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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: X77W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245293**
2.STATE VENDOR OR MEDICAID NO.
(L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **12/07/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on 12/7/2015. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving Tag F0458 (room size waiver) has been forwarded.

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 12/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 12/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245293

December 30, 2015

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

Dear Ms. Aramalay:

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

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

Effective December 1, 2015 the above facility is certified for or recommended for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirements: F458, a room size waiver.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

December 30, 2015

Ms. Talia Aramalay, Administrator
Golden LivingCenter - Hopkins
725 Second Avenue South
Hopkins, Minnesota 55343

RE: Project Number S5293026

Dear Ms. Aramalay:

On November 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 22, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 7, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 1, 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 October 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 22, 2015, effective December 1, 2015 and therefore remedies outlined in our letter to you dated November 10, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F458 at the time of the October 22, 2015 standard survey was previously forwarded to CMS. Approval of the waiver request was recommended.

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,

Kamala Fiske-Downing

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

Enclosure

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building B. Wing	12/7/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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 **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/01/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/01/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/01/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/01/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **12/01/2015**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **12/01/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/01/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **12/01/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/01/2015**
ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	Correction Completed **12/01/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	12/30/2015	18623	12/7/2015
Reviewed By CMS RO	Reviewed By	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
10/22/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245293	A. Building B. Wing 01 - MAIN BUILDING 01	12/1/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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 Reg. # NFPA 101 LSC K0052	Correction Completed 12/01/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 12/01/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TL/kfd	Date: 12/30/2015	Signature of Surveyor: 12424	Date: 12/1/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/21/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245293	02 - 2008 ADDITION	12/1/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	12/01/2015	ID Prefix Reg. # NFPA 101 LSC K0062	12/01/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	12/30/2015	12424	12/1/2015
Reviewed By CMS RO	Reviewed By	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
10/21/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X77W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00872

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245293**
2.STATE VENDOR OR MEDICAID NO.
(L2) **417633200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HOPKINS**
(L4) **725 SECOND AVENUE SOUTH**
(L5) **HOPKINS, MN** (L6) **55343**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2002**

6. DATE OF SURVEY **10/22/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. The facility is requesting a room size waiver involving the deficiency cited at F458. Documentation supporting the waiver request is attached and a copy will be forwarded to the CMS Region V Office. Refer to the CMS 2567 for health and life safety code along with the facility's POC.

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 11/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0282

November 10, 2015

Ms. Talia Aramalay, Administrator
Golden Livingcenter - Hopkins
725 Second Avenue South
Hopkins, MN 55343

RE: Project Number S5293026

Dear Ms. Aramalay:

On October 22, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 1, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 22, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F 280 The care plan for resident R103 has been revised to include the request from resident and family not to be turned and repositioned. The care plan for resident R42 has been revised to include history of suicidal ideation.	

Received 11-24-15

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

Executive Director 11/20/15

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

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F 280	Continued From page 1 by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 2 residents (R103) reviewed who declined to be repositioned in bed and for 1 of 1 resident (R42) reviewed for suicidal behaviors. Findings include: R103's care plan was not revised to reflect the fact that R103 did not wish to be turned and repositioned. R103 had a diagnosis of dementia, dated 9/14/11, per the Admission Record. The record was updated on 10/5/15, with a diagnosis of palliative care (associated with improving the quality of life for people facing life threatening illness). R103's care plan, dated 4/28/15, stated that R103 was at risk for altered skin integrity due to impaired physical immobility, incontinence, weakness. It stated that R103 previously had a history of a pressure ulcer. The care plan directed staff to reposition R103 every two hours and as needed. A review of R103's Progress Notes, from 7/28/15 to 10/20/15, indicated R103 was to be repositioned every two hours: - On 7/28/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed; - On 7/30/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed; - On 8/4/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed;	F 280	The care plans for all residents will include the necessary information in regards to turning and repositioning needs of the residents. The care plans for all residents with suicidal ideations will include information pertaining to the suicidal ideations and IDT recommendations for safety. The Clinical Managers have been re-educated on the requirement to care plan each resident's repositioning needs and to include in the care plan information, if applicable, to the resident's refusal of repositioning. The Clinical Managers and Social Workers have been re-educated on the requirement to include on the care plan for each resident, if applicable, suicidal ideations and the IDT recommendations for safety. Monitoring to ensure compliance will be conducted through random care plan audits checking for proper documentation for turning and repositioning and proper documentation of interventions for suicidal ideation. The facility QAPI committee will review the care plan audits quarterly for further recommendations The date of completion will be 12-1-15.	

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F 280	Continued From page 2 - On 10/1/15, indicated R103 was repositioned every two hours; - On 10/8/15, indicated R103 was repositioned every two hours; - On 10/15/15, indicated R103 was repositioned every two hours. R103's quarterly Minimum Data Set (MDS), dated 8/3/15, indicated R103 required extensive assist with bed mobility, including turning from side to side. The MDS stated R103 was at risk for developing a pressure ulcer and R103 was moderately impaired cognitive skills. A review of a document (not titled, not dated) which instructed the nursing assistants which cares to perform, instructed nursing assistants to reposition on back and one side on center of bed. During an observation on 10/21/15, at 7:54 a.m., R103 was observed to be laying on her right side prior receiving cares by the nursing assistants who had come to check on her. It was noted after they washed R103, she was placed back on her right side. On 10/21/15, at 8:50 a.m., R103 was observed to be lying on her right side. On 10/22/15, at 8:03 a.m., R103 was observed to be lying on her right side. When interviewed on 10/22/15, at 8:53 a.m., nursing assistant (NA)-C stated the NAs check on R103 every morning. NA-C stated the NAs go every two hours to reposition R103. When interviewed on 10/22/15, at 9:11 a.m., registered nurse (RN)-A stated that R103 is not	F 280	 Scanned JT POC 11/23/15	

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F 280	Continued From page 3 supposed to be turned and repositioned at the request of the family. RN-A stated that the family had told the staff that R103 would have pain upon movement and so did not want their mother to be turned and repositioned. She stated that R103 was placed on her right side as that was more comfortable for her. RN-A stated that R103 was at first turned and repositioned but it became more painful for her back and so the family requested that R103 not be turned or repositioned. When interviewed on 10/22/15, at 9:21 a.m., the director of nursing (DON) stated the family requested not to have R103 turned and repositioned. She was not sure how long ago the family requested that. When interviewed on 10/22/15, at 10:13 a.m., the DON stated the care plan did not contain information on the risks involved and discussed with the family when R103 was not turned and repositioned. When interviewed on 10/22/15 at 11:07 a.m., family member (F)-E stated that she was notified by the staff that R103 was at risk for developing bedsores and could potential die if not turned and repositioned. She stated that R103 would have extreme pain if turned and repositioned and so did not want her mother to be in pain. R103 did not want anything stronger than Tylenol (a mild analgesic) and so the family did not want R103 to be turned. When interviewed on 10/22/15, at 12:27 p.m., RN-F with Park Nicollet Hospice stated she was aware the facility was not turning and repositioning R103. She stated she requested a	F 280		

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F 280	Continued From page 4 hospice aide to visit R103 on a weekly basis in order to address R103's skin. RN-F stated R103 had lotions in her room and advised to have R103's bony prominences well lotioned. RN-F stated she had discussed that with the family and the family was aware of the situation. RN-F stated she did do a weekly skin assessment. The goal was to keep the skin in the best condition as it can be in lieu or R103's immobility. R42's care plan was not revised to reflect the fact R42 had suicidal ideation (SI). R42 who had been admitted 8/25/15, with diagnoses including malignant neoplasm of bronchus/lung, squamous cell skin cancer, depressive disorder and was receiving palliative care, according to the record, hospice care was initiated on 8/27/15. On 8/29/15, R42 was observed to have wrapped a T-shirt around his neck. Although he denied SI, he was sent to the Veteran's Administration (VA) for assessment. The VA notes dated 8/29/15, indicated the resident was alert and oriented but not making sense with his speech. It was determined based on mental status evaluation that R42 had delirium related to progression of his overall disease. He was readmitted to the nursing home the same day. According to the interdisciplinary (IDT) progress note dated 8/29/15, R42 "was sent to the VA Hospital via ambulance after he informed [employee name], a hospice nurse who was visiting with him, that he was going to hang himself...on-call MD [medical doctor] was updated. On-call MD ordered that resident be sent to the VA." The resident returned from the	F 280		

