stated, "I like to count them by myself before I count with the nurse at shift change."         During the medication storage review of the medication storage rerowiew of the medication storage rerowiew of the medicat						ROCHESTER, MN 55904		
and put it in the trash." When asked about the process for disposing contaminated medications, LPN-C Shrugged her shoulders, and indicated she didn't know. LPN-C stated, "I'm just a tempI had one day of orientation. I don't know what their policy is." During the medication storage review, on 4/29/15, at 2:11 p.m. of the 2nd floor West medication cart with LPN-C the following was noted: (1) A stock bottle of One Daily multivitamins with an expiration date of 3/15. LPN-C verified, although the multivitamins were expired, the bottle remained in the cart, ready for use. (2) When reviewing and reconciling narcotics located on the 2nd floor West medication cart, LPN-C took the narcotic book, flipped the pages one by one and signed her name to some of the pages. When asked about her practice, LPN-C stated she signed all of the narcotics she had given throughout the day, at the end of her shift. LPN-C stated, "That's what 1 do." When reconciling RB2's Morphine Sulfate 60 milligrams (mg), there were 87 pills in the punch pack, although the narcotic book revealed there were 88 pills. LPN-C stated, "That's because I gave one and haven't signed it out yet." When reconciling RB2's Morphine Sulfate 30 mg, there were 80 in the punch pack, although the narcotic book revealed there were 83 pills. LPN-C stated, "I like to count them by myself before 1 count with the nurse at shift change." During the medication storage review of the medication storage row located on the 2nd floor	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
process for disposing contaminated medications, LPN-C strugged her shoulders, and indicated she didn't know. LPN-C stated, "I'm just a templ had one day of orientation. I don't know what their policy is." During the medication storage review, on 4/29/15, at 2:11 p.m. of the 2nd floor West medication cart with LPN-C the following was noted: (1) A stock bottle of One Daily multivitamins with an expiration date of 3/15. LPN-C verified, although the multivitamins were expired, the bottle remained in the cart, ready for use. (2) When reviewing and reconciling narcotics located on the 2nd floor West medication cart, LPN-C took the narcotic book, flipped the pages one by one and signed her name to some of the pages. When asked about her practice, LPN-C stated she signed all of the narcotics she had given throughout the day, at the end of her shift. LPN-C stated, "That's what 1 do." When reconciling R82's Morphine Sulfate 60 milligrams (mg), there were 87 pills in the punch pack, although the narcotic book revealed there were 88 pills. LPN-C stated, "That's because I gave one and haven't signed it out yet." When reconciling R82's Morphine Sulfate 30 mg, there were 80 in the punch pack, although the narcotic book revealed there were 8 pills. LPN-C stated, "That's because I gave him three today, and I haven't signed ther were 8 pills. LPN-C stated, "That's because I gave him three today, and I haven't signed them out yet." When she knows the narcotic count is accurate, LPN-C stated, "I like to count them by myself before I count with the nurse at shift change."	F 431	puge		F4	43	11		
medication storage room located on the 2nd floor on 4/29/15, at 2:40 p.m. with LPN-C, three stock		and put it in the tras process for disposin LPN-C shrugged he she didn't know. LPI had one day of orien policy is." During the medication at 2:11 p.m. of the 2 with LPN-C the follo (1) A stock bottle of an expiration date or although the multiviti bottle remained in the (2) When reviewing located on the 2nd fil LPN-C took the narco one by one and sign pages. When asked stated she signed all given throughout the LPN-C stated, "That reconciling R82's Mo (mg), there were 87 although the narcotic 88 pills. LPN-C stated one and haven't sign reconciling R82's Mo were 80 in the punch book revealed there "That's because I gat haven't signed them she knows the narcoo stated, "I like to coun count with the nurse	th." When asked about the ag contaminated medications, er shoulders, and indicated N-C stated, "I'm just a tempI natation. I don't know what their on storage review, on 4/29/15, and floor West medication cart wing was noted: One Daily multivitamins with f 3/15. LPN-C verified, amins were expired, the be cart, ready for use. and reconciling narcotics loor West medication cart, cotic book, flipped the pages ed her name to some of the about her practice, LPN-C I of the narcotics she had b day, at the end of her shift. 's what I do." When orphine Sulfate 60 milligrams pills in the punch pack, c book revealed there were ed, "That's because I gave the dit out yet." When orphine Sulfate 30 mg, there a pack, although the narcotic were 83 pills. LPN-C stated, ve him three today, and I out yet." When asked how tic count is accurate, LPN-C t them by myself before I at shift change."	F 4	43			
		on 4/29/15, at 2:40 p.	.m. with LPN-C, three stock					

