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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Z0ZE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **03/25/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (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
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Pat Halverson, Unit Supervisor 4/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen Leach Program Specialist 5/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Poscted 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2013
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5348
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 19, 2013, the facility is certified for 49 skilled facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5348 May 29, 2013

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Dear Mr. Gershone:

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 March 19, 2013, the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

April 25, 2013

RE: Project Number S5348022

Dear Mr. Gershone:

On February 22, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 7, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 7, 2013, effective March 19, 2013 and therefore remedies outlined in our letter to you dated February 22, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 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
245348	A. Building B. Wing	3/25/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/19/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **03/19/2013**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/19/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PH/cbl	04/25/2013	12835	03/25/2013
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
2/7/2013		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z0ZE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **02/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (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
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Elmgren - HFE - NEII 03/05/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 04/07/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on February 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after March 19, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5907

February 22, 2013

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348022

Dear Mr. Gershone:

On February 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

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 March 19, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 7, 2013 (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 7, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

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

PRINTED: 02/22/2013
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
	245348	A. BUILDING _____ B. WING _____	02/07/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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) COMPLETE DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	3/19/2013
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 did not provide grooming for dignity for 1 of 3 residents (R26) in the sample reviewed for grooming needs. Findings include: R26 was observed to have long hair on her chin during all 3 days of the survey. R26's diagnoses included depression, anxiety, macular degeneration, dementia and shoulder and neck pain. The annual Minimum Data Set (MDS) dated 11/26/13, indicated R26 had moderate cognitive impairment, did not reject cares, and required	F 241	OK 3/5/13 PLH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director of Operations | (X6) DATE: 3-4-13

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.

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

PRINTED: 02/22/2013
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
	245348	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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) COMPLETE DATE
F 241	Continued From page 1 extensive assistance of one staff with personal hygiene. The physical functioning care plan dated 12/9/11, indicated R26 had selfcare and mobility deficits. The care plan directed staff to set up R26 and assist as needed with personal hygiene. The bedtime care plan dated 12/13/11, indicated R26 did not always state what she wanted even when upset and would not share complaints unless asked directly. On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and indicated she cared about her appearance and did not like it facial hair. R26 continued to have the long facial hair on 2/6/13 through 2/7/13. On 2/7/13, at 10:30 a.m. R26 was observed coming out of the main dining room and no facial hair was noted. On 2/7/13, at 8:43 a.m. nursing assistant (NA)-B was interviewed and stated the night shift got R26 up in the morning. NA-B stated, "All the day shift does for her [R26] is toilet her and lay her down on the bed. R26's razor has been broke and she just got a new razor. I think there is another razor somewhere to use for residents whose razors are broken." At 9:40 a.m. the director of nursing (DON) stated she expected shaving to be provided bath days	F 241	F241 1. R26 has been shaved and care plan has been revised to include the need to be shaved on bath day and as needed. 2. All residents requiring an assist with grooming have the potential to be affected by the deficient practice. 3. Nursing staff has been educated on the need to maintain clean shaven residents and how to handle and document refusals of offers to shave or bathe. Licensed nurses have been educated on overseeing the nursing assistants and assuring that residents are properly shaved. 4. Monitoring to ensure compliance will be done through random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. DNS is the responsible party. Corrective action will be completed March 19,2013.	3/19/2013

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	245348	A. BUILDING _____ B. WING _____	02/07/20

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F 241	Continued From page 2 and staff set up R26 and go back to check on her as needed. R26's razor was broken and she just got a new razor yesterday. There were electric razors in the social services office to use for residents that didn't have one. The facility's Shaving the Resident procedure dated 2006, indicated the purpose was to remove facial hair and improve the resident's appearance and morale.	F 241		3/19/2013
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	F272 1. R24 has been comprehensively assessed for, and has been offered dental services. The resident and family have refused dental services. 2. All residents requiring dental services have the potential to be affected by the deficient practice. 3. Licensed staff has been educated to comprehensively assess for and offer dental services to all residents upon admission, with each care conference, and as needed. 4.Audits will be completed on all new admissions and with each scheduled care conferences to assure resident has been assessed for and offer dental services. Audits will be reviewed monthly by QAPI Committee for action planning as needed. RNAC is the responsible party. Corrective action will be completed March 19,2013.	