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F 280	Continued From page 5 VA on 8/30/15, at 1:20 a.m. with no new orders. Although the 8/30/15, IDT notes indicated every 15 minute checks had been initiated, the care plan had no revisions made to identify the resident's suicidal ideation. During interview with nurse manager (NM)-A on 10/21/15, at 2:15 p.m. regarding the resident's care plan, NM-A stated the staff "do not follow the care plan. They only use the nursing care sheets." When asked whether the care sheets had been revised to include SI behaviors, NM-A stated the facility did not keep the care sheets. The DON and licensed social worker (LSW) were interviewed at 3:05 p.m. on 10/21/15. They verified the resident's care plan had not been updated to include the SI behaviors, and the DON acknowledged they may not have kept copies of the care summary.	F 280	F 309 The care plans for residents, R103 and R42, will contain information coordinating the resident's care with hospice. The care plans for all other residents receiving hospice services will contain information coordinating the resident's care with hospice. The Clinical Managers and Social Workers have been re-educated on the requirement to include on the hospice resident's care plan information coordinating the resident's care with hospice. Monitoring to ensure compliance will be conducted through random care plan audits checking for information coordinating the resident's hospice care. The facility QAPI committee will review the cre plan audits quarterly for further recommendations. The date of completion will be 12-1-15.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate hospice services with facility staff for 2 of 2 residents	F 309		

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F 309	Continued From page 6 (R103, R42) reviewed for hospice services. Findings include: R103's Admission Record, indicated R103 was admitted to the facility on 2/18/11. R103 had a diagnosis of dementia, dated 9/14/11, per the Admission Record. On 10/5/15, the Admission Record was updated with a diagnosis of palliative care (associated with improving the quality of life for people facing life threatening illness). R103's care plan dated 4/28/15, stated R103 was at risk for altered skin integrity due to impaired physical immobility, incontinence, weakness. The plan read R103 previously had a history of a pressure ulcer. The care plan directed staff to reposition R103 every two hours and as needed. A review of R103's Progress Notes, from 7/28/15 to 10/20/15, indicated R103 was to be repositioned every two hours: - On 7/28/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed; - On 7/30/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed; - On 8/4/15, indicated R103 was to be assisted by two staff members with turning and repositioning every two hours and as needed; - On 10/1/15, indicated R103 was repositioned every two hours; - On 10/8/15, indicated R103 was repositioned every two hours; - On 10/15/15, indicated R103 was repositioned every two hours. R103's quarterly Minimum Data Set (MDS), dated	F 309		

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F 309	Continued From page 7 8/3/15, indicated R103 required extensive assist with bed mobility, including turning from side to side. The MDS read R103 was at risk for developing a pressure ulcer and that R103 had moderately impaired cognitive skills. A review of a document (not titled, not dated) which instructed the nursing assistants which cares to perform, instructed nursing assistants to reposition on back and one side on center of bed. During an observation on 10/21/15, at 7:54 a.m., R103 was observed to be laying on her right side prior receiving cares by the nursing assistants who had come to check on her. It was noted after they washed R103, she was placed back on her right side. On 10/21/15, at 8:50 a.m., R103 was observed to be lying on her right side. On 10/22/15, at 8:03 a.m., R103 was observed to be lying on her right side. When interviewed on 10/22/15, at 8:53 a.m. nursing assistant (NA)-C stated that the NAs check on R103 every morning. NA-C stated the NAs go every two hours to reposition R103. - At 9:11 a.m. registered nurse (RN)-A stated R103 was not supposed to be turned and repositioned at the request of the family. RN-A stated the family had told the staff that R103 would have pain upon movement and so did not want their mother to be turned and repositioned. She stated R103 was placed on her right side as that was more comfortable for her. RN-A stated R103 was at first turned and repositioned but it became more painful for her back and so the family requested R103 not be turned or	F 309		

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F 309	Continued From page 8 repositioned. - At 9:21 a.m. the director of nursing (DON) stated the family requested not to have R103 turned and repositioned. She was not sure how long ago the family requested that. - At 10:13 a.m., the DON stated the care plan did not contain information on the risks involved and discussed with the family when R103 was not turned and repositioned. - At 11:07 a.m. family member (F)-E stated she was notified by the staff that R103 was at risk for developing bedsores and could potential die if not turned and repositioned. She stated R103 would have extreme pain if turned and repositioned and so did not want her mother to be in pain. R103 did not want anything stronger than Tylenol (a mild analgesic) and so the family did not want R103 to be turned. - At 12:27 p.m. a RN-F stated she was aware the facility was not turning and repositioning R103. She stated she requested a hospice aide to visit R103 on a weekly basis in order to address R103's skin. RN-F stated R103 had lotions in her room and advised to have R103's bony prominences well lotioned. RN-F stated that she had discussed this with the family and the family was aware of the situation. RN-F stated that she did do a weekly skin assessment. The goal was to keep the skin in the best condition as it can be in lieu or R103's immobility. The facility failed to coordinate services with hospice regarding R103's family wishes of not wanting R103 to be repositioned due to increased discomfort. R42 who had been admitted 8/25/15, with diagnoses including malignant neoplasm of bronchus/lung, squamus cell skin cancer, depressive disorder and was receiving palliative	F 309		

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F 309	Continued From page 9 care, according to the record, hospice care was initiated on 8/27/15. However, there was not effective coordination of care between the hospice provider and the nursing facility. According to an interdisciplinary (IDT) progress note dated 8/29/15, R42 "was sent to the VA [Veteran's Administration] Hospital via ambulance after he informed [employee name], a hospice nurse who was visiting with him, that he was going to hang himself...on-call MD [medical doctor] was updated. On-call MD ordered that resident be sent to the VA." The resident returned from the VA on 8/30/15, at 1:20 a.m. with no new orders. Although the 8/31/15, IDT notes indicated every 15 minute checks had been initiated, the care plan had no revisions made to identify the resident's suicidal ideation. No current hospice progress notes were available in the record. During interview with nurse manager (NM)-A on 10/21/15 at 2:15 p.m., she was unable to locate any current hospice progress notes. The DON and licensed social worker (LSW) were interviewed at 3:05 p.m. on 10/21/15. They verified the above findings.	F 309	F 323 The bedrails for residents, R27 and R31, have been safely secured to the bed. The plan of care for resident, R42, has been revised to include history of suicidal ideation. An IDT assessment note has been completed to document current safety interventions needed for resident, R42, for history of suicidal ideation. The bedrails for all residents are safely secured to the beds. The care plans for all residents with a history of suicidal ideations will include information pertaining to the suicidal ideation. All residents with suicidal ideations will have an IDT assessment note pertaining to IDT recommendations for safety interventions related to suicidal ideations. The Maintenance Department has been re-educated on the requirement to have all bedrails safely secured to the beds. The Licensed Social Workers have been re-educated on the requirement to include on the care plan for residents, if applicable, suicidal ideations and the IDT recommendations for safety. All residents with suicidal ideations must have an IDT assessment note pertaining to IDT recommendations for safety.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bedside rails were safely secured to the bed frame to minimize the risk of injury for 2 of 2 residents (R27, R31), and failed to assess 1 of 1 resident (R42) who was at risk for self injurious behaviors. Findings include: R27's room observation on 10/20/15, at 10:16 a.m. noted the grab bar on the window side was observed to be loose and wiggled back and forth, was unsteady and slipped down off surveyor hand when touched. Registered nurse (RN)-A verified the side rail was not functioning properly and stated there was potential for injury. RN-A further stated nursing completed quarterly checks on side rails and as needed. RN-A further stated she would notify maintenance if there were problems with side rails and would contact maintenance right away to get the side rail fixed. R27's Side Rail Assessment dated 5/24/12, indicated the resident utilized the rails for bed mobility and transfers. In addition, a recent quarterly assessment dated 10/9/15, indicated R27 still utilized the side rails. The assessment did not indicate whether the rails had been checked to ensure a secure fit. The care plan for R27 dated 11/20/13, indicated R27 had a physical functioning and self-care deficit related to dementia, cerebrovascular accident (CVA) with left side neglect and impaired	F 323	Monitoring to ensure compliance will be conducted through weekly side rail safety audits ensuring that all resident side rails are checked quarterly for safety. Random chart audits will be conducted of care plans and progress notes of residents with suicidal ideations to ensure the care plan reflects the suicidal ideations and safety interventions and the progress note indicates the IDT assessment for necessary safety interventions. The facility QAPI committee will review the side rail audits and the care plan/chart audits quarterly for further recommendations. The date of completion is 12-1-15.	

