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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XXCP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **286742700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** **55427**
(L6)

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)

6. DATE OF SURVEY **1/29/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (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
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 03/38/2014 CO. XXCP

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/01/2014
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 21, 2014, the facility is certified for 164 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245186

March 18, 2014

Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

Dear Ms. Guindon:

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

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

Effective January 21, 2014, the above facility is certified for:

164 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 164 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Number S5186028

Dear Ms. Guindon:

On December 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013 that included an investigation of complaint number H5186199, and H5186201. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 21, 2014 and therefore remedies outlined in our letter to you dated December 26, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure:
cc: Licensing and Certification File

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
245186	A. Building B. Wing	1/29/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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 F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/21/2014	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 01/21/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 01/21/2014
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 01/21/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/21/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 01/21/2014
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/21/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2/3/14
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
12/12/2013				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XXCP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **286742700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND**
(L4) **CARE CENTER 7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

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)

6. DATE OF SURVEY **12/12/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Marilyn Kaelke, HFE NE II — 01/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/28/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245186

At the time of the unsubstantiated complaints H5186199 and H5186201 investigated concurrent with the standard survey completed December 20, 2013 the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7192

December 26, 2013

Ms. Kristina Guindon, Administrator
Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, Minnesota 55427

RE: Project Numbers S5186028, H5186199 and H5186201

Dear Ms. Guindon:

On December 12, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 12, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5186199 and H5186201. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 12, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5186199 and H5186201 that were found to be unsubstantiated.

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

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

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

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

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

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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

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 January 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 12, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ JAN 08 2014 via mail B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

MN Dept of Health St Cloud

Received Via Jan 3 fax

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5186199 and H5186201 was not substantiated during this survey.	F 000	Disclaimer For Plan of Correction Golden Valley Rehabilitation and Care Center objects to the allegation of non-compliance. 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 against interest by the facility, the Administrator 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 this allegation by the survey agency. Golden Valley Rehabilitation and Care Center respectfully makes its allegation of compliance on all areas and has written these Plans of Correction to constitute the allegation. The Center is alleging compliance on January 21, 2014.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care related to activities of daily living and to minimize risk of falls for 1 of 3 residents (R200) reviewed. In addition the facility failed to follow the plan of care for pain management for 1 of 3 residents (R67) reviewed.	F 282	OK 1/14/14 SG	

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

LNHA | 1/3/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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 282	Continued From page 1 Findings include: R200's quarterly MDS dated 8/28/13, identified R200 to require total dependence (full staff performance) for activities of daily living and two plus physical assist for bed mobility and dressing. The MDS also identified absence of spoken words, and rarely/never understands others and diagnoses that included traumatic brain injury. The ADL/Mobility Plan of Care dated 12/10/13, identified R200 required total assist for activities of daily living (ADLs). It indicated R200 required assistance with combing hair, dressing, shaving, and undressing. It also indicated staff were to provide assist of one for oral care. The nursing assistant group sheet indicated R200 to have a low bed, a fall mat to both sides of the bed, and two staff were to assist with activities of daily living (ADLs). During an observation on 12/11/13, beginning at 11:18 a.m. nursing assistant (NA)-A indicated she checked R200's for incontinence, raised the bed up to a high position and was waiting for another staff to assist dressing R200 and transfer in his wheelchair. She then left the area with the bed in a high position. At 11:20 a.m. licensed practical nurse (LPN)-E entered the room and lowered the bed. She then washed her hands and boosted R200 up in bed. NA-B entered the room to assist with cares. At 11:46 a.m. boots were placed on resident, and at 11:48 a.m. hand splints were placed. NA-A wiped R200's face and eyes with a wet washcloth. When interviewed on 12/11/13, at 1:00 p.m. NA-A	F 282	F282 1. Resident R200 is receiving oral care and fall interventions. R67 is receiving pain management. The residents' pain, ADL's and fall careplans were reviewed and updated and there were no adverse effects. 2. All residents are receiving oral care assistance, fall interventions, and pain management per plan of care. 3. Nursing staff were reeducated. 4. 5 audits per week will be completed of residents for oral care, fall interventions and pain management. 5. Audit results will be reviewed by facility QA committee. 6. DON is responsible for compliance. (continued)	1/21/14