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F 272	Continued From page 3 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 4 residents in the sample (R24) reviewed for dental services. Findings included: R24's diagnoses included Alzheimer's disease. The significant change minimum data set (MDS) dated 9/11/12, noted R24 had severe cognitive impairment, short- and long-term memory deficits, occasional behaviors directed towards others, required extensive assistance of one person with personal hygiene and eating, and noted no dental problems. On 2/4/13, at 4:21 p.m. R24 was observed to have one lower broken off tooth and two upper front teeth broken off. Review of R24's medical record noted R24 had fallen on 9/19/11, striking her head and knocking	F 272		3/19/2013

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F 272	Continued From page 4 out two teeth. On 2/7/13, at 2:00 p.m. registered nurse (RN-C) confirmed R24's significant change MDS dated 9/11/12, lacked assessment of the dental problems and further verified the comprehensive assessment should have included R24's dental status.	F 272		3/19/2013
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide grooming as directed by the plan of care for 2 of 5 residents (R15, R26) reviewed for grooming needs Findings include: R15 did not receive nail care as directed by his current plan of care. R15's diagnoses include dementia, spastic paraplegia and aphasia (impaired ability to use and comprehend language). F15 was observed, on 2/5/13, at 8:31 a.m., with long, jagged, dirty fingernails on both hands. R15 stated he was bothered by the unkept fingernails as he was unable to trim them on his own.	F 282	F282 1. R15 and R26 have been groomed as directed per their individual care plans. 2. All residents of the facility have the potential to be affected by the deficient practice. 3. Nursing staff have been educated to provide grooming in accordance with the written plan of care. 4. Monitoring to ensure compliance will be done through random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. DNS is the responsible party. Corrective action will be completed March 19,2013.	

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F 282	Continued From page 5	F 282		3/19/2013

R15 was interviewed again on 2/6/13, at approximately 8:45 a.m., and stated he had a shower that morning, however, the fingernails remained dirty, jagged and untrimmed. The bath schedule located in the shower room indicated R15 had his bath/shower on Wednesdays in the a.m.

The care plan with a print dated of 12/13/12, indicated R15 had physical functioning deficits and staff were to provide nail care as needed (prn).

Nursing assistant (NA)C, interviewed on 2/7/13, at 9:20 a.m., stated residents fingernails are to be trimmed and cleaned on bath days and more frequently if needed.

An interview with the Director of Nursing (DON) on 2/7/13, at 1:23 p.m. verified R15's nails had not been trimmed or cleaned. The DON also stated she expected R15's nails to be trimmed on his bath day.

The bath policy dated 2006, indicated fingernail and toenail care was part of the bath. Be certain nails are clean.
R26 was observed to have long facial hair on all 3 days of the survey.

R26's diagnoses included depression, anxiety, macular degeneration, dementia and shoulder and neck pain.

The physical functioning care plan dated 12/9/11, indicated R26 had self care and mobility impairment and directed staff set up and assist as needed with personal hygiene. The bedtime care

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F 282	Continued From page 6 plan dated 12/13/11, indicated R26 did not always state what she wanted even when upset and would not share complaints unless asked directly. On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and stated she cared about her appearance and did not like to have facial hair. R26 continued to have long facial hair on 2/6/13 through 2/7/13.	F 282		3/19/2013
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility did not ensure grooming services were provided as assessed for 2 of 4 residents in the sample (R26 and R15) who were reviewed for grooming needs. Findings include: R15 was observed to have long, jagged, dirty fingernails for all 3 days of the survey.	F 312	F312 1. R15 and R26 have been groomed as directed per their individual care plans. 2. All residents of the facility have the potential to be affected by the deficient practice. 3. Nursing staff have been educated to provide grooming for all residents, in accordance with the written plan of care. 4. Monitoring to ensure compliance will be done through random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. DNS is the responsible party. Corrective action will be completed March 19,2013.	

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F 312	Continued From page 7	F 312		3/19/2013

R15's diagnoses include dementia, spastic paraplegia and aphasia (impaired ability to use and comprehend language).