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F 323	Continued From page 11 vision. Care plan indicated R27 required assist with bathing, grooming, dressing, transfers, bed mobility and repositioning. The care plan directed the use of 1/2 side rails for bed mobility and transfer. R27's quarterly Minimum Data Set (MDS) dated 8/11/15, revealed the resident was required extensive physical assist with bed mobility, toileting, dressing and transferring. A fall Care Area Assessment (CAA) dated 5/21/15, indicated resident was at risk for falls due to impulsive behavior, dementia, CVA, and physical limitations to left side. The CAA did not indicate side rails were in use. On 10/21/15, at 7:15 a.m. R27 indicated he used the side rails when turning side to side in bed with staff assistance. On 10/22/15, at 9:57 a.m. RN-A stated at the time she had done the side rail review on 10/9/15, she had checked it physically and both side rails fit properly. RN-A stated resident required extensive assist with bed mobility, transfers and all cares and would have expected staff to report to the maintenance department immediately. RN-A acknowledged at the time surveyor brought the concern up the side rail was so loose and falling off the bed. RN-A further indicated, "We will be doing education to our staff about this as it is a safety issue." R31 was observed lying on her bed on 10/20/15, at 1:47 p.m. During room observation R31 bed was observed to have two half (1/2) rails. The right side rail near the door was observed to be loose, wiggled back and forth and was unsteady	F 323		

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F 323	Continued From page 12 when touched. On 10/21/15, at 2:00 p.m. and 10/22/15, at 9:15 the side rail remained the loose and wiggled back and forth. R31's Side Rail Assessment dated 11/27/12, indicated the resident utilized the rails for bed mobility and transfers. In addition a recent quarterly assessment dated 10/5/15, indicated R31 still utilized the side rails. The assessment did not indicate whether the rails had been checked to ensure a secure fit. The care plan dated 4/1/15, indicated R31 had a physical functioning and self-care deficit related Lewy Body dementia, disorder of bone, rheumatoid arthritis, hip replacement and osteoarthrosis. Care plan indicated R31 needed assistance with bathing, grooming, dressing, transfer, bed mobility, and reposition. The plan indicated resident used 1/2 side rails for repositioning. R31's quarterly MDS dated 9/24/15, revealed the resident was required extensive physical assist with bed mobility, toileting, dressing and transferring. Falls CAA dated 1/9/15, indicated resident may be at risk for falls due to dependence on staff for transfers and mobility, and inability to make safe decisions. Staff provide for safe transfers, movement, mobility, and cares. Staff observe for potential safety concerns and implement interventions as needed to maintain safety. On 10/22/15, at 9:16 a.m. nursing assistant (NA)-A stated R31 used the side rails when being turned side to side. NA-A acknowledged the right side rail was loose and wiggled. When asked if she had noted the side rail being loose for the last	F 323		

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F 323	Continued From page 13 two days when assisting R31, NA-A stated she had noticed it that morning she thought but had not put a work order for it. On 10/22/15, at 9:24 a.m. a tour of the room was completed with two maintenance directors. Maintenance director-A acknowledged the side rail was loose. Maintenance director-B stated, "It is not considered safe at its state right now and we will take care of immediately." Maintenance director-B further stated the bolt and screw were loss. On 10/22/15, at 9:46 a.m. when asked who was responsible for making sure the side rails were in good repair and not loose RN-A stated she believed maintenance was responsible and had a log when side rails had been checked. When asked if the nurses physically checked the side rails to make sure they were in proper repair at the time of the assessments RN-A stated "I can't speak for other nurses but for me I always go to the room to make sure the side rails are in good repair." On 10/22/15, at 10:22 a.m. the director of nursing (DON) stated staff were supposed to enter the concern in the computer for maintenance to address immediately and would have expected the staff to have identified the loose side rails and reported them to be fixed. R42 who had been admitted 8/25/15, with diagnoses including malignant neoplasm of bronchus/lung, squamous cell skin cancer, depressive disorder and was receiving palliative care. The interdisciplinary (IDT) progress notes	F 323		

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F 323	Continued From page 14	F 323		

indicated on 8/29/15, R42 was observed to have wrapped a T-shirt around his neck. Although he denied suicidal ideation (SI), he was sent to the Veteran's Administration (VA) for assessment. The VA notes indicated the resident was alert and oriented but not making sense with his speech. It was determined based on mental status evaluation that R42 had delirium related to progression of his overall disease. He was readmitted to the nursing home the same day.

Additionally, an IDT progress note dated 8/29/15 indicated, R42 "was sent to the VA Hospital via ambulance after he informed [employee name], a hospice nurse who was visiting with him, that he was going to hang himself...on-call MD [medical doctor] was updated. On-call MD ordered that resident be sent to the VA." The resident returned from the VA on 8/30/15, at 1:20 a.m. with no new orders.

Although the 8/30/15, IDT notes indicated every 15 minute checks had been initiated, the care plan had no revisions made to identify the resident's suicidal ideation.

On 9/8/15, the facility progress notes documented that house psychiatric services would evaluate post suicidal ideation. The psychiatric progress notes indicated the resident had been seen by 9/8 and 9/15/15, and indicated all cords had been removed from the resident's room including phone and call light cords.

On 10/21/15, the following observations were made of R42:
From 7:10 a.m. - 8:40 a.m. the resident was observed to be in bed with call cord accessible.
At 9:20 a.m. R42 was observed to be seated at a

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F 323	Continued From page 15 table in his room with his computer and cell phone by him. At 10:15 a.m. R42 was observed to roll up a power cord. He said it was from his electric blanket which he was putting away. Other cords accessible included the call cord, and power cords for the computer and cell phone. During interview with nurse manager (NM)-A and the social worker (SW)-B, at 11:15 a.m. on 10/21/15, they stated the only incident related to suicidal ideation was the one that had occurred on 8/29/15. They stated they were unaware of any other acting out. NM-A said the social worker would be the person who maintained documentation related to resident incidents/behaviors. SW-B stated the call light cords, etc. had been put back in the resident's room after a care conference with Hospice on 9/23/15. The social worker stated she would look for documentation of any assessment regarding the decision to give the resident back the cords. At 11:30 a.m. on 10/21/15, SW-B provided a Care Conference Summary from the care conference with hospice from 9/23/15. The care conference notes indicated the facility and hospice staff had discussed discontinuing suicide statement precautions for R42. SW-B also provided an undated worksheet titled, P4 Suicidality Screener. The worksheet was an algorithm type check list where questions were answered and led to the next question. The questions included: "Have you had thoughts of actually hurting yourself? - NO, Have you ever attempted to harm yourself in the past? - NO Have you thought of how you might actually hurt yourself? - NO..." SW-B stated the worksheet had been completed 9/22/15, and was the only documented assessment of the	F 323		

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F 323	Continued From page 16 resident's current suicidal risk. The care conference summary notes only included, "Discussed d/c [discontinuing] of all suicide statement precautions." The DON and SW-B were interviewed at 3:05 p.m. on 10/21/15, they acknowledged there had been no documented assessment of the resident's need for and/or subsequent discontinuation of suicidal ideation precautions. They acknowledged such precautions included removal of cords from R42's room. They also acknowledged no revisions had been made to the resident's care plan related to the precautions.	F 323	F 329 The facility will document indications for use of prn Trazadone and prn Seroquel for resident R7. Facility will document non-pharmacological interventions used in conjunction with the use of prn psychotropic medications for resident R7. All physician orders for prn psychotropic medications will include indications for use. The medical record for each resident will reflect the non-pharmacological interventions used in conjunction with the use of prn psychotropic medications. The medical record for each resident will reflect documentation of resident's specific indications for use of the prn psychotropic medication. All licensed nurses have been re-educated on the requirements for the physician's order for psychotropic prn medications to contain indications for use. The licensed nurses have also been re-educated on the requirement to document the indications for use on the target behavior sheet in addition to the non-pharmacological interventions used whenever prn psychotropic medications are administered. Monitoring to ensure compliance will be conducted through random chart audits of physician orders for prn psychotropic medications for	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure adequate indications for use and non-pharmacological interventions had been identified for 1 of 1 resident (R7) in the sample reviewed for unnecessary medications. Findings include: R7 observed to be in her room still sleeping on 10/21/15, at 9:27 a.m. R7 was interviewed on 10/22/15, at 3:32 p.m. and stated she slept through the night. She "has had Trazodone (antidepressant) medication for a long time and Seroquel is an old medication." R7 stated she had been sleepy for a few days and did not know why she received the medication. She did not ask for Seroquel (antipsychotic) , staff brings it to her, and did not know why she gets it. The Minimum Data Set (MDS) admission assessment dated 9/30/15, indicated R7 had moderate cognitive impairment. The diagnoses included manic depression and schizoaffective disorder. The care plan dated 9/23/15, indicated R7's anti-psychotic medication target behaviors were: being overwhelmed, history of suicidal ideation, and irrational fears. R7 was to be monitored for side effects of antipsychotic medication, which	F 329	indications for use. Random audits will be completed of nursing documentation on the target behavior sheets to record indications for use for psychotropic medications and non-pharmacological interventions used in conjunction with administration of prn psychotropic medications. The facility QAPI committee will review the psychotropic chart audits quarterly for further recommendations. The date of completion will be 12-1-15.	

