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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YVUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00935

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245201**
2.STATE VENDOR OR MEDICAID NO.
(L2) **973842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNWOOD**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

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

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

6. DATE OF SURVEY **04/10/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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):

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 04/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/10/2015 (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
04/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5201

April 10, 2015

Ms. Jennifer Florian, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, Minnesota 55432

Dear Ms. Florian:

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 April 6, 2015 the above facility is certified for or recommended for:

54 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2015

Ms. Jennifer Florian, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, Minnesota 55432

RE: Project Number S5201024

Dear Ms. Florian:

On March 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 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 April 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 7, 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 February 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2015, effective April 6, 2015 and therefore remedies outlined in our letter to you dated March 9, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
245201	A. Building B. Wing	4/10/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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 **F0160** Reg. # **483.10(c)(6)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/06/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/06/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **04/06/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/06/2015**	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/AK	04/10/2015	18623	04/10/2015
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
2/25/2015			

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 A. Building B. Wing	(Y3) Date of Revisit
245201	01 - MAIN BUILDING 01	4/7/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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 K0056	04/06/2015	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 04/10/2015	Signature of Surveyor: 28120	Date: 04/07/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/3/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YVUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00935

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245201**
2.STATE VENDOR OR MEDICAID NO.
(L2) **973842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNWOOD**
(L4) **5700 EAST RIVER ROAD**
(L5) **FRIDLEY, MN** (L6) **55432**

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

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

6. DATE OF SURVEY **02/25/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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):

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 03/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/07/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
X 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
04/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5896

March 9, 2015

Ms. Jennifer Florian, Administrator
Golden LivingCenter - Lynwood
5700 East River Road
Fridley, Minnesota 55432

RE: Project Number S5201024

Dear Ms. Florian:

On February 25, 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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 6, 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 April 6, 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 May 25, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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:

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
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
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000	This facility objects to the allegations of non-compliance in this Statement of Deficiency and disagrees with both the findings of non-compliance and the level of deficiency cited. 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 of the facility, the administrator of any employees, agents or other individuals who draft or may be discussed in this Response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the facility.	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey within 30 days, resident funds and a final accounting of those funds to the individual (or probate jurisdiction) administering the resident's estate for 2 of 2 residents (R96, R97) reviewed for personal funds. Findings include: On 2/24/15, at 10:38 a.m. during review of the facility personal funds account with the business	F 160	F 160 Resident # 96 final accounting and administration of personal funds has been completed and account closed on 2/23/15	

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

Executive Director 3/18/15

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
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 160	Continued From page 1 office manager (BOM) the following was revealed: R96's Resident List Report dated 2/24/15, indicated R96 was deceased on 1/5/15. During the review the business office manager indicated at the time of death R96 had $664.09 and a communication had been sent on 2/20/15, to the Resident Fund Management at the cooperate office and account was closed on 2/23/15, which was 18 days over the required time frame. R97's Resident List Report dated 2/24/15, indicated R97 was deceased on 12/22/14, with balance of $170.07. Business office manager indicated on 2/24/15, at 10:39 a.m. "daughter had called today but I don't have the exact time, inquiring if the money was going to be sent to her or what the process was." The business office manager stated she had an email to the consultant who would let her know how to deal with the issue. Business office manager verified the money had not been conveyed for over 63 days since R97 had deceased and no attempts had been made to dispose the money to the appropriate jurisdiction. On 2/24/15, at 10:48 a.m. when asked who was responsible to ensure the money was conveyed to the probate jurisdiction the business office manager stated in the presence of the executive director (ED) "Because we did not have someone in the business office on a consistent basis and people would come to fill in when they would" as ED concurred and stood by the business office manager. The undated Business Office Policies and Procedures Documentations Closing Resident	F 160	Resident # 97 final accounting and administration of personal funds has been completed and account closed on 2/25/15. Other residents who expire with a personal fund account in the facility will have a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate within 30 days of the death of the resident. Business office manager has been re-educated on the process of personal funds upon death. Monthly audits to be completed ED or designee will be responsible for compliance. QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