1

	TMENT OF HEALTH							FORM	05/21/2018 APPROVED 0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION				ECONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
		245184	.	B. WING				05	/04/2015
NAME OF	PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, S	TATE, ZIP CODE	1	
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST				1 EIGHTH AVENUE SO			
					R	OCHESTER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED I SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	x	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
	bottles of One Daily an expiration date of although the multivity bottle remained on to of Aplisol tuberculin refrigerator. The via LPN-C indicated shi opened and verified dated. LPN-C verifies new admissions to the the refrigerator, read During an interview director of nursing (( medications should should be labeled w stated, "They're not [medications] in our indicated she had re- medications] in our indicated she had re- medications. DON so not be thrown in the didn't how the facility contaminated medic "Narcotics should be book] when given." A review of the pack cartridges revealed, FlexPen or Novolog should be kept at ter (86°F) for up to 28 d A review of the facility Preparation and Ger 5/12, included, durin "The expiration date is checked."	multivitamins were of 3/15. LPN-C ver tamins were expire the shelf, ready for was noted in the m il was opened, but e didn't know where that it should have ed the Aplisol was dy for use. on 4/30/15, at 1:39 DON) concurred et not be used and m ith the date opened rotating our stock central supply," ar emoved all of the e stated, "Medication garbage," but stat y disposed of unus eations. DON also s e signed [in the nar age insert for Nove "Once a cartridge FlexTouch is punc mperatures below to ays"	ified, ed, the use. A vial nedication not dated. n it was been used for stored in 0 p.m., xpired nedications d. DON nd she xpired ns should ed she ed or stated, rcotics blog or Novolog tured, it 30°C ninistration, container	F 45	31				
	A review of the facilit	-	Struction	F	Facilit	ty ID: 00953	If continuatio	n sheet F	Page 79 of 86

		AND HUMAN SERVICES				FORM	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245184	B. WING			05/0	04/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 F 441	and non-returnable removedMix drug substance, such as groundsThe provi the facility is unsure for a medication" A review of the facil policy, dated 5/12, i or package types, s injectable vials, of expiration date sho expiration date sho expiration date to in potency." Also inclu of a manufacturer's broken, the contain nurse will check the medication before a medication before a medication will be a expired medication active supply and d regardless of amou A review of the facil policy, dated 5/12, i accountability of the drugs is maintained controlled drug is an nurse administering enters the following accountability recor administration 2) Remaining quantity administering the do medication is actual	ncluded, "Unused, unwanted medications should be s with an undesirable cat litter or used coffee ider pharmacy is contacted if e of proper disposal methods ity's Storage of Medications ncluded, "Certain medications such asmultiple dose nce opened, require an rter than the manufacturer's near medication purity and ided, "When the original seal container or vial is initially er or vial will be datedThe expiration date of each administering itNo expired administered to residentAll will be removed from the estroyed in the facility, nt remaining" ity's Controlled Substances ncluded, "Accurate e inventory of all controlled at all times. When a dministered, the licensed of the medication rd (MAR): 1) Date and time of Amount administered3) 4) Initials of the nurse ose, completed after the		431			