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F 329	Continued From page 18 included antipsychotic medication-sedation. The side effects were to be reported to physician. R7's anti-depressant medication target behaviors were sleeping less than eight hours a day. R7 was to be monitored for side effects of anti-depressant medication which included antidepressant medication-sedation. The side effects were to be reported to physician. Although the care plan listed target behaviors, it did not include non-pharmacological interventions and how to monitor when giving as needed (PRN) medications. Seroquel use: September and October 2015 daily behavior observation sheets for Seroquel indicated R7 target behavior signs/symptoms of overwhelming sadness, history of suicidal ideation and irrational fear. No behavior episodes documented. Review of the October 2015 Medication Administration Record (MAR) revealed Seroquel PRN was given on 10/2/15, 10/11/15, 10/13/15, 10/16/15, and 10/21/15. The MAR did not include documentation of indications for the Seroquel PRN use nor did the MAR note R7 had behavior symptoms of being overwhelmed, suicidal ideation, and irrational fears. The signed Physician Orders dated 10/15/15, indicated R7 received Seroquel 100 milligrams (mg) give one tablet by mouth two times a day for schizophrenia, Seroquel 25 mg give two tablets by mouth as needed for schizoaffective disorder three times a day PRN. The orders did not address indications for when to administer Seroquel PRN.	F 329		

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F 329	Continued From page 19 The Assessment of Behaviors and Contributing Factors Prior to Initiation of Antipsychotic Treatment form undated, included: signs of confusion, disorientation, able to understand, able to be understood, depressed, uninvolved in activities, relationship difficulties, easily frustrated for medical diagnoses of schizophrenia, schizoaffective disorder. On 10/22/15, at 9:48 a.m. licensed practical nurse (LPN)-G stated R7 does not usually have behaviors but did yesterday and therapy was working with her. LPN-G stated R7 was angry and thought R7 would fall, as R7 repeatedly stated she "couldn't see the middle of her feet." It took lots to calm her down. LPN-G gave PRN Seroquel, and then she calmed down. LPN-G stated she also sat with R7 for a while. LPN-G stated that was the first time she had to give PRN Seroquel. Although the nurse stated R7 had hallucinations, there was no documentation of non-pharmacological interventions and indications for use in the electronic medical record. Review of progress notes dated 9/23/15, through 10/17/15, revealed no documentation of non-pharmacological interventions for schizoaffective disorder attempted prior to medication administration. - The 10/11/15, note read R7 was administered Seroquel PRN "Patient yelling and offered prn Seroquel." According to the plan of care "yelling" was not an indication use. - The 10/13/15, note indicated R7 had a fall. "PRN Seroquel given." According to the documentation R7 received Seroquel due to being restless and agitated. - The 10/16/15, documentation indicated "no	F 329		

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F 329	Continued From page 20 behaviors noted" however, R7 received a PRN Seroquel on this date. - The 10/21/15, note indicated "no behaviors noted thus far. She is complying with all treatments and cares." The Progress Notes lacked evidence of any indications for the Seroquel use and if the medication was effective. However, R7 received a PRN Seroquel on that date. Trazodone use: Review of progress notes dated 9/23/15, through 10/17/15, revealed no documentation of insomnia prior to medication administration and lacked evidence of the medication effectiveness. Although the PRN Trazodone was given on 10/1/, 10/5, and 10/16/15, the electronic medical record lacked evidence of the resident having periods of insomnia. September and October 2015 daily behavior observation sheets for Trazodone indicated R7 target behavior signs/symptoms of sleep less than eight hours a day. No insomnia episodes were documented for September or October. Review of the October 2015 MAR revealed Trazodone PRN was given on 10/1/15, 10/5/15, and 10/16/15. The MAR did not address indications for when to administer Trazodone PRN nor did the MAR note R7 had episodes of sleeplessness. The signed Physician Orders dated 10/15/15, indicated R7 received Trazodone 50 mg give two tablets by mouth PRN for insomnia (x1) and Trazodone 50 mg give two tablets by mouth at bedtime for insomnia (may repeat x 1).	F 329		

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F 329	Continued From page 21 On 10/21/15, at 2:28 p.m. LPN-E stated R7 had peaks and valleys with sleep. "Some days R7 is super alert, some days is wiped out." Although the nurse stated R7 had episodes of insomnia, there was no documentation of non-pharmacological interventions and indications for use in the electronic medical record. On 10/22/15, at 1:19 p.m. LPN-G stated R7 always lays down after lunch, takes a nap, and will get up when therapy comes to work with her. LPN-G indicated therapy did not have a set schedule of when they came. On 10/22/15, at 3:55 p.m. registered nurse (RN)-B, indicated medications should state reasons given and should look at symptoms. RN-B stated medications should be given for schizoaffective disorder and expected to see something she was doing that was causing internal distress, such as self-harm. RN-B stated staff asks residents if they know the reason why they are receiving medications and did not know staff were not telling the residents. RN-B stated when staff saw delusional behaviors they should be documenting the behaviors. When asked what should be tried first, she indicated staff should be doing non-pharmacological interventions. RN-B stated they had noticed and informed psychologist of R7's change in behavior. The first week R7 was alert, talkative, socializing, out and about, in the beauty shop, and the past few days noticed R7 was sleeping all the time, not engaged in activities. AlixaRX (facility's pharmacy) Medication Monitoring Medication Management policy dated 05/12 indicated "6) as needed (PRN) orders	F 329		

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F 329	Continued From page 22 include an indication for use. a. If the PRN medication is used to modify behavior, the indication(s) for use is clearly defined in objective terms, e.g., what specific symptom(s) is being addressed. b. The resident is monitored for the effectiveness of the medication or possible adverse consequence. Results are documented in the resident's active record." AlixaRX Specific Medication Administration Procedures Administration Procedures for All Medications policy dated 05/12 indicated "M. When administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record (on the PRN effectiveness sheet/nurse's notes)."	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of medication errors for 2 of 8 (R239, R176) residents observed for medication administration related to insulin administration. The medication error rate was at 12%. Findings include: R239's Order Summary Report printed 10/22/15, indicated R239 had diagnosis of diabetes mellitus with diabetic nephropathy. R239's blood sugars	F 332	F 332 The residents, R239 and R176, will have insulin administered correctly with the use of the insulin pens. All residents receiving insulin via the insulin pens will have the insulin administered correctly. All licensed nurses have been re-educated on the requirement to affix the needle to the insulin pen first, then to properly prime the pen with 2 units of insulin prior to dialing up the insulin dose for administration. Monitoring to ensure compliance will be done through random observational audits of licensed nurses administering insulin via the insulin pen to ensure proper procedures for administration are being followed. The facility QAPI committee will review the insulin administration audits quarterly for further recommendations. The date of completion will be 12-1-15.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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F 332	Continued From page 23 between 10/16/15, to 10/22/15, ranged from a low of 144 to a high of 452. The Order Summary Report printed 10/22/15, directed staff to administer Levemir FlexPen 100/unit/milliliter to inject 42 units two times a day. R239 also had an order for Novolog Flexpen insulin 100Unit/milliliter to inject seven units one time a day with breakfast. During medication administration observation on 10/22/15, at 8:20 a.m. licensed practical nurse (LPN)-C prepared Levemir FlexTouch pen for injection. LPN-C wiped off the stopper of the Levemir FlexPen, dialed 2 units on the FlexTouch pen and primed pen by expressing it into the air without a needle attached to the FlexPen. LPN-C then attached the needle to the FlexPen and dialed 42 units for administration. LPN-C prepared the Novolog Flexpen for injection by wiping off the stopper of the Novolog FlexPen, dialed 2 units on the FlexPen and primed FlexPen by expressing it into the air without a needle attached to the FlexPen. LPN-C then attached the needle to the FlexPen and dialed the 7 unit dose. LPN-C Wiped R239's abdomen with alcohol wipe and gripped skin to administer the Levemir. Surveyor stopped the administration and had LPN-C correctly prime the Levemir FlexPen and Novolog FlexPen with needles attached. R176's quarterly Minimum data Set (MDS) dated 9/9/15, indicated R176 was severely cognitively impaired. Diagnosis identified on the MDS include diabetes mellitus. The Order Summary Report printed 10/22/15, directed staff to administer Novolog Flexpen	F 332		