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F 282	Continued From page 2 stated she only washed his face today and did not provide oral care to R200. She also verified the bed should not have been left in the up position when she left the area. When interviewed on 12/11/13, at 2:42 p.m. RN-C noted the bed was to be lowered and mat should be in place while R200 was in bed without staff next to him. When interviewed on 12/12/13, at 10:15 a.m. RN-C indicated an oral swab would be used as R200 is unable to take fluids by mouth and is at risk for aspiration, and this would be expected of the nursing assistants to provide. RN-C verified oral care is not noted on the group sheets. When interviewed on 12/12/13, at 3:40 p.m. director of nursing (DON) confirmed it is her expectation that NAs provide cares as they have been educated on and follow the plan of care. The facility failed to provide R67 with scheduled pain medications in accordance with the plan of care. R67's diagnoses per physician's orders sheets, dated 12/13, listed lymphedema (a condition of localized fluid retention and tissue swelling), pain and osteoarthritis (a degenerative joint disease caused by cartilage loss and characterized by pain and stiffness). R67's quarterly minimum data set (MDS), dated 9/17/13, identified the resident as cognitively intact. R67's care plan, dated 12/10/13, included interventions of administering pain medications as ordered. R67's medication administration sheets, dated	F 282	(continued)	

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F 282	Continued From page 3 12/13, included physician orders for acetaminophen (Tylenol) 500 mg (milligrams) two caplets three times daily at 0800 (8:00 a.m.), 1200 (12:00 p.m.) and 2200 (8:00 p.m.) and Lidoderm 5% patches (a topical analgesic patch), apply one patch to both knees and change daily - on for 12-hours, off for 12 hours for pain. The Lidoderm patches were scheduled to go on at 0800 (8:00 a.m.) and be removed at 2000 (8:00 p.m.). On 12/10/13, at 9:15 a.m., R67 was observed in her room. R67 stated she was still waiting for her meds [medications] which R67 reported she preferred to have at 7:30 a.m. R67 further remarked she had waited until 11:30 a.m. on 12/09/13 for her morning pain medications. R67 indicated pain in both knees. During interview on 12/11/13, at 12:58 p.m., trained medication aide (TMA)-A said he administered R67's pain medications including the acetaminophen, Lidoderm patches and a newly scheduled medication, oxycodone, sometime after 9:30 a.m. because it was busy. During interview on 12/12/13, at 8:16 a.m., licensed practical nurse (LPN)-C was asked about the morning medication pass on 12/11/13, and her expectations for time frame for medications to be administered. LPN-C commented that it was "very tough" to get the med pass done in a timely fashion, and that it "is not right" for the residents to get their pills late. During interview on 12/12/13, at 10:58 a.m., registered nurse (RN)-A remarked they would expect medications to be given within an hour before or after the scheduled time.	F 282	(continued)	

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F 282	Continued From page 4 During interview on 12/12/13, at 11:00 a.m., RN-B indicated they would expect medications to be given within an hour before or after the scheduled medication pass time. During interview on 12/12/13, at 11:12 a.m., the director of nursing (DON) indicated her expectation was for medications to be given within an hour before or after the medication was scheduled.	F 282		
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 provide scheduled pain medications in a timely manner for 1 of 3 residents (R67) reviewed for pain. Findings include: R67's diagnoses per physician's orders sheets, dated 12/13, listed lymphedema (a condition of localized fluid retention and tissue swelling), peripheral vascular disease (a circulatory condition affecting the limbs), pain and osteoarthritis (a degenerative joint disease	F 309	F309 1. Resident listed (R67) is receiving pain medications per MD order. Resident's careplan was reviewed and updated. Resident indicated good pain relief. 2. All residents are receiving pain medications per MD order. 3. Nursing staff were educated on pain medication administration. 4. 5 audits per week will be completed of resident's receiving pain medications. 5. Audit results will be reviewed by facility QA committee. 6. DON is responsible for compliance. (continued)	1/21/14