Facility ID: 00953

If continuation sheet Page 80 of 86

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		245184	B. WING		05/04/2015
	PROVIDER OR SUPPLIER	OCHESTER EAST	5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441 SS=F	Continued From pa SPREAD, LINENS	ge 80	F 441		
	Infection Control Prisafe, sanitary and c to help prevent the o of disease and infect (a) Infection Control The facility must est Program under white (1) Investigates, cor- in the facility; (2) Decides what pri- should be applied to (3) Maintains a reco- actions related to in- (b) Preventing Sprea- (1) When the Infecti- determines that a re- prevent the spread of isolate the resident. (2) The facility must communicable disea- from direct contact will tra- (3) The facility must hands after each dir hand washing is ind professional practice (c) Linens Personnel must han	Program tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and rd of incidents and corrective fections. ad of Infection on Control Program isident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted			nce use ind ing to ce. ed NS on rts Bi- be are dit nd

Facility ID: 00953

If continuation sheet Page 81 of 86

	MENT OF HEALTH							FORM	APPROVED
	RS FOR MEDICARE				TID				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO							E SURVEY PLETED
		245	184	B. WING				05/04/2015	
NAME OF F	PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP	CODE		
	LIVINGCENTER - RO		T		5	501 EIGHTH AVENUE SOUTHEAST			
GOLDEN	LIVINGCENTER - RC	CHESTER EAS	•		F	ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFI) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 81		F 4	41				
Γ 44 I	This REQUIREMEN by: Based on observat review the facility in evidence that reside so that surveillance the spread of infect infection control pro open wound was pr for 1 of 5 residents This had the potent all residents who re Findings include: Lack of a functionin Infection control do surveyors included of February, March When the Line Listi was reviewed for Fe documentation lack outcome surveilland collecting/documen and comparing the on the log did not ha culture of the infect the correct antibiotic	NT is not met a ion, interview and fection control p ent infections we and investigation ion occurred thr ogram and failed otected from co (R51) with woun ial to affect staff side in the facili g infection cont cumentation pro documentation pro documentation and April 2015. Ing of Resident I ebruary, March ed any tracking ce process that ting data on ind collected data. ave documentation ion was comple c was prescribe ed.	nd document program lacked ere monitored on to prevent ough an active d to ensure an ontamination nd treatments. f, visitors and ity. rol program: ovided to for the months Infections form and April 2015, analyzing and consisted of ividual cases The infections tion that a ted to identify d or whether	F 4	-41				
	Documentation related to the analysis of residen infections to determine whether the treatment was effective to reduce the spread of infection was requested but none provided.								
FORM CMS-25	On 4/27/15 at 2:53 67(02-99) Previous Versions		r of nursing Event ID:W6S511	1	Fa	cility ID: 00953	continuatio	on sheet f	Page 82 of 86
01111 010-20		000000	2101110.110001			1	sonnualle		-90 01 01 00