RECEIVED
MAR 23 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 160	Continued From page 2 Account directed "When a resident whose funds are held and managed by the Living Center in the Resident Trust Fund expires or is permanently discharged, the Business Office will ensure that the balance of the account is refunded, and a full accounting provided, within 30 days of expiration or discharge (or as required by state law) to the: Resident or legal representative Individual or probate jurisdiction administering the resident's estate OR Other agency or entity, as required or allowed by state regulation or case-specific notification of fund disbursement ..."	F 160		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining assistance, related to standing while feeding, for 1 of 2 residents (R7), who was dependent on staff assistance for eating. Findings include: During the breakfast meal on 2/24/15, at 8:05 a.m. in the Main dining room, the following was observed: -At 8:05 a.m. nursing assistant (NA)-A was observed enter the dining room cleansed his hands then was observed going to the left side of	F 241	F 241 Resident # 7 is being fed by staff. Staff are sitting and assisting resident with feeding Other residents requiring assistance with feeding will have assistance provided by staff sitting down. Nursing assistants, Trained medication aides and nurses are being retrained on providing dignity with feeding. Weekly audits to be completed DNS or designee is responsible for compliance. QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 241	Continued From page 3 R7 like was going to get the stool which was stationed between R7 and another resident but then came over to the right and was observed standing over R7 as he was assisting him with eating. -At 8:23 a.m. NA-A still standing over as he fed R7. Several staff walked past the dining room which was wide open, looked inside no one intervened. At the time of observation another NA was observed seated next to another resident assisting. In addition, licensed practical nurse (LPN)-A was observed standing outside the dining room by the medication cart dishing medications came into the dining room administered medications to two residents but never intervened. -At 8:31 a.m. NA-A completed assisting R7 by pulling the bedside table from R7's lap and set the tray to the side. NA-A walked over to the end table was observed assisting another resident again with his beverages as he stood over resident with two sips of orange juice then wheeled resident out of the dining room. R7's quarterly Minimum Data Set (MDS) dated 1/29/15, indicated R7 required extensive physical assistance from one staff for eating. The MDS identified R7's cognition was severely impaired. On 2/24/15, at 8:35 a.m. when asked what the facility expectation was of staff when assisting residents to eat NA-A indicated he was supposed to be seated during the meal and when he had walked into the DR he had noticed there was no stool that staff would usually sit when assisting to feed residents and he thought instead of not helping R7 it was better to stand over him. -At 8:43 a.m. when asked if she had noticed NA-A standing over resident as he feed him, LPN-A	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 241	Continued From page 4 stated "I actually to tell you the truth was not paying attention the staff is supposed to sit when assisting resident." On 2/25/15, at 12:27 p.m. when asked what her expectation was of staff practice during meal assistance the director of nursing (DON) stated "they should sit." On 2/25/15, at 3:30 p.m. a policy was requested but was indicated the facility did not have one.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure individual preferences were honored for 2 of 4 residents (R90, R2) who were reviewed for choices. Findings include: R90's diagnoses included hemiplegia and cerebral edema obtained from admission Minimum Data Set (MDS) dated 2/7/15. In addition the MDS indicated R90 required total dependence with physical assist of one staff. R90's activities of daily living (ADL) Care Area	F 246	F 246 Resident # 2 choice of bed time varies. Staff ask resident when she wants to go to bed and assistance is provided based on resident choice. Resident # 90 is receiving either a shower or bed bath per his choice. Resident core strength is weak therefore tilt in space w/c is used when providing shower Nursing assistants, nurses are being re-trained on resident choices that allow resident to choose their bed time and bath preference Weekly audits to be completed DNS or designee is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 246	Continued From page 5 Assessment (CAA) dated 2/13/15, identified R90 had impaired ADL functioning and was unable to do ADL's independently. The CAA directed staff to provided one to two staff assistance with all ADL's and mobility. R90's plan dated 2/18/15, identified R90 had a physical functioning deficit related to deconditioning secondary to esophageal and gastric bleed, cerebral edema with left hemiplegia. The care plan directed staff to encourage choices with care. On 2/22/15, at 4:39 p.m. during interview when R90 was asked if he choose how many times a week he took a bath or shower R90 stated "They say they don't have equipment big enough to give me a shower. I feel nasty and girlfriend says I stink and I don't want her to leave me. No efforts has been really been done." When R90 was asked if he choose whether to take a shower, tub, or bed bath R90 stated "No." On 2/24/15, at 1:14 p.m. when interviewed during a visit to the facility family member (F)-A indicated "I believe he has had probably four bed baths since the he was admitted here. I remember the day before Valentine's Day he smelled bad and I gave him a bed bath myself. I have given him two bed baths now and a week after he was admitted to the facility I snapped here about it because I had enough of it ... I feel so bad and his mercy lies on the staff here some of the aides are good and some just don't care." On 2/25/15, at 12:30 p.m. the director of nursing (DON) indicated "this was the first time she was hearing about this and neither the resident nor girlfriend have brought this to the facility attention" when asked about R90 being showered. DON further stated she thought with R90's upper core	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 246	Continued From page 6 strength R90 was not able to tolerate sitting up for a long time and thought that was why he was getting bed baths but was not certain enough. On 2/25/15, at 12:33 p.m. maintenance director (MD) stated he had not gotten any concerns about R90 not being able to be given a shower or tub bath. MD further stated "if so tall residents have to sit high in the tub to accommodate the height and should be a problem." On 2/25/15, at 12:39 p.m. DON provided a copy of R90's Bathing type Detail Report dated 2/25/15, for time period 2/2/15, through 2/24/15, it was revealed R90 had received two full bed baths on 2/3/15, and 2/8/15, and the rest of the time had received partial baths. When asked what partial baths were DON indicated that was the cares provided when staff was in the room providing regular cares. When asked if she expected staff to have provided R90 at least a full bath weekly DON stated "Yes" and verified R90 had not received a full bed