The quarterly Minimal Data Set (MDS) dated 11/29/12, indicated R15 had moderate cognitive impairment and needed extensive assist with activities of daily living (ADL's) including personal hygiene.

The quarterly assessment dated 12/19/12, indicated R15 required assistance of one staff for grooming and bathing.

During an observation on 2/5/13, at 8:31 a.m. R15 was noted to have long, jagged, dirty fingernails. R15 stated he was bothered by the unkept fingernails as he was unable to trim them on his own.
R15 was interviewed again on 2/6/13, at approximately 8:45 a.m. R15 was asked if he had a shower that morning and he replied, "yes". R15's fingernails were observed to still be dirty, jagged and untrimmed. The bath schedule which was located in the shower room, indicated R15 had his bath/shower on Wednesdays in the a.m. Nursing assistant (NA)C was interviewed on 2/7/13, at 9:20 a.m. stated residents fingernails are to be trimmed and cleaned during bath days and more frequently if needed. NA-C also stated, she was not sure why R15's nails were not trimmed yesterday as she did not have R15 on her slip,,

The care plan with a print dated of 12/13/12, indicated R15 had physical functioning deficits and staff were to provide nail care as needed

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F 312	Continued From page 8 (prn).	F 312		3/19/2013

An interview with the Director of Nursing (DON) on 2/7/13, at 1:23 p.m. verified R15's nails had not been trimmed or cleaned. The DON also stated she would expect R15's nails to be trimmed on his bath day.

The bath,bed policy dated 2006, indicated fingernails and toe nails is part of the bath. Be certain nails are clean.

R26 was observed to have long facial hair on her chin during all 3 days of the survey.

R26's diagnoses included depression, anxiety, macular degeneration, dementia and shoulder and neck pain.

The annual Minimum Data Set (MDS) dated 11/26/13, indicated R26 had moderate cognitive impairment. R26 required extensive assistance of one staff with personal hygiene and R26 had not rejected cares.

The annual comprehensive assessment dated 11/26/12, indicated R26 had moderate cognitive impairment and required the assistance of one staff for dressing, grooming and bathing.

The physical functioning care plan dated 12/9/11, indicated R26 had a deficit related to self care and mobility impairment. The care plan directed staff to set up R26 and assist as needed with personal hygiene.
The bedtime care plan dated 12/13/11, indicated R26 did not always state what she wanted even

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F 312	Continued From page 9	F 312		3/19/2013

when upset and would not share complaints unless asked directly.

On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and indicated she not like it and she cared about her appearance.
R26 continued to have the long facial hair on 2/6/13 through 2/7/13. On 2/7/13, at 10:30 a.m. R26 was observed coming out of the main dining room and no facial hair was noted.

On 2/7/13, at 8:43 a.m. during an interview with nursing assistant (NA)-B, the NA indicated the night shift got R26 up in the morning. The NA stated, "all the day shift does for her is toilet her and lay her down on the bed. R26's razor has been broke and she just got a new razor. I think there is another razor somewhere to use for residents whose razors are broken."
At 9:40 a.m. the director of nursing (DON) indicated she would expect shaving to be done on the bath day. The staff set up R26 and go back as needed. The DON would expect residents to be shaved. R26's razor was broken and she just got a new razor yesterday. There were electric razors in the social services office for residents to use if residents did not have a razor or their razor was broken.

The facility's Shaving the Resident procedure dated 2006, indicated the purpose was to

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F 312	Continued From page 10 remove facial hair and improve the resident's appearance and moral.	F 312		3/19/2013
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to monitor clinical indications for use of medications for 2 of 10 residents (R14, R27) reviewed for unnecessary medications.	F 329	F329 1. R14 and R27 are monitored for clinical indicators for use of Trazadone for sleep. 2. All residents receiving psychotropic medication for sleep have the potential to be affected by the deficient practice. 3. Licensed staff have been educated of the requirement to monitor clinical indicators for the use of psychotropic medication for sleep. 4. Monitoring to ensure compliance will be done through random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. DNS is the responsible party. Corrective action will be completed March 19,2013.	