	TMENT OF HEALTH							FORM	05/21/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/ IDENTIFICAT	SUPPLIER/CLIA FION NUMBER:					(X3) DAT	E SURVEY IPLETED
		24	5184	B. WING	·			05/	04/2015
NAME OF	PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER EA	ST			501 EIGHTH AVENUE SOUT ROCHESTER, MN 55904			
(X4) ID	SUMMARY STA	TEMENT OF DEFI	CIENCIES	ID		PROVIDER'S PLAN		N	(X5)
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L			PREFI		(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPR	BE	COMPLETION DATE
	(DON) stated the for control documentat [2015] now. I just go now." When questi knowledgeable abo surveillance and act the DON replied, "" There has been like On 5/1/15 at 10:27 was no documentat surveillance. The D would put a map in too late to analyze, doing in May. We w one line at a time to "We make sure the one to make sure it allergies, and if they the last 30 days so working or not work urinary tract infectio and vitals. Sometim have no more signs the doctor's orders, usually evaluates wi to look at, vitals eve Look at the confusio neuro checks, intak R51 was observed t seated on a soiled p soiled pad: During an observatio licensed practical nu brown adhesive dres while he was standir surrounding skin of was deep red with s present. Without co	ollowing regard ion, "I'm work of February an ioned who wou ut infection co tivity prior to F There probably a 30 day turn a.m. the DON ion of infection ON also stated the infection c so mapping wi ere doing one get what we co y have a cultur is the right and y have been or they don't have ing. Before the ns] try cranber es we do a fol and symptom the NP [nurse hen they are h ry day and the on, is it from m e and output." o have open w ad with wound on on 4/29/15, urse (LPN)-A p ssing from R5 ng on the meci the bilateral op ome excoriation mpletion of the	king on April d March done lld be ntrol ebruary 2015, y isn't anyone. over here." verified there n control d, "Normally we ontrol book. It's ill have to start thing at a time could done." re if they need tibiotic, no n it [antibiotic] in e a pattern, is it e antibiotic [for rry tabs, fluids, low up if they s, depends on practitioner] ere. Symptoms ir patterns. eds, possibly younds and was d in contact with at 2:15 p.m. ulled off a 1's right buttock hanical lift. The pen wounds on and irritation e dressing	F					
FORM CMS-256	67(02-99) Previous Versions (	Obsolete	Event ID:W6S511		Fac	cility ID: 00953	If continuatio	n sheet P	age 83 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	: 05/21/2015 APPROVED . 0938-0391	
STATEMENT	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184					(X3) DAT	X3) DATE SURVEY COMPLETED	
		245184	B. WING			05/	04/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		,	
GOLDEN	I LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
F 441	Continued From page 83		F 4	141				
	change, R51 was then lowered unto a soiled pad located on the recliner.							
	During an interview	on 4/29/15, at 5:57 p.m. IA)-B stated she had worked						
	the day shift and ha	d provided morning cares to m. which included peri care						
	and a partial bed ba	th. NA-B indicated that es the dressings had come off						
	from the wounds loo	cated on the buttock and en redressed before seating						
	back in chair. NA-B	e stated she assisted R51 at e was blood evident on the						
	protective pad. NA-	B explained a nurse shortly dressings to the wounds, after						
	it had been requeste	ad at 12:00 p.m NA-B stated dressings on the wounds						
	since they had faller							
	DON concurred that	t sitting in a chair with no wound would cause						
	contamination to the	wounds. In addition, the if the dressing change could						
		ne open areas should have						
	483.75(o)(1) QAA	J	F 5	20				
SS=F	COMMITTEE-MEMI QUARTERLY/PLAN							
	A facility must maint	ain a quality assessment and						
	assurance committe nursing services; a p	e consisting of the director of physician designated by the 3 other members of the						
		ent and assurance least quarterly to identify o which quality assessment						

Facility ID: 00953

If continuation sheet Page 84 of 86

		AND HUMAN SERVICES				FOR	D: 05/21/2015 MAPPROVED	D
		& MEDICAID SERVICES				OMB N	<u> 0. 0938-0391</u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		ATE SURVEY	
		245184	B. WING			0	5/04/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			1
GOLDE	N LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST			
					ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX i	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 520	and assurance activ develops and implet action to correct ide A State or the Secret disclosure of the rec- except insofar as su compliance of such requirements of this Good faith attempts and correct quality d a basis for sanctions This REQUIREMEN by: Based on interview facility failed to hold and Process Improve This had the potentia the facility. Findings include: Quality Assurance ar [QAPI] committee do surveyors lacked doo of 8/2014 through 2/2 meeting. On 5/1/15 at 1:02 p.m (DON) stated,"There [QAPI meetings]. I pu- here last, you have to maybe he has inform On 5/1/15 at 1:08 p.m	<ul> <li>vities are necessary; and ments appropriate plans of ntified quality deficiencies.</li> <li>etary may not require cords of such committee to identify committee with the section.</li> <li>by the committee to identify leficiencies will not be used as s.</li> <li>T is not met as evidenced and document review the quarterly Quality Assurance ement committee meetings. al to affect all 99 residents in</li> <li>nd Process Improvement commentation for the months 2015 for having had a QAPI</li> <li>n. the Director of Nursing is nothing in between there ut them in motion when I was o ask [the] administrator</li> </ul>	F	520	<ul> <li>F520 <ul> <li>-QAPI meetings are being heregulatory guidelines.</li> <li>-QAPI members have educated on the requirement meetings.</li> <li>-Education will be provided 6/13/2015.</li> <li>-Audits will be completed month insure QAPI meetings are 10 held per regulatory requirement -ED/Designee will be response party.</li> <li>-Corrective action will be completed solution will be completed by 6-13-2015.</li> </ul></li></ul>	been s for l by hly to being s. sible	6/13/1	