bath since 2/8/15, which was over 14 days. On 2/25/15, at 1:12 p.m. when approached F-A indicated after looking at the calendar she had given another good bed bath to R90 on 2/20/15. On 2/25/15, at 2:11 p.m. DON and nursing assistant (NA)-C approached surveyor. NA-C indicated R90 had been noted to be weak at the time when he had been gotten up shortly after admission for a shower after F-A had brought the concern to his attention and at the time NA-C reported to the nurse R90 was not able to sit straight in the chair and was not safe. NA-C indicated at the time after lying R90 back down he had provided a bed bath. When DON was	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 246	Continued From page 7 asked if a bathing assessment had been completed by a nursing or therapy for the safety concerns identified after the incident DON indicated she was not sure and would have to check. On 2/25/15, at 2:36 p.m. the director of physical therapy stated she had not gotten any concerns about staff having concerns to get R90 in the shower chair and directed surveyor to occupational therapy -At 2:42 p.m. occupational therapist (OT) stated no safety concerns had been brought up regarding putting R90 on the shower chair. OT indicated if there were concerns it would have been brought up at stand up. -At 2:45 p.m. certified occupational therapist assistant (COTA) stated she had not had any concerns brought to her attention about safety concerns with the shower chair from the nursing department. COTA further stated the staff would come directly with concerns and she had assisted with showers in the past. On 2/25/15, at 3:30 p.m. policy was requested and it was revealed the facility did not have one. R2's diagnosis included obesity, chronic airway obstruction, Alzheimer's disease, and malaise and fatigue. The brief interview for mental status obtained from the admission MDS dated 1/9/15, was 14 indicating intact cognition. The MDS also indicated R2 required extensive assistance to complete transfer, dressing and hygiene tasks. She had impaired balance and did not ambulate. During an interview with R2 on 2/23/15, at 9:00 a.m. R2 stated, "They put me to bed whenever they want. I want to go to bed at 9:00 and they put	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 246	Continued From page 8 me to bed at 7:00 or 8:00." - At 9:43 a.m. R2 stated, "When I tell staff I don't want to go to bed, they just take my clothes off and don't listen to me." The preferences for customary routine section of the admission MDS dated 1/9/15, revealed it was very important for R2 to choose her own bedtime. The care plan dated 1/20/15, and the nursing assistant care sheet, undated, did not direct staff to to offer or honor R2's bedtime choices. A telephone interview on 2/25/15, at 11:25 a.m. with R2's family member (F)-A revealed her mother did not go to bed before 10:00 or 11:00 p.m. prior to admission to the facility. She explained her mother liked to stay up to watch the David Letterman Show on television. She said her mother had mentioned she goes to bed too early. - During a telephone conversation at 11:58 a.m. R2's F-B revealed she came to visit between 6:30 and 7:00 p.m. within the first week of R2's admission. R2 was in bed with her pajamas on. She again visited last Tuesday (2/17/15) at approximately 8:00 p.m. R2 was in bed. She had her pajamas on and staff was administering medications. R2 stated she was put to bed because she had to go to the toilet. She explained staff did that so they would not have to lift her a second time from her chair. F-B then stated. "I know she is a night person. She likes to stay up late. This is why I come to visit her later in the day. It gives her something to do." A conversation with the director of therapeutic recreation (TR) on 2/25/15, at 3:21 p.m. revealed the preferences for customary routine section of the MDS was completed by the TR department upon admission and with each MDS assessment.	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 246	Continued From page 9 She further stated R2's choices were not put on the care plan, the nursing assistant sheet or communicated to staff because R2 was able to make her needs known. - At 3:30 p.m. the MDS coordinator (RN)-D stated the facility's practice was if a resident was able to direct their own care, we would rely on them each night to communicate their preference of time to go to bed. She would expect staff to honor her wishes. She further stated she would expect TR to bring that information to interdisciplinary team (IDT) meetings and care plan accordingly. - At 3:45 p.m. the director of TR provided documentation of the preferences for customary routine interview dated 2/9/15 for R2. Below the question "choose your own bedtime" was the handwritten note: "9pm. R2 indicated it was very important." An interview with the director of education (RN)-E on 2/25/14, at 1:16 p.m. revealed she expected information regarding choices of customary routine to be brought to nursing and discussed in the daily morning meeting. She further stated she would expect that information to be on a resident's plan of care and carried through.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	F 279 Resident # 2 plan of care was reviewed and revised to indicate resident will continue to choose when she wants to go to bed. Other residents will continue to choose when they want to go to bed New admissions, re-admissions will have clinical health status assessment completed. Assessment includes sleep patterns. Care plan will be developed as indicated by assessment. Care plan will be reviewed quarterly and with any significant change.	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 279	Continued From page 10 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care for hour of sleep for 1 of 3 residents (R2) who indicated that was very important to them. Findings include: R2's diagnosis included obesity, chronic airway obstruction, Alzheimer's disease, and malaise and fatigue. The brief interview for mental status obtained from the admission MDS dated 1/9/15, was 14 indicating intact cognition. The MDS also indicated R2 required extensive assistance to complete transfer, dressing and hygiene tasks. She had impaired balance and did not ambulate. During an interview with R2 on 2/23/15, at 9:00 a.m. R2 stated, "They put me to bed whenever they want. I want to go to bed at 9:00 and they put me to bed at 7:00 or 8:00." - At 9:43 a.m. R2 stated, "When I tell staff I don't want to go to bed, they just take my clothes off and don't listen to me." The preferences for customary routine section of the admission MDS	F 279	Weekly audits to be completed' DNS or designee will be responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 279	Continued From page 11 dated 1/9/15, revealed it was very important for R2 to choose her own bedtime. The care plan dated 1/20/15, and the nursing assistant care sheet, undated, did not direct staff to offer or honor R2's bedtime choices. A telephone interview on 2/25/15, at 11:25 a.m. with R2's family member (F)-A revealed her mother did not go to bed before 10:00 or 11:00 p.m. prior to admission to the facility. She explained her mother liked to stay up to watch the David Letterman Show on television. She said her mother had mentioned she goes to bed too early. - During a telephone