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F 309	Continued From page 5 caused by cartilage loss and characterized by pain and stiffness). The quarterly Minimum Data Set (MDS), dated 9/17/13, identified R67 as cognitively intact. R67's current pain assessment, dated 12/10/13, indicated throbbing and aching pain frequently in the joints, rated six out of ten (with 10 being most severe) in the last five days previous the assessment. The pain assessment indicated a resident goal of being pain free, with an acceptable pain rating goal of one to two on a ten-point scale. The pain assessment indicated facility staff would implement scheduled oxycodone (a narcotic pain medication) for R67's pain. R67's pain flow sheet, dated December 2013, revealed pain on a daily basis for the dates of 12/9/13 through 12/12/13 at a level of eight or higher on a ten-point scale. R67's care plan, dated 12/10/13, included interventions of administering pain medications as ordered. R67's medication administration sheets, dated 12/13, included physician orders for acetaminophen (an oral analgesic) 500 mg (milligrams) two caplets three times daily at 0800 (8:00 a.m.), 1200 (12:00 p.m.) and 2200 (8:00 p.m.) and Lidoderm 5% patches (a topical analgesic patch), apply one patch to both knees and change daily - on for 12-hours, off for 12 hours for pain. The Lidoderm patches were scheduled to go on at 0800 (8:00 a.m.) and be removed at 2000 (8:00 p.m.). On 12/10/13, at 9:15 a.m., R67 was observed in her room. R67 stated she was still waiting for her medications which she preferred to have at 7:30 a.m. R67 further remarked she waited until 11:30 a.m. on 12/09/13, for her morning medications.	F 309	(continued)	

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F 309	Continued From page 6 R67 reported pain in both knees. On 12/10/13, at 9:27 a.m., licensed practical nurse (LPN)-A administered R67 morning pain medications including the acetaminophen and Lidoderm patches, 87 minutes (1 hour and 27 minutes) after the scheduled time. During interview on 12/11/13, at 12:46 p.m., R67 stated she had pain in her legs. She said that her usual morning medications were given late today. During interview on 12/11/13, at 12:58 p.m., trained medication aide (TMA)-A said he administered R67's pain medications including the acetaminophen, Lidoderm patches and a newly scheduled medication, oxycodone (a narcotic analgesic), sometime after 9:30 a.m. because it was busy. He indicated he had come to the unit around 9:30 a.m. to assist LPN-C. During interview on 12/12/13, at 8:16 a.m., LPN-C was asked about the morning medication pass on 12/11/13, and her expectations for time frame for medications to be administered. LPN-C commented that it was "very tough" to get the med [medication] pass done in a timely fashion, and that it "is not right" for the residents to get their pills late. LPN-C further stated it would be easier to get the med pass done if there was a TMA full-time on the shift. During interview on 12/12/13, at 10:58 a.m., registered nurse RN-A remarked they would expect medications to be given within an hour before or after the scheduled time. During interview on 12/12/13, at 11:00 a.m., registered nurse RN-B indicated they would	F 309	(continued)	

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F 309	Continued From page 7 expect medications to be given within an hour before or after the scheduled medication pass time. During interview on 12/12/13, at 11:12 a.m., the director of nursing (DON) indicated her expectation was for medications to be given within an hour before or after the medication was scheduled. During interview on 12/12/13, at 2:32 p.m., LPN-C said R67 likes to get up around 6:30 to 7:00 a.m., is awake and waiting for her medications. The facility policy, entitled Med Administration, revised 07/10, lacked guidelines for expected time parameters for administration of scheduled medication.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene care for 1 of 3 residents (R200) and bowel incontinence cares for 1 of 1 residents (R193) reviewed who were both dependent for cares. Findings include:	F 312	F312 1. Resident R200 and R193 are receiving assistance with ADL's. Residents' careplans were reviewed and updated with no adverse effects noted. 2. All dependent residents are receiving assistance with ADL's. 3. Nursing staff were educated on F312. 4. 5 audits per week will be completed on ADLs. 5. Audit results will be reviewed at facility QA meeting. 6. DON is responsible for compliance. (continued)	1/21/14