If continuation sheet Page 85 of 86

		AND HUMAN SERVICES					FORM	05/21/20 APPROVE 0938-03
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DAT	E SURVEY
		245184	B. WING				05/	04/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE	00/	04/2013
GOLDEN	I LIVINGCENTER - RO	OCHESTER FAST		50	01 EIGHTH AVENUE SOUTHE	EAST		
				R	OCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPF	BE	(X5) COMPLETIO DATE
F 520	meeting. The forme did attend but we di administrator verifie documentation of Q through 2/2015. On 5/4/15 at 4:30 p. the QAPI committee	or DON and medical director idn't document." The	F 5	520				
RM CMS-256	7(02-99) Previous Versions O	bsolete Event ID:W6S511		Facilit	ty ID: 00953	If continuation	sheet Pa	909 86 of 8

		AND HUMAN SERVICES		F5184024	FOR	D: 05/21/2015 MAPPROVED D. 0938-0391	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION <sup>T</sup> ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245184		B, WING		04	4/28/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	rs	кс	00			
	FIRE SAFETY			1 n /			
3-15	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		Pocok B 6-5-15			
V: 61.	ONSITE REVISIT ( CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
5-4-15- L	Minnesota Departm Fire Marshal Divisio Golden Livingcente not in substantial co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		RECEIVED			
XIT:	Chapter 19 Existing PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-TAGS) TO:			JUN ~ 4 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION			
F	Health Care Fire Ins State Fire Marshal I 445 Minnesota St., St Paul, MN 55101-	Division Suite 145 5145, or					
BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		L	(X6) DATE	
a XQ	wyn	Tach		titution may be excused from correcting provident	ector.	63	

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
			A. BUILDIN	NG 01 - MAIN BUILDING 01		
		245184	B. WING		04/	28/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST		501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 000	Continued From pa	ge 1	к ос	00		
	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr prevent a reoccurre The Golden Livingo 3-story building with was built in 1968 ar Type II(222) constru- The facility is fully s fire alarm system w detection and space monitored for autor notification. The facility has a ca	n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. renter - Rochester East, is a n a full basement. The facility nd was determined to be of		<ul> <li>K 000 Submission of this replan of Correction is not a light that a deficiency exists or the Statement of Deficiency was cited, and is also not to be cardinission of fault by the fact Executive Director or any eagents or other individuals may be discussed in the response of Correction does not constant admission or agreement of a facility of the truth of any fact the correctness of any conclusion.</li> <li>Accordingly, the facility has submitted this Plan of Correction for the resolution of any appeal filed solely because of the resulting of a Plan of Correction the submission of a Plan of Correction for the submission of a Plan of Correction for the submission of a Plan of Correction for the facility in Title 18 and programs. This Plan of Correction facility's crallegation of compliance.</li> </ul>	egal adm tat this s correct onstrued cility, the mployees who draft oonse and titute an any kind acts alleg usions se s prepare ection pr which m equirement hat mand rection w s a cond Title 19 rection is	ission ly as an s, t or d Plan by the ed or et d and ior to hay be ents date vithin ition
K 054	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 05	.4		

Event ID:W6S521

Facility ID: 00953

If continuation sheet Page 2 of 8

		AND HUMAN SERVICES				FORM	05/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		LE CONSTRUCTION 8 01 - MAIN BUILDING 01		E SURVEY PLETED
		245184	B. WING	·		04//	28/2015
	(EACH DEFICIENC)	OCHESTER EAST ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
K 054 K 062 SS=D	All required smoke activating door hold maintained, inspect with the manufactu This STANDARD i Based on docume interview, the facilit system in accordar 2000 NFPA 101, Cl NFPA 72, Section 7 affect all 100 reside Findings include: On facility tour betw 04/28/2015, the rev inspection and test dated 02/16/2015, was found: 1. Count of device equal each other; 2. There is a sepa elevator recall but r 3. Unknown if both 4010 simplex) are i purposes These deficient pra Facility Maintenance discovery. NFPA 101 LIFE SA	detectors, including those d-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3 s not met as evidenced by: ntation review and staff y failed maintain the fire alarm nce with the requirements of hapters 19.3.4.1, 9.6.1.4, 1999 7. The deficient practice could		054	K54 Custom Alarm reports v reviewed by Custom Alarm a for smoke alarm and sensitiv numbers to reflect true result report has been generated an facility which include test res- elevator panel. Custom Alar Elevator and State Fire Mars Schroeder verified on Friday that both panels and all syste properly functioning per life	and corrity test s. Ane d issue sults of m, All hall Ga , May f ms are	ing ew d to `the City ry I 5th