conversation at 11:58 a.m. R2's F-B revealed she came to visit between 6:30 and 7:00 p.m. within the first week of R2's admission. R2 was in bed with her pajamas on. She again visited last Tuesday (2/17/15) at approximately 8:00 p.m. R2 was in bed. She had her pajamas on and staff was administering medications. R2 stated she was put to bed because she had to go to the toilet. She explained staff did that so they would not have to lift her a second time from her chair. F-B then stated. "I know she is a night person. She likes to stay up late. This is why I come to visit her later in the day. It gives her something to do." A conversation with the director of therapeutic recreation (TR) on 2/25/15, at 3:21 p.m. revealed the preferences for customary routine section of the MDS was completed by the TR department upon admission and with each MDS assessment. She further stated R2's choices were not put on the care plan, the nursing assistant sheet or communicated to staff because R2 was able to make her needs known. - At 3:30 p.m. the MDS coordinator (RN)-D stated	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 279	Continued From page 12 the facility's practice was if a resident was able to direct their own care, we would rely on them each night to communicate their preference of time to go to bed. She would expect staff to honor her wishes. She further stated she would expect TR to bring that information to interdisciplinary team (IDT) meetings and care plan accordingly. - At 3:45 p.m. the director of TR provided documentation of the preferences for customary routine interview dated 2/9/15 for R2. Below the question "choose your own bedtime" was the handwritten note: "9pm. R2 indicated it was very important." An interview with the director of education (RN)-E on 2/25/14, at 1:16 p.m. revealed she expected information regarding choices of customary routine to be brought to nursing and discussed in the daily morning meeting. She further stated she would expect that information to be on a resident's plan of care and carried through.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an initial care plan with interventions based on the resident's health needs at the time of admission for 1 of 4 residents (R70) reviewed for accidents. Findings include:	F 281	F 281 Resident # 70 has discharged from facility. New admissions, re-admissions will have clinical health status assessment completed. Clinical assessment includes risk factors for falls. Residents identified at risk for falls will have initial care plan developed to address risk. Care plans will be reviewed quarterly and with significant change in condition Nurse managers, nurse supervisors and staff nurses are being re-trained on completion, identification and development of care plans to address risk factors. Weekly audits to be completed. DNS is responsible for compliance	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 281	Continued From page 13 The hospital Nursing Progress Notes dated 1/6/15, indicated R70 was identified as a falls risk. R70 was admitted to the facility on 1/14/15, per the Clinical Health Status tool. The form depicted R70 to be alert with intact memory and no behavioral concerns. The oxygen saturation was 95%. The form identified R70 as being at risk for falls due to falling in the past six months, poor vision status, balance problems with standing and walking, and lower extremity weakness, medications and predisposing diagnoses such as seizures, and fractures. R70 received a score of "10" which according the form indicated "Total score of 10 or above deems resident at risk for falls." Under the section of "Resident Education for immediate Plans of Care" the falls section was void of any resident education even though R70 was identified as being at risk for falls. Pain was the only concern identified for "Immediate Plans of Care." R70's admission Physician's Orders dated 1/14/15, noted R70 received quetiapine (an antipsychotic medication), venlafaxine (antidepressant) and bupropion (antidepressant) on a daily basis. However, the Clinical health Status form dated 1/14/15, did not indicate R70 received any psychotropic medication under the section "Behavioral Symptoms." There was no oxygen ordered for R70 upon admission. On 1/16/15, the physician had ordered an antibiotic for R70 as R70 was diagnosed with a respiratory infection. On 1/19/15, the Physical Therapy (PT) - Therapist Progress note read, "patient reports not needing oxygen continuously, however O2	F 281	QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 281	Continued From page 14 [oxygen] sats [saturation -normal blood oxygen levels in humans are considered 95-100 percent. If the level is below 90 percent, it is considered low resulting in hypoxemia. When the level of oxygen falls below a certain amount, hypoxemia occurs and the resident may experience shortness of breath] dropped to 80% without O2 with gait and Borg 7/10 [a test used to determine exertion with exercise and shortness of breath]. Patient recovers at 2L [liters] O2." The electronic record and paper care plan dated from 1/15/15 to 1/20/15, was reviewed. The care plans in the medical record were for nutrition, pain, adjustment to the facility, activity of daily living and bowel care. The medical record lacked evidence of any care planning interventions to minimize/decrease the potential for falls from the psychotropic medication use and the newly diagnosed respiratory infection and dropping of the oxygen levels upon exertion. On 1/25/15, at 4:32 a.m. a progress note indicated R70 fell. The note read, "Resident reported to writer that he fell while trying to go to the bathroom. Resident got himself up then called staff using call light. Found resident sitting on the bed. Reported hitting head and shoulder. Resident noted to have swelling at back of head and abraison [sic] on the right shoulder and redness on the back of neck." R70 was transported to the hospital and then admitted. The director of nursing was interviewed on 2/24/15, at 3:30 p.m. and acknowledged the temporary care plan could not be located. She verified a falls temporary care plan should have been completed.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 281	Continued From page 15 The package insert for venlafaxine by Osmotica Pharmaceutical Corp. last revised on 6/3/08, noted side effects which included "confusion and vertigo...." The package insert for quetiapine by AstraZeneca Pharmaceuticals LP last revised on 10/29/13, noted side effects of which included "dyskinesia, thinking abnormal, tardive dyskinesia, vertigo, involuntary movements, confusion, incoordination, abnormal gait, myoclonus, delusions, manic reaction, ataxia, stupor ...." The package insert for bupropion by RxChange Co. last revised on 12/2/14, noted side effects which included "abnormal coordination ....." The Falls Management Guidelines dated 1/22/15, directed staff to assess newly admitted for falls risk using the Clinical Health Status tool and to initiate the "Immediate Plan of Care At Risk - Falls Risk." R70 did not have a care plan in place to potentially minimize or decrease the risk for falls after he was newly admitted.