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F 312	Continued From page 8 R200 did not received oral hygiene during morning cares. R200's quarterly Minimum Data Set (MDS) dated 8/28/13, identified R200 to require total dependence (full staff performance) of all activities of daily living and needed two plus physical assist for personal hygiene, including brushing teeth and identified diagnosis that included, but not limited traumatic brain injury. The ADL/Mobility Plan of Care dated 12/10/13, identified R200 required total assist for activities of daily living (ADLs). It indicated R200 required assistance with combing hair, dressing, shaving, and undressing. It also indicated staff were to provide assist of one for oral care. The nursing assistant group sheet identified R200 required assist of two staff with ADLs. No indication was noted that oral care was to be provided. During an observation on 12/11/13, beginning at 11:18 a.m., nursing assistant (NA)-A indicated she checked R200's incontinent pad to see if he had been incontinent, At 11:20 a.m. licensed practical nurse (LPN)-E entered the room. Washcloth was removed and re-rolled to place in R200's left and right hand. NA-B entered the room to assist with cares. At 11:46 a.m. boots were placed on resident, and at 11:48 a.m. hand splints were placed. NA-A wiped R200's face and eyes with a wet washcloth. When interviewed on 12/10/13, at 3:08 p.m. family members (FM)-C and FM-D indicated R200 did not receive assistance with oral care,	F 312	(continued)	

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F 312	Continued From page 9 and his family typically provided the oral care. They also indicated they had only witnessed one NA use a mouth swab to swipe R200's mouth. When interviewed on 12/11/13, at 1:00 p.m. NA-A verified she had not provided oral care to R200. When interviewed on 12/12/13, at 10:15 a.m. registered nurse (RN)-C verified oral cares should be provided at least once per day, but would prefer twice per day. RN-C indicated a mouth swab would be used as R200 is unable to take fluids by mouth and is at risk for aspiration, and this would be expected of the nursing assistants to provide. RN-C verified oral care is not noted on the group sheets. When interviewed on 12/12/13, at 3:40 p.m. director of nursing (DON) confirmed it is her expectation that nursing assistants provide personal and oral care as they were trained. R193 was not provided bowel incontinent cares in a timely manner R193's quarterly MDS dated 12/2/13, identified R193 was totally dependent on two staff for activities of daily living including bowel care. It was also identified that R193 was always incontinent of bowel and was not on a bowel program. R193's family (FM)-E was interviewed on 12/10/13, at 6:32 p.m. FM-E reported concerns regarding care given to R193. She reported she visited R193 almost daily and had observed R193 to wait for staff assistance for up to two hours and wait times on weekends sometimes are longer.	F 312	(continued)	

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F 312	Continued From page 10	F 312		

FM-E reported she had come to visit resident on weekends, arriving between 9:30 a.m. to 10:00 a.m. and had found the resident still in her bed, incontinent and personal cares had not been given.

She reported R193 had a history of diarrhea and urinary incontinence and it took two staff to assist her with a Hoyer lift. She reported there were occasions when a Hoyer was not available and as result R193 would have to wait longer for assistance.

A second interview with FM-E and second family member (FM)-F was completed on 12/11/13, at 11:59 am in R193's room at the facility. R193 was also present. FM-E indicated she had talked to a variety of facility staff regarding her concerns regarding the length of time it took for staff to respond to R193's requested. FM-F reported that about one month ago, R193 had used the letter board and typed out " I am so tired of sitting in my own feces ". During this discussion, the resident nodded her head and her face became red and tears swelled in her eyes. They indicated on this date (12/11/13), an occupational therapist (OT) was working with R193 and the resident became incontinent of stool. They (FM-E and FM-F) informed the therapist of this and she (OT staff) left the room to inform staff of this and no one had returned.