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F 332	Continued From page 24 insulin 100 Unit/milliliter (medication used to control blood sugar) inject per sliding scale: if 0-70=0 treat and call; 71-140=0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-399=6 units; 400+call subcutaneous before meals for Diabetes During medication administration observation on 10/21/15, at 11:46 a.m. LPN-D wiped R176's right arm with an alcohol wipe, dialed 2 units on the FlexPen and then primed flex pen by expressing it into the air without a needle attached to the FlexPen. LPN-D then attached the needle to the FlexPen without wiping the rubber stopper. LPN-D dialed 1 unit and injected it into R176's right arm. During interview on 10/22/15, at 8:26 a.m. interview LPN-C stated that it would not be good to not have the needle attached when priming the FlexPens because the resident would get too little insulin. During interview on 10/22/15, at 9:40 a.m. the director of nursing (DON) said the staff had training on how to use FlexPens in 2014. The DON stated " I expect them to put needle on before they prime flex pens, there is always a greater risk when administering insulin and you always want to administer the correct dose. " Undated Pen Devices for Insulin Administration educational documentation provided by facility instructed staff to: "* Remove the pen cap and clean the rubber seal on the insulin cartridge with a sterile alcohol swab. * Attach the disposable needle onto the pen. Remove the outer needle cap and save it to use	F 332		

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F 332	Continued From page 25 later when you are done with your injection. Remove the inner needle cap and throw it away. Use a new needle every time you inject insulin. * With the needle pointing upward, tap the insulin cartridge to force any air bubbles to the top. Prime the pen before each injection. Priming the pen gets rid of air bubbles that may be in the pen. Air bubbles can affect the flow of insulin from a pen and cause you to inject the wrong amount of insulin. * Dial two units of insulin on the dose selector. Point the needle up and firmly press the plunger until a drop of insulin appears at the needle tip. Repeat this step if a droplet does not appear. You may need to use a different needle or pen if you have to repeat this step several times." NovoLog FlexPen manufacture guidelines dated April 2015, instruct users to Step 1: prepare your NovoLog FlexPen: Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your FlexPen tightly. Step 2: Step 2: Doing the air shot before each injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop appears, change the needle and repeat. Levemir FlexTouch manufacture guidelines revised 02/2015, instruct users to: Step 7: priming your Levemir FlexTouch Pen:	F 332		

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F 332	Continued From page 26 Turn the dose selector to select 2 units Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 4 (R239, R176) residents were free of significant medication errors related to insulin administration this has the potential to affect 11 residents who receive insulin by insulin pens. Findings include: R239's Order Summary Report printed 10/22/15, indicated that R239 had diagnosis of diabetes mellitus with diabetic nephropathy. R239's blood sugars between 10/16/15, to 10/22/15, ranged from a low of 144 to a high of 452. The Order Summary Report printed 10/22/15, directed staff to administer Levemir FlexPen	F 333	F 333 The residents, R239 and R 176, will have insulin administered correctly with the use of the insulin pens. All residents receiving insulin via the insulin pens will have the insulin administered correctly. All licensed nurses have been re-educated on the requirement to affix the needle to the insulin pen first, then to properly prime the pen with 2 units of insulin prior to dialing up the insulin dose for administration. Monitoring to ensure compliance will be done through random observational audits of licensed nurses administering insulin via the insulin pen to ensure proper procedures for administration are being followed. The facility QAPI committee will review the insulin administration audits quarterly for further recommendations. The date for completion will be 12-1-15.	

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F 333	Continued From page 27 100/unit/milliliter to inject 42 units two times a day. R239 also had an order for Novolog Flexpen insulin 100Unit/milliliter to inject seven units one time a day with breakfast. During medication administration observation on 10/22/15, at 8:20 a.m. licensed practical nurse (LPN)-C prepared Levemir FlexTouch pen for injection. LPN-C wiped off the stopper of the Levemir FlexPen, dialed 2 units on the FlexTouch pen and primed pen by expressing it into the air without a needle attached to the FlexPen. LPN-C then attached the needle to the FlexPen and dialed 42 units for administration. LPN-C prepared the Novolog Flexpen for injection by wiping off the stopper of the Novolog FlexPen, dialed 2 units on the FlexPen and primed FlexPen by expressing it into the air without a needle attached to the FlexPen. LPN-C then attached the needle to the FlexPen and dialed the 7 unit dose. LPN-C Wiped R239's abdomen with alcohol wipe and gripped skin to administer the Levemir. Surveyor stopped the administration and had LPN-C correctly prime the Levemir FlexPen and Novolog FlexPen with needles attached. R176's quarterly Minimum Data Set (MDS) dated 9/9/15, indicated R176 was severely cognitively impaired. Diagnosis identified on the MDS include diabetes mellitus. The Order Summary Report printed 10/22/15, directed staff to administer Novolog Flexpen insulin 100 Unit/milliliter (medication used to control blood sugar) inject per sliding scale: if 0-70=0 treat and call; 71-140=0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-399=6 units; 400+call	F 333		

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F 333	Continued From page 28 subcutaneous before meals for Diabetes During medication administration observation on 10/21/15, at 11:46 a.m. LPN-D wiped R176's right arm with an alcohol wipe, dialed 2 units on the FlexPen and then primed flex pen by expressing it into the air without a needle attached to the FlexPen. LPN-D then attached the needle to the FlexPen without wiping the rubber stopper. LPN-D dialed 1 unit and injected it into R176's right arm. During interview on 10/22/15 at 8:26 a.m. interview LPN-C stated that it would not be good to not have the needle attached when priming the FlexPens because the resident would get too little insulin. During interview on 10/22/15, at 9:40 a.m. the director of nursing (DON) said the staff had training on how to use FlexPens in 2014. The DON stated, " I expect them to put needle on before they prime flex pens, there is always a greater risk when administering insulin and you always want to administer the correct dose. " Undated Pen Devices for Insulin Administration educational documentation provided by facility instructed staff to: "* Remove the pen cap and clean the rubber seal on the insulin cartridge with a sterile alcohol swab. * Attach the disposable needle onto the pen. Remove the outer needle cap and save it to use later when you are done with your injection. Remove the inner needle cap and throw it away. Use a new needle every time you inject insulin. * With the needle pointing upward, tap the insulin cartridge to force any air bubbles to the top.	F 333		

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F 333	Continued From page 29 Prime the pen before each injection. Priming the pen gets rid of air bubbles that may be in the pen. Air bubbles can affect the flow of insulin from a pen and cause you to inject the wrong amount of insulin. * Dial two units of insulin on the dose selector. Point the needle up and firmly press the plunger until a drop of insulin appears at the needle tip. Repeat this step if a droplet does not appear. You may need to use a different needle or pen if you have to repeat this step several times." NovoLog FlexPen manufacture guidelines dated April 2015, instruct users to Step 1: prepare your NovoLog FlexPen: Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your FlexPen tightly. Step 2: Step 2: Doing the air shot before each injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop appears, change the needle and repeat. Levemir FlexTouch manufacture guidelines revised 02/2015, instruct users to: Step 7: priming your Levemir FlexTouch Pen: Turn the dose selector to select 2 units Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top Step 9: Hold the Pen with the needle pointing up.	F 333		

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F 333	Continued From page 30 Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F 441 The isolation precautions for resident, R233, will be followed by all facility staff. Resident, R79, will receive catheter care per protocol to prevent the spread of infection. Resident, R85, will have the glucometer appropriately disinfected after use. The insulin pen stoppers for residents, R176 and R39, will have the insulin pen stoppers properly cleansed prior to affixing the needle. The isolation precautions for all residents will be properly followed by all facility staff. All residents with catheters will receive catheter care per protocol to prevent the spread of infection. All residents receiving insulin via the insulin pens will have the insulin pen stoppers properly cleansed prior to affixing the needle. All facility staff have been re-educated on the requirement to follow isolation precautions as set up to prevent the spread of infection. All staff will be educated on the types of isolation and the precautions to follow for each type. All nursing staff will be re-educated on the protocol to follow for catheter care and will also be educated to disinfect any surface that	