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F 329	Continued From page 11 Findings include: R14's Physician orders, dated 2/9/12, directed Trazodone (antidepressant prescribed as a sleep aid) 50 mg every day at bedtime. A Sleep Hygiene Assessment, dated 2/27/12, established that R14 took over 15 minutes to fall asleep, never woke during the night, and had not ever taken sleeping pills prior to admission on 2/9/12. The quarterly minimum data set (MDS)s, dated 8/10/12, and 11/2/12, identified R14 had no trouble falling asleep, staying asleep, or sleeping too much. The care plan, dated 2/1/13, indicated R14 was at risk for sleep pattern disturbance related to a history of insomnia or not being able to sleep. The care plan directed staff to assess for pain, assess usual sleep patterns, assist R14 to establish a daily routine, discourage physical activity and caffeine within 2 hours of bedtime, maintain an environment conducive to sleeping, offer warm milk and encourage family to bring in comforting items from home. The most recent Sleep Monitoring Tool, dated February 2012, indicated that R14 received non-pharmacological interventions on 2/26/12, at 8:00 p.m. and was sleeping at 10:00 p.m.. On 2/27/12 and 2/29/2012, R14 was awake and provided non-pharmacological interventions and Trazadone 50 mg at 8:00 p.m.; and was asleep at 9:00 p.m.. There was no evidence of additional sleep monitoring completed as of 2/6/13.	F 329		3/19/2013

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F 329	Continued From page 12	F 329		3/19/2013

The registered nurse (RN)-C, interviewed on 2/7/13 at 12:45 p.m., stated that no other monitoring had been documented since since 2/29/12, because R14 had no trouble sleeping. She added that R14 was due for another Sleep Hygiene Assessment on 2/13/13, since they are completed annually.

The executive director was interviewed on 2/7/13, at approximately 2:00 p.m., and stated Trazodone used as a sleep aid needed to be monitored for effectiveness on a routine basis.

R27's physician orders dated 1/11/12, directed Trazodone 50 mg at bedtime.

A Sleep Hygiene Assessment dated 1/30/13, indicated R27 fell asleep in less than 15 minutes and woke 1 to 3 times during the night. The other assessment areas on this dated form were left blank.

The annual MDS dated 11/20/12, indicated R27 had severe cognitive impairment, short- and long-term memory deficits, exhibited no behaviors, and rarely had problems falling or staying asleep.

R27's care plan dated 12/8/12, identified R27 was at risk for sleep pattern disturbance related to a history of insomnia or not being able to sleep. The care plan directed staff to assess for pain and offer pain medications and other interventions if needed, assess usual pattern of sleep, assist R27 in establishing a daily routine with periods of rest and activity, allow family to bring in personal items to increase R27's comfort, maintain a sleep-conducive environment, offer

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	660 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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F 329	Continued From page 13 back rub and other relaxation techniques, and review R27's medication for sleep interference. Review of the Sleep Monitoring Tool (undated), noted R27 had received no pharmacological or non-pharmacological interventions. On 2/7/13, at 2:00 p.m. the director of nursing (DON) stated sleep monitoring could not be located in R27's medical record. The DON further stated the Sleep Monitoring Tool is filled out by exception, meaning only negative findings are recorded. The DON was able to locate one progress note in R27's electronic record dated 8/3012, indicating R27 was sleeping in bed.	F 329		3/19/2013
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide dental services for 1 of 4 residents in the sample (R24). Findings included:	F 412		