An interview with occupational therapist (OT)-G was completed on 12/11/13, at 12:05 p.m. OT-G verified that she had been informed of 193's incontinence by family and left the room and informed NA-C of the incontinence incident and the resident needed assistance.

(continued)

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F 312	Continued From page 11 An interview with NA-C was completed on 12/11/13, at 12:15 p.m. She reported she was unaware that R193 needed assistance and was not assigned to her case nor had she provided any continence care. An interview with NA-D and NA-E was completed on 12/11/13, at 12:30 p.m. They reported they were not aware R193 had not been assisted. NA-E reported she was in the dining room assisting residents when NA-C informed her of 193's incontinence. NA-E reported NA-C left the dining room and therefore she assumed the nursing assistant had left to assist the resident. A second interview with NA-C was completed on 12/11/13, at 12:44 p.m. NA-C reported OT-G had informed her of R193's incontinence. She indicated she found NA-E, who was assigned to provide the resident cares, in the dining room assisting other resident and informed her of the resident's incontinence. NA-C left the dining room and did not follow up to ensure the resident received assistance. A second interview with NA-D and NA-E was done on 12/11/13, at 1:06 p.m. They reported they had assisted R193 after they were informed by surveyor of her continued incontinence. They indicated R193 was incontinent of a large amount of stool and verified R193 had been incontinent for over one hour and no one had assisted her. NA-D and NA-E reported feeling short of staff and not able to provide the care the residents needed. An interview with registered nurse (RN)-D was completed on 12/11/13, at 2:15 p.m. She reported being unaware of the above incident. She indicated the resident was to be repositioned	F 312	(continued)	

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F 312	Continued From page 12 and checked every two hours. She also reported being unaware of R193's family expressing any concerns regarding staff not being attentive to resident's requests or responding to resident call light quickly.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary care and services to prevent pressure ulcer development for 1 of 4 resident (R193), who was a dependent resident and at high risk for the development of pressure ulcers. Findings include: R193 was admitted to the facility on 9/12/13, and according to the physician's orders, she had diagnosis that included brain aneurysm, traumatic brain injury and chronic respiratory failure, A quarterly Minimum Data Set (MDS) was completed on 11/19/13, and noted R193 had problems communicating and sometimes was	F 314	F314 1. Resident R193 is receiving services to prevent the development of pressure ulcers as evidenced and skin is intact. Careplan and medications were reviewed and modified. The resident has had no adverse effects. 2. Other residents are receiving services to prevent/heal pressure ulcers. 3. Nursing staff education was completed. 4. 5 skin audits per week will be completed. 5. Audits to be reviewed at facility QA committee. 6. DON is responsible for compliance. (continued)	1/21/14

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GOLDEN VALLEY REHABILITATION AND CARE CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 able to make herself understood but usually was able to understand others. She was considered to be cognitively intact and at times had an altered level of consciousness. She was totally dependent on facility staff for all of her activities of daily living and did not ambulate. She had functional limitations of both her upper and lower extremities and was incontinent of urine and stool. She was identified as being at risk for pressure ulcer development but had no history of pressure ulcers. The Care Area Assessment, completed on 9/25/13, indicated R193 was unable to talk. She used a letter board and answered yes/no questions. She had limited range of motion of her arms and legs, received total assist with all ADLS [activities of daily living], and staff used a Hoyer lift to transfer her. She was also incontinent of urine and stool. She had no pressure ulcers. R193 was considered to be at high risk for pressure ulcer development and had a pressure reduction wheelchair cushion and mattress. Staff assisted her with turning and repositioning. The plan of care, initially developed on 10/13, identified R193 at high risk for alteration in skin integrity and needed an increase of frequency of turning, pressure reduction support surface and staff needed to manage moisture, nutrition, friction and shear. The established goal was for the resident to remain free of open areas and staffs were instructed to complete a Braden Scale (used to assist in predicting the development of pressure ulcers) upon admission and then weekly for four weeks, quarterly and with a change in the resident's condition. The care plan instructed staff to use absorbent pads that wick and hold moisture. The head of the bed was to be	F 314	(continued)	