Event ID: W6S521

Facility ID: 00953

If continuation sheet Page 3 of 8

GENTER	AS FUR MEDICARE	& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245184	B. WING		04/2	8/2015
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER EAST		1 EIGHTH AVENUE SOUTHEAST DCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25. This deficient practice could affect all 30 out of 100 residents Findings include:		1	K62 Viking Sprinkler has repl standard response sprinkler he quick response heads that were in the smoke compartment. Th sidewall sprinkler heads that ap be over 10 years old have been with new dry sidewall sprinkle	ads with e intermixe he dry ppeared to replaced r heads.	
K 069 SS=F	04/28/2015, observ following were four 1. 3rd floor - elevat standard response intermixed; 2. Review of the an Viking, dated 8/22/ maybe (2) dry sides are over 10 years of at this time and dat corrected. These deficient pra Facility Maintenand discovery. NFPA 101 LIFE SA	veen 8:30 AM and 12 noon on vation revealed that the ad: or lobby, quick response and fire sprinkler heads are anual inspection report from 14 stating "it appears there wall heads in front entry that old and need to be replaced" the this hasn't been verified or actices were confirmed by the se Director (RE) at the time of FETY CODE STANDARD re protected in accordance	K 069			

ATEMENT	T OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA	1 ' '		LE CONSTRUCTION	(X3) DATE	0938-0391
J PLAN G	)F COHHEGTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING 01 - MAIN BUILDING 01			IPLETED
		245184	B. WING			04/28/2015	
AME OF H	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	N LIVINGCENTER - RO	CHESTER EAST			501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 069	Continued From pa with 9.2.3. 19.3.2	-	КC	069			
	Based on observat facility's kitchen gas accordance with 20 19.3.5 and 9.7 and	is not met as evidenced by: tion and staff interview, the s piping was not installed 000 NFPA 101 - Sections 1998 NFPA 96 section 9-1.2. ice could affect all 100		k F	K69 The main horizontal gas liine kitchen appliances has been affixed proper way to an upright that has b bolted to the kitchen floor.	ed in a	
	04/28/2015, observa horizontal gas line funder the kitchen ho	veen 8:30 AM and 12 noon on vation revealed that the main feeding the kitchen appliances bood is being supported by a					le-13-5
SS=F	across the bottom of This deficient practic Facility Maintenance discovery. NFPA 101 LIFE SAF Transferring of oxyg (a) separated from a wherein patients are treated by a separate fire-resistive constru- (b) in an area that is	ice was confirmed by the ce Director (RE) at the time of FETY CODE STANDARD gen is: any portion of a facility e housed, examined, or tion of a fire barrier of 1-hour	K 1		K143 The oxygen transfill room with the current exhaust fan taken out of and the opening to building ductw be sealed off from the oxygen roo window in the transfill room will removed and the op0ening will be with fire resistant materials. A ne continuous running exhaust fan wi installed in the room that will be d	of servit work will om. The be closed ew <i>r</i> ill be	ice 111 e 1 6-28-