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F 412	Continued From page 14 R24 was observed, on 2/4/13, at 4:21 p.m., to have one lower front tooth and two upper front teeth broken off. R24's diagnoses included Alzheimer's disease. The quarterly minimum data set (MDS) dated 12/4/12, indicated R24 had severe cognitive impairment with both short- and long term memory deficits, displayed occasional behaviors directed towards others, and required extensive assistance of one for personal hygiene and eating. Both the significant change MDS dated 9/11/12, and the quarterly MDS dated 12/4/12, noted R24 had no dental problems and no behaviors of resisting cares. The Care Conference Review Sheet (CCRS) dated 1/11/12, indicated R24 had missing teeth with average meal intake at 3% and a significant weight loss with R24 weighing 102 pounds. The CCRS dated 4/4/12, noted R24's dental area as "0 no apt"[appointment]. Another CCRS (undated) noted R24's dental status as adequate. The CCRS dated 9/5/12, noted R24's dental status as "N/A" [not applicable]. The CCRS dated 11/28/12, noted R24's dental status was blank. The Quarterly Interdisciplinary Resident Review dated 11/20/12, indicated R24 had broken, loose or carious teeth. R24's care plan dated 1/4/12, noted R24 was at risk for dental problems related to some or all natural teeth loss with goal R24 would be free of complications related to dental/oral issues. R24's care plan interventions for dental problems included assistance with oral care as resident allows and medication and/or treatment as ordered.	F 412	F 412 1. R24 has been offered dental services. The resident and family have refused dental services. 2. All residents requiring dental services have the potential to be affected by the deficient practice. 3. Licensed staff has been educated to comprehensively assess for and offer dental services to all residents upon admission, with each care conference, and as needed. 4.Audits will be completed on all new admissions and with each scheduled care conferences to assure resident has been assessed for and offer dental services. Audits will be reviewed monthly by QAPI Committee for action planning as needed. RNAC is the responsible party. Corrective action will be completed March 19,2013.	3/19/2013

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A Social Services electronic progress note dated 1/11/13, indicated R24 had no dental, hearing or vision appointments needed at this time; social services will continue to follow.

Medical record review indicated R24 had fallen on 9/19/11, striking her head and knocking out two teeth. There was no evidence of dental services offered or discussion with R24's family regarding the need for dental services.

On 2/6/13, at 2:00 p.m. nursing assistant (NA-D) stated R24 was totally dependent in all activities of daily living (ADLs). NA-D further reported R24 will resist help with oral cares, and when NA-D is able to complete oral cares, R24's gums will bleed. On 2/7/13, at 9:05 a.m. NA-C confirmed R24 often resists oral cares when approached, verified R24's gums will bleed with gentle brushing or use of toothette oral sponges, and stated this has been reported to the registered nurse (RN).

On 2/7/13, at approximately 1:00 p.m. licensed practical nurse (LPN-B) stated the NA's had not reported any bleeding from R24's gums and would expect the NA's to report those problems.

On 2/7/13; at 2:00 p.m. the director of nursing (DON) stated [he/she] was not aware R24 had bleeding gums and would expect the NA's to report the bleeding gums to the nurse. RN-C confirmed no knowledge of R24's oral gum condition and would expect the comprehensive assessment to address R24's dental status.

On 2/7/13, at 3:00 p.m. social worker (SW-A)

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F 412	Continued From page 16 stated the medical record lacked evidence R24's family had been offered a dental visit for R24's broken teeth or bleeding gums.	F 412		3/19/2013
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 interview and document review, the facility failed to administer medications according to physician orders for 1 of 10 residents in the sample (R27) whose medications were reviewed. Findings included: R27's diagnoses included Alzheimer's disease,	F 425	F425 1. R27 is receiving medications per the MD orders. 2. All residents receiving MD ordered medication have the potential to be affected by the deficient practice. 3. Licensed nursing staff have been educated on the correct procedures for checking, clarifying, and transcribing of MD orders. 4. Monitoring to ensure compliance will be done through daily review of medications ordered and random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. DNS is the responsible party. Corrective action will be completed March 19,2013	