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F 314	Continued From page 14 elevated 30 degrees due to her tracheotomy and she was to be repositioned every two hours and as needed. The nursing assistant care sheet, dated 12/10/13, directed nursing assistants to reposition R193 every two hours or as needed. It also instructed the nursing assistants to check R193 for incontinent of urine and stool every two hours and change as needed. Upon her admission (9/12/13), the admission skin assessment noted no open areas on her skin, however redness was observed to her buttock; which staff felt was related to stool incontinence and a barrier cream was applied. A review of the facility's progress notes noted on 12/12/13 (incorrect date) at 10:45 p.m. NAR [nursing assistant] reported small open area to buttocks, observed to be small 1.0 x 0.5 Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) likely skin breakdown influenced by diarrhea . A phone interview with R193's family member (FM)-E was completed on 12/10/13, at 6:32 p.m. FM-E reported concerns regarding care given to R193. She reported she visited R193 almost daily and had observed R193 to have to wait for staff assistance for up to two hours and wait times on weekends sometimes are longer. She reported R193 had a history of diarrhea and urinary incontinence. A second interview with FM-E and second family member (FM)-F was completed on 12/11/13, at 11:59 am in R193's room at the facility. R193 was also present. FM-E and FM-F verified concerns regarding the length of time it takes for	F 314	(continued)	

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F 314	Continued From page 15 the facility to respond to her call light and indicated they had witnessed it taking 30 minutes to two hours for them to respond to the residents request for assistance. FM-F reported that about one month ago, R193 used the letter board and typed out "I am so tired of sitting in my own feces ". During this discussion, the resident nodded her head, her face became red and tears swelled in her eyes. They indicated on this date (12/11/13), an occupational therapist (OT) was working with R193 and the resident became incontinent of stool. They (FM-E and FM-F) informed the therapist of this and she (OT staff) left the room to inform staff of the incontinence and no one had returned. An interview with occupational therapist (OT)-G was completed on 12/11/13, at 12:05 p.m. OT-G verified she had been informed of 193's incontinence by family after which she left the room, informed nursing assistant (NA)-C of the incontinence incident and expected the resident would be assisted. An interview with NA-C was completed on 12/11/13, at 12:15 p.m. She reported she was unaware that R193 needed assistance and was not assigned to her case nor had she provided any incontinence care. An interview with NA-D and NA-E was completed on 12/11/13, at 12:30 p.m. They reported they were not aware R193 had not been assisted. NA-E reported she was in the dining room assisting residents when NA-C informed her of 193's incontinence. NA-E reported NA-C left the dining room and therefore she assumed the nursing assistant had left to assist the resident.	F 314	(continued)	

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F 314	Continued From page 16 A second interview with NA-C was completed on 12/11/13, at 12:44 p.m. NA-C reported OT-G had informed her of R193's incontinence. She indicated she found NA-E, who was assigned to provide the resident cares, in the dining room assisting other resident and informed her of the resident's incontinence. NA-C left the dining room and did not follow up to ensure the resident received assistance. A second interview with NA-D and NA-E was done on 12/11/13, at 1:06 p.m. They reported they had assisted R193 after they were informed by surveyor of her continued incontinence. They indicated R193 was incontinent of a large amount of stool and verified R193 had been incontinent for over one hour and no one had assisted her. An interview with registered nurse (RN)-D was completed on 12/11/13, at 2:15 p.m. She reported being unaware of the above incident. She indicated the resident was to be repositioned and checked every two hours. She reported being unaware of R193's family expressing any concerns regarding staff not being attentive to resident's requests. An interview with the director of nurses (DON) was completed on 12/12/13, at 3:35 p.m. She reported she was just made aware of R193's open area to her buttock. She reported she was the wound nurse at the facility and would assess the area. A progress note, written by the DON on 12/12/13, at 5:00 p.m. verified the resident had an open area on coccyx 1.0 cm x 0.5 cm and less than 0.2 cm in depth. The open area had macerated tissue (the softening and breaking down of skin	F 314	(continued)	