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F 315 Resident # 42 urinary bladder needs have been re-assessed New admissions, re-admissions will have bladder assessment needs assessed. Other residents will be reviewed quarterly and with any change in condition Nurse managers, nurse supervisors and nurses are being re-trained on assessing resident bladder needs Weekly audits to be completed DNS is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 315	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not monitor and assess urinary needs to prevent a decline in continence status for 1 of 1 resident (R42) who was observed for urinary incontinence. Findings include: On 2/25/15, at 9:22 a.m. during morning care observation, a strong urine odor was noticed in R42's room. A nursing assistant (NA)-B assisted R42 to the toilet. Her incontinent brief was wet. NA-B stated she was usually incontinent during the night but mostly continent during the day. -At 2:25 p.m. NA-B again assisted R42 to toilet. Her incontinent pad was dry. The admission Minimum Data Set (MDS) dated 11/1/14, described R42 as occasionally incontinent of bladder and required limited assistance with toileting needs. R42 had moderate cognition impairment. A toileting plan was not indicated. R42's diagnosis included other specified disorders of bladder (overactive bladder), chronic kidney disease (CKD) stage III, and congestive heart failure (CHF). The Care Assessment Area (CAA) in for urinary incontinence dated 11/6/14, referenced the overall objective was improvement of urinary continence and minimizing risks. The CAA identified R42 as occasionally incontinent and at risk due to impaired mobility and multiple comorbidities. R42's care plan, initiated 11/17/14, identified the	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 315	Continued From page 17 focus as: alteration in bowel and bladder related to incontinence, overactive bladder and history of diverticulitis. The care plan directed staff to assist R42 to toilet every two hours and upon request and also use briefs/pads for incontinence protection. The quarterly MDS dated 1/26/15, described R42 as frequently incontinent of bladder and required extensive assistance with toileting. Her BIMS score was 10 indicating moderate cognitive loss. A toileting plan was not in place. The Lynwood nursing assistant registered (NAR) Assignment Sheet-Group 2, undated, directed staff to assist R42 to toilet upon request and every two hours as needed. An interview with the MDS nurse (RN)-E on 2/24/15, at 9:39 a.m. revealed an assessment and evaluation for urinary continence was not completed in accordance with the quarterly MDS assessment dated 1/26/15. She further stated the only documentation and monitoring that was done was a continence checklist performed by the NAs every shift. RN-E further stated that facility usually does a comprehensive assessment upon admission and then occasionally. RN-E explained one was not done because R42 had not had a change, "I can tell you one was not done or it would be in the chart." The director of nursing stated on 2/24/15, at 10:15 a.m. stated she was not aware that an assessment was not done but would expect this process to be carried out in the future to ensure residents are monitored, assessed and evaluated to prevent decline.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 315	Continued From page 18 A request for the facility policy regarding bowel and bladder assessment and monitoring protocol and R42's bladder assessments and monitoring (Care Tracker - electronic record) from admission were requested but not provided. R42 went from being occasionally incontinent to frequently incontinent and a re-assessment of R42's declining bladder status was not completed.	F 315		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334	F 334 Resident # 90 received education on benefit/risk of pneumococcal immunization. Resident was offered and received immunization on 2/25/15. New admissions will be provided with education on benefit and side effect of medication Each resident will be offered a pneumococcal immunization unless the immunization is medically contraindicated or resident has been immunized or refuses the immunization Nurses are being retrained on policy and procedure for pneumococcal immunization Weekly audits to be completed DNS is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 334	Continued From page 19 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by:	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 334	Continued From page 20 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R90) was offered and/or received pneumococcal vaccination as recommended by Centers for Disease Control (CDC). Findings include: R90's Admission Record dated 2/5/15, indicated R90 was admitted to the facility on 2/1/15. Review of R90's print out sheet of Minnesota Immunization Information Connection dated 2/5/15, it was revealed R90 record lacked documentation if a pneumococcal vaccination had been received, contraindicated or refused. During further document review, it was revealed on R90's Interagency Transfer Orders dated 2/1/15, it had been indicated "Pneumovax, Adult deferred." On 2/25/15, at 11:30 a.m. registered nurse (RN)-D verified R90's medical record lacked documentation of immunization "I don't see it was indicated as deferred." On 2/25/15, at 11:59 RN-A stated as far as she had check R90 had no record of pneumovax in his record and had put a call out to the doctor. When asked who was responsible to ensure immunization information was reviewed and verified to be current RN-A indicated that was reviewed on admission and she had checked under the consent tab and verified there was no consent filled for pneumococcal to give, offered and/or was contraindicated/refused. -At 12:13 p.m. RN-A indicated after she had reviewed the facility house standing orders she	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 334	Continued From page 21 indicated R90 had not met the guidelines as R90 was younger. RN-A had reviewed the CDC guidelines to give immunization which indicated over 65 years and that was would explain why he had not received or was not offered the immunization. On 2/25/15, at 12:24 the director of nursing (DON) acknowledged R90's immunization record should have been reviewed on admission when he had come in. The undated Influenza/Pneumococcal Immunization Guideline indicated "It is the practice of this center to offer and encouraged that all residents receive the Pneumococcal immunization unless already previously received." The guideline in addition directed staff to "verify that consent was given for resident to receive the vaccine and that education of the risks and benefits was provided. If the immunization was refused, verify that the Immunization Consent and Declination Form was completed and signed."	