Event ID: W6S521

Facility ID: 00953

If continuation sheet Page 5 of 8

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI			FORM	: 05/21/2019 APPROVED . 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ` <i>′</i>		01 - MAIN BUILDING 01		PLETED
		245184	B. WING	-		04/	28/2015
	PROVIDER OR SUPPLIER	DCHESTER EAST		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 143	<ul> <li>(c) in an area poster transferring is occur immediate area is not with NFPA 99 and the Association.</li> <li>This STANDARD is Based on observational facility failed to associate as required deficient practice of Findings include:</li> </ul>	ed with signs indicating that rring, and that smoking in the not permitted in accordance he Compressed Gas 2.5.2 s not met as evidenced by: tion and staff interview, the ure oxygen transfill room is by 1999 NFPA 99. The build affect all 100 residents.	K	143	K143 The oxygen transfill roo the current exhaust fan taken o and the opening to building du be sealed off from the oxygen window in the transfill room w removed and the op0ening will with fire resistant materials. A continuous running exhaust far installed in the room that will b vented to the exterior of the bu	out of sectwork room. vill be l be clo new n will b be direc	ervice will The sed e
K 144 SS=D	04/28/2015, the Ma asked could not ver room was directly v further investigation outside. This deficient pract Facility Maintenanc discovery. NFPA 101 LIFE SA Generators are insp	veen 8:30 AM and 12 noon on intenance Director (RE) when rify that the oxygen transfill ented to the outside. Upon in it was found not to be vented the evented by the e Director (RE) at the time of FETY CODE STANDARD bected weekly and exercised inutes per month in FPA 99. 3.4.4.1.	K	44	K144 A new generator trans is programmable has been in replace older defective trans. This new switch has been pr run an additional 5 minutes of time after transfer of load ba power to reflect life safety co requirements. In addition, on text sheet has had an addition added to show how many mi generator has been run durin time during monthly testing.	stalled fer swit ogramm of cool ck to ut ode ur gene nal test nutes tl g cool o	to cch. ned to down tility rator result he

Event ID: W6S521

Facility ID: 00953

If continuation sheet Page 6 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	MB NO.	
			A. BUILDING	01 - MAIN BUILDING 01	COMP	
		245184	B. WING		04/2	8/2015
	PROVIDER OR SUPPLIER	OCHESTER EAST	5	BTREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 144	Continued From pa	ge 6	K 144			
K 147 SS=D	Based on documer interview, the facility emergency generat requirements of 200 NFPA 110 Chapter of practice could affec Findings include: On facility tour betw 04/28/2015, docume monthly generator for monthly generator for months) there was a down time of emerg This deficient practic Facility Maintenance discovery. NFPA 101 LIFE SAF Electrical wiring and	een 8:30 AM and 12 noon on entation review of the past 12 ogs, revealed that (5 out 12 no documentation for cool	K 147	K144 A new generator transfer s is programmable has been install replace older defective transfer sy This new switch has been progra run an additional 5 minutes of co time after transfer of load back to power to reflect life safety code requirements. In addition, our ge text sheet has had an additional to added to show how many minute generator has been run during coo time during monthly testing.	ed to witch. mmed to ol down o utility enerator est resul s the ol down	D I t
	Based on observati facility failed to main accordance with the 101 - 19.5.1, 9.1.2,	not met as evidenced by: on and staff interview, the tain electrical outlets in requirements of 2000 NFPA 1999 NFPA 70 and 2007 it practice could affect 25 out	a	147 The electrical outlet has been fixed in a proper way to an uprigh as been bolted to the kitchen floor.	nt that	0-13-15

CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DAT COM	0938-0391 E SURVEY PLETED 28/2015
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 245184 OCHESTER EAST	A. BUILDIN	NG 01 - MAIN BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE	СОМ	PLETED
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	B. WING _		04/	29/2015
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL				20/2013
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL				
GOLDEN LIVINGCENTER - R	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		501 EIGHTH AVENUE SOUTHEAST		
	Y MUST BE PRECEDED BY FULL		ROCHESTER, MN 55904		
PREFIX (EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 147 Continued From pa	age 7	K 14	17		
04/28/2015, observ floor kitchen -behir electrical outlet on another pipe by ele This deficient pract Facility Maintenand discovery.	ice was confirmed by the e Director (RE) at the time of		K147 The electrical outlet h affixed in a proper way to a has been bolted to the kitche	upright	that 3-۱۵ -ی
FORM CMS-2567 (02-99) Previous Versions	Obsolete Event ID: W6S521		Facility ID: 00953		t Page 8 of 8

If continuation sheet Page 8 of 8