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F 314	Continued From page 17 resulting from prolonged exposure to moisture) around the peri wound in gluteal crease. The progress note also noted a linear area over the right inferior trochanter (femur) in the shape of a triangle, 1.0 cm x 8.0 cm and lined up with the sling from the Hoyer lift which was used for the resident. The facility policy Wound Prevention and Treatment, last revised April, 2009, indicated considered all residents at risk for skin impairment and would implement the following interventions to prevent the development of pressure ulcers: Reduction of occurrence of pressure over bony prominence to minimize injury, protection against adverse effects of external mechanical forces (pressure, friction, shear), increase the awareness of pressure ulcer prevention through educational program and Braden Risk Assessment. The facility procedure, revised July, 2013 directed staff to complete weekly skin assessments A request was made of facility staff for documentation of all skin assessments completed on R193. None were provided. In addition, a request was made for evidence of an assessment being completed to determine the frequency R193 should be repositioned to minimize the risk for pressure ulcer development. None were provided.	F 314		
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	F 323	F323 1. Resident's fall interventions are in place. Resident's plan of care was reviewed and updated. R200 has not sustained a fall. 2. All other residents' fall interventions are in place.	1/21/14 (cont.)

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F 323	Continued From page 18 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to utilize safety precautions to minimize the risk of injury for 1 of 4 residents (R200) reviewed in the sample for accidents. Findings include: R200's quarterly MDS dated 8/28/13, identified R200 was totally dependent (full staff performance) with two plus physical assist for bed mobility. The MDS also identified R200 had an absence of spoken words, and rarely/never understands others and had diagnosis that included traumatic brain injury. The Fall/Injury Assessment: Prevention and Management Plan of Care dated 12/10/13, indicated R200 was at risk for fall/injury related to sedative/hypnotic, seizure disorders related to a traumatic brain injury, weakness, pulse irregularities, bowel and bladder incontinence, and being non-verbal. Interventions indicated a low bed, seizure precautions, and a mat and mattress to the floor. The nursing assistant group sheet indicated R200 to have a low bed, mat to both sides of the bed, and required assist of two staff with activities of daily living (ADLs). During an observation on 12/11/13, beginning at	F 323	3. Nursing staff education was completed on fall interventions. 4. 5 audits per week of fall interventions will be completed. 5. Audit results will be reviewed at facility QA meeting. 6. Director of Nursing is responsible for compliance. (Continued)	1/21/14

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F 323	Continued From page 19 11:18 a.m., nursing assistant (NA)-A raised the bed to the high position while she waited for another staff to assist her in dressing R200. She then left the room and left the bed in the highest position. At 11:20 a.m. licensed practical nurse (LPN)-E entered the room and lowered the bed. When interviewed on 12/11/13, at 1:00 p.m. NA-A verified the bed should not have been left in the up (high) position when she left the area. When interviewed on 12/11/13, at 2:42 p.m. registered nurse (RN)-C noted the bed was to be lowered and mat should be in place while R200 was in bed without staff next to him. When interviewed on 12/12/13, at 3:40 p.m. director of nursing (DON) confirmed it was not acceptable to leave resident with the bed in the upward position while staff were not in the area, and that bed mobility and ADLs require the assist of two staff. Procedure titled Falls and Injuries, revised November 2013, identified: Centers are obligated to provide adequate supervision to prevent accidents.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 1. The expired and undated medications were removed. Residents had no adverse effects. 2. All medication carts and medication rooms will be audited for improperly stored medications. 3. Licensed staff were educated on medication storage.	1/21/14 (cont)