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356	F 356 Posted Nursing staff information reflects the correct number of licensed nursing staff and the correct actual hours worked by each category of licensed staff responsible for direct care at the facility. Nurse managers, nurse supervisors, staffing coordinator are being re-trained on posted nursing staff information Weekly audits to be completed Executive Director or designee is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 356	Continued From page 22 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required posted nurse staffing information reflected the corrected number of licensed nursing staff and the correct actual hours worked by each category of licensed staff responsible for direct care at the facility. This had the potential to affect all 46 residents residing in the facility as well as family and visitors. Findings include: Upon review of the facilities form titled Golden Living Center-Lynwood dated 2/17/15, with the facilities Golden Living Center-Lynwood Report of Nursing Staff Hours Directly Responsible for Resident Care dated 2/17/15, revealed the actual number of nursing hours on the evening shift were not what were identified on the required	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 356	Continued From page 23 posted nursing staffing information. Review of the facilities actual schedule dated 2/17/15, revealed four nursing assistants (NAs) working the evening shift and one NA working 4:15 p.m. to 11:00 p.m. The actual posted schedule revealed five NA's working 2:00 p.m. to 10:00 p.m. Review of the facilities actual schedule dated 2/18/15, revealed five NA's working evening shift. The actual posted schedule revealed six NAs working 2:00 p.m. to 10:00 p.m. and one NA working 5:00 p.m. to 9:00 p.m. The actual night schedule revealed two NAs working plus another NA working 10:45 p.m. to 6:00 a.m. The actual posted schedule revealed three NAs working 10:00 p.m. to 6:00 a.m. Review of the facilities actual schedule dated 2/19/2015 revealed one registered nurse (RN) and one licensed practical nurse (LPN) working plus another nurse working 10:00 a.m. to 2:00 p.m. The actual posted schedule revealed one RN and one LPN working 6:00 a.m. to 2:30 p.m. The actual day schedule revealed five NAs working 6:00 a.m. to 2:00 p.m. The actual posted schedule revealed six NAs working 6:00 a.m. to 2:00 p.m. The actual evening schedule revealed five NAs working. The actual posted schedule revealed five NAs working 2:00 p.m. to 10:00 p.m. and one NA working 5:00 p.m. to 9:00 p.m. The actual night schedule revealed two NAs working plus another NA working 10:45 to 6:00 a.m. The actual posted schedule revealed three NAs working 10:00 p.m. to 6:00 a.m. On 2/25/15, at 12:52 p.m. director of nursing (DON) and medical records staff reviewed actual staff schedules with actual posted schedules which indicated posted schedules were not being	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 356	Continued From page 24 updated with accurate staff and shift hours. DON stated staffing patterns were determined based on resident census for each shift. Day shift had two floor nurses Monday through Friday and one nurse manager. Evening shift had the same nurse structure and night shift had two nurses. Weekends had two day nurses and another supervisor 10:00 a.m. to 6:30 p.m. Saturday and Sunday. Day shift had five day NAs, evening shift had four full-time NAs and one NA worked 5:00 p.m. to 9:00 p.m. If census was low NA did not work 5:00 p.m. to 9:00 p.m. Night shift had two nurses and two NAs. DON stated when she was not there staffer-H did staffing on weekdays and supervisor did staffing on weekends. In addition, nurses would cover when there was no supervisor. Review of the policy titled: Nursing Staff Hours, last review date 12/23/14, effective date 12/29/14, directed "nursing staff hours will be posted in accordance with state and federal regulations in all facilities. The posting shall be in a clear and readable format and posted in a prominent place readily accessible to residents and visitors. The following information shall be posted on a daily basis at the beginning of each shift. Center/location name, current date, total number and actual hours worked by licensed and unlicensed staff responsible for resident care, including RNs, LPNs/LVNs [licensed vocational nurse], and CNAs [certified nursing assistants], resident status. Request for staffing hours: Each center/location, upon receipt of either an oral or written request, shall make nursing staff data available to the public for review at a cost not to exceed the community standard. Retention: Each center/location shall retain the posted daily nursing staff data for a minimum of eighteen (18)	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 356	Continued From page 25 months or as otherwise required by State law, whichever is greater."	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure Fentanyl patches (narcotic patch) used to control pain were destroyed in a manner to prevent potential diversion for 2 of 2 residents (R87, R97) who utilized Fentanyl patches. Findings include:	F 425	F 425 Resident # 87 and 95 Fentayl patches are being destroyed in a manner to prevent potential diversion. Two nurses are witness to the destruction via the sewer system and the two nurses both document in bound narcotic book on the line representing that dose. Nurses and trained medication aides are being trained on the removal, destruction and documentation of Fentayl patches. Weekly audits to be completed DNS or designee is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 425	Continued From page 26 On 2/25/15, at 2:49 p.m. during medication storage tour it was observed only one nurse was signing off on Fentanyl patches for R87 and R97 on page 151 and page 8 of both narcotic books located on the side of cart 2. During review of the narcotic books it was observed there were no additional signatures in the books from a second nurse on the column for verification. -At 2:50 p.m. when approached RN-A verified the narcotic pages both did not have a second nurse signature. When asked if there was another place the nurse documented witnessing the destruction she indicated she did not think so and indicated "I have to ask the DON and get back to you about that." -At 2:50 p.m. when asked if two nurses witnessed the destruction LPN-C indicated she had changed the patch for R95 on 2/24/15, and the other nurse had witnessed her take the patch off but had not witnessed her flush the patch down the sewer which she did by herself. -At 3:10 p.m. when asked what the facility policy was for destroying Fentanyl Patch LPN-C indicated she had to find that out. -At 3:13 p.m. when approached RN-C stated when she had removed the patch the last time she had disposed it off in the open bucket with medications awaiting to be destroyed stored inside the medication room. -At 3:17 p.m. the consultant pharmacist indicated two nurses were supposed to witness the destruction and document it "I will do education on that and will be in the plan of correction." - At 3:29 p.m. DON stated the facility policy was two nurses were supposed to witness the destruction and document after. R87's diagnosis which included osteoarthrosis obtained from admission Minimum Data Set	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 425	Continued From page 27 (MDS) dated 1/9/15. R87's Physician's Orders indicated R87 had an order for the Fentanyl patch (used for pain) as of 1/28/15. During review of R87's Electronic Medication Administration Record (EMAR) dated 2/1/15, through 2/25/15, it was revealed R87 had the Fentanyl patch removed and disposed of with only one nurse signing off. It could not be determined if there were two nurses or one nurse signing off for the removal and destruction of the Fentanyl patch. R97's diagnoses included malignant neoplasm of prostate, generalized pain and shoulder joint pain obtained from