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F 441	Continued From page 31 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate infection control precautions were implemented for 1 of 1 resident (R233) who was on contact isolation precautions; for 1 of 3 residents (R79) reviewed for catheter care; and failed to ensure multi use glucometers were appropriately disinfected for 1 of 3 (R85) residents reviewed for glucometer use to prevent the spread of blood borne infection; In addition the facility failed to properly clean insulin pen stoppers for 2 of 4 (R176, R39) residents observed for insulin administration. Findings include: On 10/19/15, at 12:30 p.m., a sign was observed on the door to R233's room, "Please Inquire at the nursing station prior to entering room, Thank you." On 10/19/15, at 1:55 p.m., prior to conducting an interview with R233, the surveyor inquired at the nursing station with respect to the sign on the resident's door. The registered nurse (RN)-Y stated the resident had an infection requiring contact precautions including use of a gown, and gloves. RN-Y provided the surveyor with the	F 441	may come in contact with urine. All licensed nurses will be re-educated on the requirement to swab off the insulin pen stopper with alcohol prior to affixing the needle to the pen and to cleanse the glucometers after use with the bleach wipes. Monitoring to ensure compliance will be conducted through random observational audits of staff when in contact with a resident in isolation. Random observational audits will also be conducted of staff providing catheter care to ensure proper protocols are being followed. Random observational audits will also be conducted of licensed nurses administering insulin via the insulin pen to ensure compliance with cleansing of the pen stopper prior to affixing the needle. The facility QAPI committee will review the isolation observational audits, the catheter care audits,, and the insulin pen administration audits quarterly for further recommendations. The date of completion will be 12-1-15.	

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F 441	Continued From page 32 appropriate personal protective attire. During interview with R233 on 10/19/15, at 2:00 p.m., the resident's husband was present seated in a chair next to her. The resident's husband was not wearing any personal protective attire. When questioned the husband looked at R233 and said, "I thought you didn't have an infection anymore?" R233 responded, "Yes, I'm still using the antibiotic." During the interview with R233 on 10/19/15, at 2:00 p.m., the maintenance man laid on the floor next to the resident's bed to work on some electrical equipment. The maintenance man was not wearing any personal protective attire. When questioned about use of the precautions at that time, he stated, "I just thought we weren't supposed to handle any body fluids." On 10/21/15, at 2:14 p.m. the infection control RN-B verified R233 was on contact precautions for clostridium difficile colitis (inflammation of the large intestine). When asked if staff was supposed to follow contact precautions when entering R233's room or when in contact with equipment in the room. RN-B stated, "I would expect him to have talked to nursing and to have worn a gown and gloves." -When asked about cleaning of the floor RN-B stated, "We have not told them to clean the floor that way. We have bleach wipes, if there was a wet area would expect them to wipe it off then contact housekeeping to bring a certain type of solutions and equipment to clean the floors." On 10/22/15, at 10:25 a.m. when asked what her expectation of staff was in regards to following infection control precautions the director of	F 441		

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F 441	Continued From page 33 nursing stated all the staff at the facility were to follow infection control precautions as indicated at the door to prevent spreading the infection and this included the maintenance staff. Isolation- Initiating Transmission- Based Precautions policy revised August 2012 directed 5. When Transmission-Based Precautions are implemented, the infection Preventionist (or designee) shall: a. Ensure that protective equipment (i.e., gloves, gowns, mask, etc.) is maintained outside the resident's room so that everyone entering the room can access what they need; b. Post the appropriate notice on the room entrance door, so that all personnel and staff will be aware of precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room ... " R79 was observe to have catheter care on 10/21/15, at 9:25 a.m. Nursing assistant (NA)-X placed a cloth towel on the floor prior to emptying the Foley catheter drainage bag into a urinal. The NA was observed to take the urinal into the resident ' s bathroom, measured the urine, emptied the urinal into the toilet, put the urinal under the faucet and filled with water, and emptied the water into the toilet. When finished, NA-X picked up the towel from the moistened paper towels with soap and water and wiped the area on the floor where the towel had been placed. During interview with NA-X immediately following the observation, NA-X verified the facility maintained a supply of disinfectant wipes which	F 441		

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F 441	Continued From page 34 she said she should have used in lieu of the paper towels with soap and water applied. Glucometer: R85's admission Minimum Data Set (MDS) dated 8/11/15, indicated R85 had short and long term memory problems and had diabetes mellitus, dementia. R85's Order Summary Report dated 10/22/15, indicated staff were to check R85's blood sugars four times a day. On 10/19/15, at 5:03 p.m. licensed practical nurse (LPN)-B was observed performing a blood sugar check on R85. LPN-B put on gloves and explained to R85 what was going to happen. LPN-B wiped the glucometer (a handheld machine for checking blood sugars) with a UP and UP (brand name) lemon scented disinfecting wipe. LPN-B allowed the glucometer to dry. LPN-B cleaned R85's finger with alcohol wipe, allowed it to dry and did blood stick. After reading the blood sugar result LPN-B again cleaned the glucometer with a UP and UP lemon scented disinfecting wipe. On 10/22/15, at 9:04 a.m. RN-B stated the up and up lemon sanitizer did not meet the criteria for blood borne pathogen disinfection. "We use bleach wipes for glucometer cleaning." RN-B stated there have been no skin infections at insulin injection sites or fingers. "We have not had a hepatitis out break." RN-B stated staff are educated on how to correctly clean glucometers. The UP and UP lemon scented disinfecting wipes label dated 2014, indicated the product killed the cold and Flu virus. The label did not indicate that it sanitized or disinfected surfaces exposed to blood borne pathogens like HIV or hepatitis C.	F 441		

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	245293	A. BUILDING _____ B. WING _____	10/22/2015

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F 441	Continued From page 35 Blood Glucose Monitor Decontamination policy revised August 2012, instructed staff ,a wipe that was EPA registered as effective against HIV or Hepatitis virus will be utilized to clean the monitor. The Up and Up product was not effective against HIV or the Hepatitis virus as indicated on the manufacturer's label therefore did not meet the definitions of the facility policy for decontamination. FlexPens: R176's quarterly MDS dated 9/9/15, indicated R176 was severely cognitively impaired. Diagnosis identified on the MDS include Diabetes Mellitus. The Physicians Orders printed 10/22/15, directed staff to administer Novolog Flexpen insulin 100Unit/milliliter (medication used to control blood sugar) inject per sliding scale: if 0-70=0 treat and call; 71-140=0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-399=6 units; 400+call subcutaneously before meals for Diabetes During medication administration observation on 10/21/15, at 11:46 a.m. LPN-D wiped R176's right arm with an alcohol wipe, dialed 2 units on the flexpen and expressed it into the air without a needle attached to the flexpen. LPN-D then attached the needle to the flexpen without wiping the rubber stopper. LPN-D dialed 1 unit and injected it into R176's right arm. R39's quarterly MDS dated 7/13/15, indicated resident had a diagnosis of diabetes. The Order Summary Sheet printed 10/22/15, instructed staff	F 441		

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F 441	Continued From page 36 to administer Lantus 42 units by a Lantus SoloStar pen and Novolog 17 units by a Novolog FlexPen. During medication administration on 10/22/15, at 7:24 a.m. LPN-F did not wipe rubber stopper with alcohol prior to attaching the needle to the Lantus SoloStar. LPN-F did not wipe rubber stopper with alcohol prior to attaching the needle to the Novolog FlexPen. On 10/22/15, at 9:04 a.m. RN-B stated staff are to wipe the rubber top of the insulin pens off then attach needle the needle prime the insulin pen, dial correct amount of insulin and give. RN-B remarked staff are educated on how to correctly use the insulin pens. Glucometer policy requested from facility but not provided. NovoLog FlexPen manufacture guidelines dated April 2015, instruct users to Step 1: prepare your NovoLog FlexPen: Pull of the pen cap. wipe the rubber stopper with an alcohol swab. remove the protective tab from the needle and screw it onto your flexpen tightly. The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on November 2013, directed the provider/consumer to: "...Step 2. Attach the needle Always use new sterile needle for each injection. This helps prevent contamination and potential needle blocks. A. Wipe the rubber seal with alcohol."...	F 441	F 458 Golden Living Center Hopkins would like to request a waiver under F458 in regards to resident room size. The specific rooms to be included in this waiver are: 142, 144, 240, 260, 264, 269, 271, 277. The following rooms previously identified for the waiver have now been made into private rooms: 141, 143, 146, 165, 171, 258. These rooms were constructed in 1955 and do not meet the current requirements for square footage in two bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility. Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The resident's health, treatments, comfort, safety, and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. The Executive Director is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	
F 458	483.70(d)(1)(ii) BEDROOMS MEASURE AT	F 458		