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F 431	Continued From page 20 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper labeling and storage of medications for 7 residents (R28, R95, R179, R38, R200, R47, R227) in 3 of 8 medication carts. Findings include: Review of the fourth floor middle medication cart on 12/9/13, at 5:32 p.m. was completed. A vial of Lantus insulin (an injectable medication used to treat diabetes) for R28 was opened and undated. Two Lantus pens were also found and were	F 431	4. 5 audits per week will be completed of med rooms and med carts to monitor for compliance. 5. Audit results will be submitted to facility QA committee. 6. DON is responsible for compliance. (continued)	1/21/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 431	Continued From page 21 identified to be used with R95. One of the pens was opened and undated and the second pen was opened on 11/13/13. A vial of Levemir insulin (an injectable medication used to treat diabetes) was opened, undated, and identified for use for R179. Review of the fourth floor south medication cart on 12/9/13, at 5:40 p.m. found one vial of Lantus insulin, opened and undated for R38. In addition, a vial of Acetylcysteine (a medication to help to dissolve mucous) for R200 had an expiration date of 12/8/13. Registered nurse (RN)-C was present during the review of the medication carts and verified the medication as being undated or expired as noted above. He further stated these expired or undated medications were not to be in the medication cart and were not to be used on residents. RN-C also reported the facility procedure was if a liquid medication was opened, it was to be discarded if not used in 28 days. RN-C indicated it is most likely the undated and expired medications had been used and should have not been. Review of the third floor medication cart on the secure unit was done on 12/10/13, at 11:22 a.m. risperidone liquid (used to treat mental illness such as schizophrenia) 1 milligram (mg) labeled for use for R47 was opened and the date as to which it was opened was not found. In addition, a liquid container of haloperidol 0.5 mg (also used for mental illness such as schizophrenia) labeled for use for R227 was opened and the date it was opened was not found. An interview with RN-D was completed on 12/10/13, at 11:25 a.m., verified the findings and also reported the medications needed to be discarded as they had not been dated when opened. The policy Storage and Expiration of Medications,	F 431	(continued)	

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F 431	Continued From page 22 Biologicals, Syringes and Needles, last revised on 01/01/13, directed staff to should ensure medications and biologicals had not been retained longer than recommended by manufacturer or supplier guidelines. The policy also directed staff to ensure: Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.	F 431		
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	F 441	F441 1. Glucometers are disinfected per manufacturer's recommendations. Residents had no adverse effects. 2. Nursing staff education was completed on proper disinfection of glucometers. 3. 5 audits per week will be completed of glucometer cleaning. 4. Audits to be reviewed at facility QA committee. 5. DON is responsible for compliance. (continued)	1/21/14

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F 441	Continued From page 23 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 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 follow manufacturer's recommendations to disinfect a glucometer for 2 of 3 residents (R2 and R182) observed. Findings include: During an observation on 12/10/13, at 11:18 a.m., licensed practical nurse (LPN)-D was observed to check R182's blood glucose. After completion, LPN-D wiped the glucometer (machine used to monitor blood sugars) with a Super Sani Wipe for 5 seconds, and disposed of the wipe. LPN-D administered R182's ordered insulin, and then using the same glucometer, checked R2's blood glucose. After completion LPN-D wiped the machine for 3 seconds and threw the wipe away. Interview with LPN-D on 12/10/13, at 11:30, revealed he was taught to clean the glucometer with a sani wipe for 10 seconds. Review of the undated document labeled	F 441	(continued)	

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F 441	Continued From page 24 Microdot xtra [extra]Cleaning your meter, directed the following: Germicial wipes are readily available through major medical distributors. To use these products, remove a wipe from container and follow product label instructions to disinfect meter. Review of the container of Super Sani Wipes, indicated the germicidal wipe was effective against 27 microorganisms in 2 minutes. Interview on 12/10/13, at 4:25 p.m. with the director of nursing who indicated staff have two glucometers on each cart, so one can be wrapped in a wipe for the necessary two minutes, while using the other glucometer. She indicated the policy was the one provided with the glucometers.	F 441	(end)	

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F5186026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/20/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY REHABILITATION AND CAR	**7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Valley Rehab and CC was found 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. This 3-story building was constructed in 1972 and was determined to be of Type II (222) construction. It has partial basement and is automatic fire sprinkler protected throughout. The facility has fire alarm detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 1 and had a census of 1 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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