Admission Record dated 2/16/15. The Physician's Orders indicated R97 had an order for the Fentanyl patch as of 2/16/15. During review of R97's EMAR dated 2/16/15, through 2/25/15, it was revealed R97 had the Fentanyl patch removed and disposed of three times with only one nurse signing off. It could not be determined if there were two nurses or one nurse signing off for the removal and destruction of the Fentanyl patch. Controlled Substance Disposal policy dated 5/12, directed "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of |two licensed nurses|, and the disposal is documented on the accountability record/book on the line representing that dose ..." The policy did not	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 425	Continued From page 28 indicate who was responsible to oversee the narcotic books were audited regularly to ensure nurses were consistently documenting Fentanyl patch disposal to prevent potential diversion. The facility did not ensure the Fentanyl patches were wasted which involved a secure and safe method, so diversion and/or accidental exposure are minimized.	F 425		
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. 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	F 431	F 431 Resident # 5, 26, 42, 49 expired medication has been removed from medication cart and refrigerator. Stock meds have expiration dates on the container Medications are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. Medication carts are being cleaned weekly by the night nurse and PRN as needed Licensed nurses, trained medication aides are being re-trained on checking expiration dates of medication and cleaning of medication carts. Weekly audits to be completed. DNS or designee is responsible for compliance QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Completion: 4/6/15	4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 431	Continued From page 29 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 medications were stored in accordance with facility policy and/or manufacturer instruction, including the removal of expired medications for R42, R26, R49 and R5. This systematic failure to effectively implement medication and supply storage procedures resulted in the potential to affect 40 of 47 residents in the facility. Findings include: Medication room On 2/24/15, at 2:27 p.m. a medication room tour was completed with registered nurse (RN)-C during the tour R42's bottle of Vancomycin (antibiotic) 2.5 ml 125 milligram (mg) by mouth every other day for six weeks with discard date 2/6/15, was observed stored in the refrigerator located in the medication room. RN-C verified stated medications that were expired were not supposed to be stored in the refrigerator and she would remove it. Cart 1 On 2/24/15, at 2:37 p.m. medication cart tour was completed with licensed practical nurse (LPN)-B during the tour the following were identified and verified by the LPN-B -One 100 quantity bottle of Multiple Vitamins with	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 431	Continued From page 30 minerals dietary supplement with approximately 20 pills left no expiration date on the bottle. -One 100 quantity bottle of Tylenol (pain reliever) 325 milligrams no expiration date. -One 60 quantity bottle of Lactose enzyme supplement with expiration date 1/15. -R26's Etodolac (used to treat pain or inflammation caused by arthritis) 400 mg 25 tablets with expiration date 10/28/14. -R49 Trazodone (anti-depressant) 50 mg 5 half (1/2) tablets in a pill card expiration date 7/29/14. In addition during the tour heavy white powder with multiple pieces of foil paper and approximately 10 loose pills were observed in both the middle medication cart drawers between and on the edges of the drawers. When asked who was responsible for cleaning the medication cart LPN-B indicated all the nurses were. -At 2:57 p.m. when asked if expired medications were supposed to be stored in the cart LPN-B stated "No we are supposed to take them out." When asked about the medications without expiration dates were to be administered LPN-B stated "Not really." Cart 2. On 2/24/15, at 3:11 p.m. the medication cart tour was completed with LPN-A during the tour the following were verified and observed: - R5's furosemide (medication used to treat fluid build-up and swelling) 40 mg 50 tablets in two pill card with expiration date 10/25/14. Also another pill card for R5's furosemide 20 mg nine tablets with expiration date 12/11/14. -R5's Haldol (anti-psychotic) 0.5 mg 27 tablets in the pill card with expiration date 10/18/14. -Stock Calcitrate Calcium Citrate (calcium supplement) 100 quantity bottle with expiration	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 431	Continued From page 31 date 11/14. -Stock Lutein (supplement) 20 mg extra strength expiration date Mar 2013. -Stock Regular strength Antacid tablets 500 mg 150 quantity bottle expiration date Jan 2015. -Magnesium Oxide (supplement) 400 mg 120 bottle quantity with four remaining in the bottle expiration date 9/12. -Stock box of Ferrous Gluconate (iron supplement) 324 mg 130 quantity tablets bottle with expiration date 9/14. - Bisacodyl 5 mg (laxative) 100 quantity bottle with expiration date 12/14. -Vitamin B-6 50 mg dietary supplement 100 quantity bottle with expiration date 8/14. -Acetaminophen 325 mg 100 quantity bottle no expiration date. -Stock Famotidine tablets 10 mg (acid controller) 30 quantity box with 12 remaining in the box. In addition the medication cart was observed to have heavy build up debris of a white powder, multiple pieces of foil paper and approximately 15 loose pills in two middle drawers. When asked who was supposed to clean the cart LPN-A stated all the nurses were. On 2/24/15, at 3:27 p.m. LPN-A verified all the medications concerns and stated expired medications were not supposed to be stored in the medication cart. On 2/25/15, at 12:26 p.m. the director of nursing (DON) stated "they should be removed" when asked about the expired and not dated medications stored in the medications carts and medication room. On 2/25/15, at 3:17 p.m. the consultant	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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 431	Continued From page 32 pharmacist stated expired medications were not supposed to be stored in the medication cart. When asked about medication that did not have expiration date on the bottle consultant pharmacist indicated the bottle that did not have an expiration date came from another pharmacy and in fact medications were not supposed to be dispensed without an expiration date. Storage of Medication procedure dated 5/12, directed: "I. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity... Expiration Dating A. Expiration dates of dispensed medications shall be determined by the pharmacist at the time of dispensing. B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. F. The nurse will check the expiration date of each medication before administering it. G. No expired medication will be administered to a resident. H. All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	**5700 EAST RIVER ROAD** **FRIDLEY, MN 55432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Lynwood Building 01 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JS 3-25-15 RECEIVED MAR 23 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