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F 458 SS=C	Continued From page 37 LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not provide 80 square feet per resident for rooms 141, 142, 143, 144, 146, 165, 171, 240, 258, 260, 264, 269, 271, and 277. Findings include: During the survey cares were observed in two of the 14 rooms with no concerns noted in the delivery of care. During the survey from 10/19/15 through 10/22/15, neither the residents nor the families had concerns or complaints related to room size.	F 458	F 463 The call light for resident, (R221), has been repaired and is now functioning properly. The call lights for all residents residing in the facility have been checked and are functioning properly. All facility staff have been re-educated on the requirement to immediately report to the Maintenance Dept. .if a call light is not functioning or any other resident equipment device that requires repair. Monitoring to ensure compliance will be conducted through weekly call light function audits ensuring that all resident call lights are checked quarterly for proper function. The facility QAPI committee will review the call light audits quarterly for further recommendations. The date of completion is 12-1-15.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a non-functioning call light for 1 of 7 residents (R221) reviewed on the 2 West unit who had a non-functioning call light.	F 463		

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F 463	Continued From page 38 Findings include: During an observation on 10/20/15, at 9:26 a.m. the call light on the bed for R221 was checked and did not work. On 10/20/15, at 9:28 a.m. licensed practical nurse (LPN)-A confirmed the call light was not working. LPN-A stated she would notify the maintenance department and they would get it fixed. She stated the call light should have functioned properly. When interviewed on 10/20/15, at 9:40 a.m. maintenance (M)-A stated he replaced the cord in R221's room. He said it was a faulty cord and that was why it was not working. M-A stated the facility performed weekly spot checks on the call lights in the facility. They did that by picking a random sample of call lights. M-A stated the facility did not keep a record of which call lights in which rooms they did check on a weekly basis. When interviewed on 10/20/15, at 9:41 a.m. licensed practical nurse (LPN)-A stated the potential risk when there was a non-functioning call light would be a safety issue. The resident could have been at a risk for falls. At 9:47 a.m. LPN-A added R221 probably used the call light on a weekly basis. She stated R221 would only use the call light if something were wrong. When interviewed on 10/20/15, at 11:18 a.m., the director of nursing (DON) stated maintenance was currently auditing all the call lights in every room in the facility. She stated that it would be her expectations that all the call lights in the facility would be working properly. When interviewed on 10/21/15, at 8:38 a.m.	F 463		

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F 463	Continued From page 39 (M)-A stated the facility had initiated recording which rooms they do audit on a weekly basis so there would be a record of which call lights they checked. He stated they typically audit ten rooms per week but had never recorded which rooms until now. When interviewed on 10/22/15, at 5:11 p.m., R221 stated she used her call light, "Only if I need to." She stated if she pressed the button on the call light someone would come. R221's care plan, dated 8/24/15, identified R221 was at risk for falls. The care plan identified that the call light should be available. It also noted R221 was at risk for urinary tract infections. The care plan read R221 should have the call bell within reach and to remind R221 to use the call bell as needed. The facility policy titled, Call Light, Use of (last reviewed on 1/26/15), identified the purpose was to assure the call system (including the bedside call light) was in proper functioning order. It stated that all facility personnel must be aware of call lights at all times. It stated that maintenance was to be notified of defective call light locations and entered in the maintenance log if such a log existed.	F 463	F 465 The fans mounted in the hallways in the 2 East and 2 West units have been cleaned. All bathroom floors identified have been cleaned or if the flooring needs to be replaced a flooring company will be contacted by 12-1-15 to arrange for replacement. All resident room floors identified have been cleaned. All toilets identified have been cleaned or replaced. For the hallway carpets on the 2 East and 2 West units the facility will have contacted a commercial carpet cleaning company to address the stained areas by 12-1-15. If the commercial carpet cleaning company can not remove the stains the carpeting will be replaced in the first quarter of the next budget cycle which begins January 1, 2016. The light fixtures, grab bars, and bathroom caulking identified as needing repair have been repaired. All walls identified have been repaired. All hallway transition strips, door frames and kick plates identified have been repaired. All hallway fans in the facility have been cleaned. All bathroom and resident room floors in the facility have been cleaned. All toilets in the facility are clean. All hallway carpets in the facility are clean. All light fixtures, grab bars, and bathroom caulking are in good repair. All resident room walls	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure equipment was kept in a clean and sanitary manner in 2 of 4 units. This had the potential to affect 50 of 111 patients. Findings include: On 10/20/15, at 8:00 a.m. to 3:15 p.m. through 10/22/15, at 2:30 p.m. the fans mounted on the walls down the hallways in the 2 West and 2 East units were observed to have fluffly gray grey black matter build-up on the on the fan grates. During the survey time the fans were observed to be running and blew air into the hallways where residents, staff and visitiors walked past. During environmental tour on 10/22/15, from 11:51 a.m. to 1:17 p.m. with Maintenance supervisor maintenance (M)-A, M-B, housekeeping district manager (HDM) and the housekeeping supervisor the following rooms were observed. M-A and HDM acknowledged all findings. Room 124: Bathroom floor was stained under sink, directly under soap dispenser. There was a black ring on floor around toilet. M-A stated "We will replace the soap dispenser." That should reduce the staining. Room 140: Room floor was sticky to walk on and was noted to have a grimy build-up of dirt. Unit 2 East: The north hall carpet stained in front of room 274. HDM acknowledged the south hall carpet heavily soiled and stained throughout.	F 465	are in good repair. All hallway transition strips, door frames, and kick plates are in good repair. The Housekeeping staff have been re-educated on the proper procedures to follow for cleaning of resident rooms, bathrooms, and hallways. The Maintenance staff have been re-educated on the requirement to maintain wall repair, light fixture repair, grab bar repair, caulking repair, transition strip repair, door and door frame repair. Monitoring to ensure compliance will be conducted through weekly observational audits encompassing the proper cleaning of resident rooms, bathrooms, hallways, and circulating air fans. Weekly observational audits will also be completed to encompass the proper maintenance of walls, light fixtures, grab bars, caulking, transition strips, doors and door frames. The facility QAPI committee will review the observational environmental audits quarterly for further recommendations. The date of completion will be 12-1-15.	

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F 465	Continued From page 41 Room 254: the floor was dirty with a large purple stain in front of closet. HDM stated that was a "shoe mark." The bathroom noted the light switch next to the sink was missing. M-A stated it was just brought to my attention now. There was a gray basin on the floor under the sink with brown soiled cloths, the grab bars on either door frame was missing paint. The bathroom floor was dirty. HDM verified the grab bars did not have a cleanable surface and that room and bathroom were not clean. Room 255: HDM stated the caulking was bad around the sink and needed to be replaced. Toilet bowl had a black ring in it. Bathroom floor around toilet was stained brown. Room 261: The floor was missing the transition strip between the hall and room. The also had a build-up of brown dirt. Bathroom floor was heavily stained. Room 269: The wall by head of bed was gouged and showed the sheetrock beneath. The Bed tires rubbing on the floor leaving black marks. Room 273: The kick plate on door to the room had several medium to large gouges out of it. The door frame was missing paint which exposed the metal beneath it. M-A stated, "I planned to paint this week." Room 275: There was a 1 x 4.5 inch hole in bathroom door. The bathroom door and door frame had several gouges which exposed the product beneath the gouges. Room 276: The floor had brown spots from the	F 465		

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F 465	Continued From page 42 closet to under the bed. The kick plate on door had gouges in it. The door frame was missing paint. The bathroom floor had brown and yellow stains and the grout was yellow orange stained. The toilet bowl was stained gray to black from water line to bottom of bowl. Room 243: There was brown debris build up at transition strip, and a large brown stain in front of bed. M-A scraped the stain with his shoe and some of it came loose. Unit 2 West - The east mini hallway carpet stained and worn. Room 223: Anti-slip strips were on the floor in front of the bed. The strips were broken and collecting black dirt, which rendered uncleanable. There were gouges on the bottom of the bathroom door and the wall next to the bathroom which exposed the raw material beneath. Room 224: The transition strip missing between hall carpet and room. Room 211: The room floor was dirty, sticky build up in corners, and the inside handle of the room door was sticky. There was an odor of urine in the bathroom. The toilet bowl was gray-green from water line to base of bowl. The bathroom floor was stained and black to brown debris was built up in corners. The inner bathroom door was gouged. Room 213: The floor was stained by nightstand with 2 x 3 inch gray stain. The bathroom floor was dirty with buildup in corner and at transition. The frame of bathroom door between room 213 and 215 was missing paint. There were gouges on	F 465		

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F 465	Continued From page 43 215's inner bathroom door which exposed the raw material beneath it. Room 216: The bathroom was leaking toilet water on the floor. M-A stated he had not notified about leaking toilet. Toilet bowl from water line to base was gray. M-B stated there was a probable seal failure. The leak of water was yellow and brown matter which had dissolved in the water. There was a brown ring around toilet for about 1.5 inches M-B scraped with knife and brown substance came up. Room 217: The bathroom floor was dirty and the toilet bowel was streaked gray from water line to base of bowl. The inner bathroom door frame had gouges and was missing paint. Room 218: The floor has multiple black scuff marks between bed and wall. The bathroom floor was dirty, the toilet was streaked gray from water line to bottom of toilet, and the bilateral door frame was missing paint and had gouges. Room 207: The bathroom floor was stained. The toilet bowl was gray brown from water line to bottom of toilet. There was brown build up at transition from the bathroom to room 205. During interview after tour on 10/22/15, at 1:17 p.m. M-A stated everything was reported through building engines at the kiosks. " We check whatever is entered and the daily building to do list. If it is a safety issue or needs immediate action the staff have our cell phone numbers. " M-A further stated " We check on things as soon as possible. We check a room prior to admission to ensure it is admit ready. We check on issues whenever told about them. Not having a cover on	F 465		

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F 465	Continued From page 44 a light switch is not good someone could touch a wire. We have a preventative maintenance program: every room pops up about every 6 months for a check. Housekeeping can write down issues. Housekeeping works more closely. Housekeeping staff have been trained to report issues to their supervisor." The HDM stated the toilets can be cleaned with a "little elbow grease." If unable to clean the toilet bowls they would need to be replaced. The facility policy for cleaning rooms dated 1/1/2000, Number 7-Step Daily Washroom Cleaning instructed staff to check supplies in rooms, empty trash, Dust mop floor, clean and sanitize sink and tub, clean and sanitize commode including inside of bowl, spot clean walls and or partitions and damp mop floor. On 10/22/15, at 2:30 p.m. an environmental tour was completed with the district manager for healthcare services and housekeeping superviosr both verified the fans were not kept clean and had build-up. When asked who was responsible for cleaning all the fans around the facility resident care areas the district manager stated "Floor techs [technicians] are supposed to take them and cleans them."	F 465		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced	F 469	F 469 The room for resident, R8, has been thoroughly cleaned. All cob webs have been removed and the room has been treated for the fruit flies. All resident rooms are free from cob webs and insects. The housekeeping staff have been re-educated on the requirements for proper cleaning of resident rooms and of the requirement for notification to maintenance if insects are present in rooms.	

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F 469	Continued From page 45 by: Based on observation, interview, and document review, the facility failed to prevent fruit flies and spiders in 1 of 2 resident rooms (R8) reviewed for insects. Findings include: R8's quarterly Minimum Data Set dated 7/31/15, indicated R8 was cognitively intact. During an initial interview on 10/20/15, at 11:15 a.m. with R8 cobwebs were observed on ceiling and dead fruit flies on the window sill. During the interview on 10/20/15, at 11:15 a.m. R8 stated, "Lots of time they don't come in to clean. Cobweb on ceiling. Dead fruit fly's on windowsill. Last couple weeks have come in more often to clean. During the environmental tour on 10/22/15, at 12:04 p.m. extensive cob webs were observed on ceiling track above the foot of the bed, forming a large triangle. There were small flies (18) on two stripes of tack paper, approximately 3x8 inches each, sitting in window sill at the head of R8's bed. Maintenance director verified observation. During environmental tour on 10/22/15, at 12:04 p.m. Maintenance-A stated, "We just changed the stripes out the other day, the pest guy was here this morning." Phone interview completed with manager of Presto-x on 11/2/15, at 3:45 p.m. to clarify Service Report dated 10/22/15. Manager stated that they started working with facility about six months ago to treat a big problem with phorid flies. Phorid flies are not Fruit flies although the look very similar. They are due to excessive	F 469	Monitoring to ensure compliance will be conducted through weekly environmental/sanitation audits of resident rooms. The facility QAPI committee will review the environmental audits quarterly for further recommendations. The date of completion will be 12-1-15.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 46 dampness in a wall cavity where the staff clean out their mops. The flies are all over the facility. The manager stated did offer to place a light trap in R8's room but R8 did not want it. The manager stated the facility was having an outside contractor fix the wall cavity and that was the only way to fix the problem however, the facility did not provide any information regarding the contractor fixing the wall. Integrated Pest Management Service Program dated 6/1/13, indicated Presto-X flying insect management included flying insect light traps and glue boards. The placement of units was reviewed and any any relocation or additional placement recommendations would be offered. Get Rid of Phorid Fly Undated policy directed "The phorid fly breeds primarily in and feeds on moist decaying organic matter. The phorid fly can be found breeding wherever moisture exists, such as around plumbing and drains in bathrooms and kitchen areas, garbage containers, crawl spaces and basements. Because it frequents unsanitary areas (with the ability to spread disease causing bacteria onto food products) this fly is of particular concern to hospitals, health care facilities and restaurants."	F 469		

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

F5293024

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS APPROVED By Tom Linhoff at 3:09 pm, Nov 20, 2015 Rexeisen, Ro FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden LivingCenter Hopkins was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. RECEIVED NOV 20 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins was constructed as follows: The original building was built in 1958, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 1st Addition was built in 1960, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 2nd Addition was built in 1965, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 3rd Addition was built in 1989, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(222) construction; The 4th Addition was built in 1993, is two-stories, has no basement is fully fire sprinkler protected and is of Type II(222) construction; The most recent addition was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222)	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 138 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K-052 A fire alarm system test was conducted on 10/29/15. The fire alarm system test will be conducted annually by the fire alarm maintenance company. The maintenance department has been trained on the regulation requiring annual fire alarm system testing. Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through auditing to ensure that the regulation is met and documented. The facility QAPI Committee will review the maintenance audits quarterly for further recommendations. The date of completion will be 12-1-15.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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K 052	Continued From page 3 Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 10/21/2015, record review revealed that the fire alarm system was last inspected on 09/18/2014. This deficient practice was verified by the administrator at the time of the inspection.	K 052	K-062 A Fire Sprinkler Test was conducted on 10/27/15. The Fire Sprinkler Flow Test will be conducted on a quarterly basis beginning October 2015 and going forward. The Maintenance staff has been trained on the regulation requiring quarterly fire sprinkler flow tests and the documentation of the sprinkler flow tests.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating 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 record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 10/21/2015, record review revealed that the fire sprinkler system was last annually inspected on 09/18/2015.	K 062	Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through audits to ensure quarterly sprinkler flow tests are completed and documented. The facility QAPI committee will review the maintenance audits quarterly for further recommendations. The date of completion will be December 1, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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K 062	Continued From page 4 This deficient practice was verified by the administrator at the time of the inspection.	K 062		

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

F5293024

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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K 000	INITIAL COMM[illegible]	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	

APPROVED
By Tom Linhoff at 3:08 pm, Nov 20, 2015

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden LivingCenter Hopkins building 2 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

RECEIVED
NOV 20 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

All building one for signature and date

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Hopkins Therapy building 2 was constructed in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. Because the original building and the five (5) additions meet the construction type allowed for both new and existing health care occupancies, the facility was surveyed as 1-building and two (2) Form CMS-2786R booklets were completed; Building 01 in accordance with Chapter 19 Existing Health Care Occupancies and Building 02 in accordance with Chapter 18 New Health Care Occupancies. The facility has a capacity of 138 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 NOT MET as evidenced by:	K 000	K-052	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 10/21/2015, record review revealed that the fire alarm system was last inspected on 09/18/2014. This deficient practice was verified by the administrator at the time of the inspection.	K 052	A fire alarm system test was conducted on 10/29/15. The fire alarm system test will be conducted annually by the fire alarm maintenance company. The maintenance department has been trained on the regulation requiring annual fire alarm system testing. Monitoring to ensure compliance will be conducted by the Maintenance Director or designee through auditing to ensure that the regulation is met and documented. The facility QAPI Committee will review the maintenance audits quarterly for further recommendations. The date of completion will be 12-1-15.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245293	A. BUILDING 02 - 2008 ADDITION B. WING	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HOPKINS	725 SECOND AVENUE SOUTH HOPKINS, MN 55343

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