[signature], Executive Director — 3/18/15

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
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	**5700 EAST RIVER ROAD** **FRIDLEY, MN 55432**

(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 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1-story building was determined to be of Type II (111) construction. Original year of construction was 1962 with an addition in 1990, both buildings are of the same type of construction and 1-story. It has a partial basement. The building interior is protected by automatic fire sprinklers. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. All resident sleeping rooms have smoke detection. The facility has a capacity of 54 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056	K 56 The combustible material located in the crawl space underneath the north/south corridor will be removed in accordance with NFPA 13 and NFPA 25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	**5700 EAST RIVER ROAD** **FRIDLEY, MN 55432**

(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 056	Continued From page 2 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation 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: During facility tour between 10:30 AM and 12:00 PM 03/02/2015, observation revealed the the combustible crawl space underneath the north/south corridor is not fire sprinkler protected. This deficient practice was verified by the maintenance director at the time of the inspection.	K 056	QAA will provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date. Scott Degroot, Director of Maintenance is responsible for the correction and will continue to monitor to prevent a reoccurrence of the deficiency. Corrective Action will be completed by April 6. 2015.	4/6/15

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

FB201024

PRINTED: 03/09/2015
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
	245201	A. BUILDING **02 - BUILDING 2** B. WING _____	**03/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNWOOD	**5700 EAST RIVER ROAD FRIDLEY, MN 55432**

(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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Lynwood Building 02 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 18 New Health Care. In 2007, a 1 story addition to the 1990 building West was constructed and was determined to be of type II(111) construction. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in each resident room that is monitored for fire department notification. The facility has a capacity of 54 with a census was 47 at the time of this survey. The requirement at 42 CFR, Subpart 483.70(a) is Met.	K 000	3-25-15 RECEIVED MAR 23 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 3-25-15 DC: 4-6-15

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

Executive Director 3/18/15

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.