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F 425	Continued From page 17 depression, hypothyroidism, hypertension, dementia, insomnia, and anxiety The annual minimum data set (MDS) dated 11/20/12, indicated R27 had severe cognitive impairment, short and long-term memory deficits, exhibited no behaviors, and was not assessed for mood due to the severe cognitive impairment. R27's Physician Orders dated 6/29/12, directed Seroquel (an anitpsychotic medication) 12.5 mg twice daily. Another Physician's Order handwritten dated 10/2/12, directed R27's morning dose of Seroquel be discontinued. Review of R27's Medication Administration Records (MAR) dated 10/1/12, through 2/7/13, noted R27 had been receiving 12.5 mg of Seroquel twice daily. On 2/7/13, at 1:30 p.m. licensed practical nurse (LPN)-B stated either LPN's or registered nurses (RNs) would transcribe a telephone or handwritten order for a medication change and confirmed R27 was receiving the Seroquel twice daily. On 2/7/13, at 2:00 p.m. the director of nursing (DON) stated [he/she] is ultimately responsible for all transcribed physician orders and R27's physician order for Seroquel was incorrect.	F 425		3/19/2013
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 18 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview the consultant pharmacist failed to identify the lack of monitoring related to the use of Trazadone for insomnia for 1 of 10 residents (R14) reviewed for unnecessary medications. Findings include: Physician orders dated 2/9/12, included Trazodone (an antidepressant occasionally prescribed as a sleep aid) 50 mg every day at bedtime. The quarterly MDSs, dated 8/10/12 and 11/2/12, identified R14 had no trouble falling or staying asleep, or sleeping too much. A Sleep Hygiene Assessment, dated 2/27/12, established that R14 took over 15 minutes to fall asleep, never woke during the night, and had not ever taken sleeping pills, prior to admission on 2/9/12. The Sleep Monitoring Tool, dated February 2012, noted on 2/26/12, R14 received non-pharmacological interventions at 8:00 p.m. and was sleeping at 10:00 p.m.. On 2/27/12 and 2/29/2012, R14 received non-pharmacological interventions at 8:00 p.m. and was awake at 8:00 p.m.. R14 also received Trazodone 50 mg 8:00	F 428	3/19/2013 F428 1. R14 has clinical monitoring in place for the use of Trazadone. 2. All residents receiving medication have the potential to be affected by the deficient practice. 3. The Pharmacist has been educated on the requirement to review each resident's drug regimen monthly and to report irregularities to the DNS and the attending physician for the reports to be acted upon. 4. Monthly review of reports and MD response will be completed by the DNS/designee to assure compliance with the regulation Pharmacy reports will be entered monthly QAPI minutes for review and action planning as needed. DNS is the responsible party. Corrective action will be completed by March 19, 2013	

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F 428	Continued From page 19 p.m. and was noted to be sleeping at 9:00 p.m.. No other Sleep Monitoring Tools were completed since February 29, 2012, as of 2/6/13. The monthly pharmacy consultant review sheets dated 2/20/12, through 1/24/13, did not identify the lack of monitoring related to the use of Trazodone for sleep. The consultant pharmacist, interviewed on 2/8/13, at 12:51 p.m., stated the lack of monitoring was not addressed in the monthly consultant reports.	F 428		3/19/2013
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 1. All resident meals are being served in a sanitary manner. 2. All residents have the potential to be affected by the deficient practice. 3. All dietary and nursing staff have been educated on appropriate gloving, hand-washing, and food serving techniques. 4. Monitoring to ensure compliance will be done through random weekly audits. Audits will be reviewed monthly by QAPI Committee for action planning as needed. Dietary Services Manager is the responsible party Corrective action will be completed by March 19, 2013	

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from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations, interview and document review, the facility failed to ensure meals were served in a sanitary manner to reduce potential of food born illnesses. This had the potential to effect 28 of 34 residents residing in the facility.

Findings included:

During observation of the supper meal on 2/4/13, cook-A was observed touching sandwiches after handling menu request papers, touching the refrigerator door handles, wiping his nose and gloved hands on a cloth kitchen towel without changing gloves or washing hands. Cook-A was also observed to blow up the gloves with [his/her] mouth and then put them on to serve the sandwiches to the residents. The meal served on 2/4/13, was turkey club sandwiches with potato salad and coleslaw with the alternate as goulash.

On 2/4/13, at 5:43 p.m. in the kitchen food serving line Cook-A was observed to blow into

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each glove with [his/her] mouth and put the gloves on, beginning to serve sandwiches to the residents out in the dining room. Cook-A served several sandwiches by taking them out of the service table with gloved hands, placing them on a cutting board, cutting them diagonally, and then picking up the sandwich and placing it on a plate. At 5:46 p.m. Cook-A was observed to be sniffling while food was being prepared for service, touched paper menus with gloves hands, reading the resident's request for dinner meal, then touched the sandwiches in the service table, to prepare the sandwiches for serving. At approximately 5:52 p.m. Cook-A turned around, with gloved hands touched a piece of paper on counter, then turned back and again touched several paper menus on upper shelf of service table, and began handling the sandwiches again for service to the residents. At approximately 5:57 p.m. dietary aide (DA)-A place paper menus on upper shelf of service table for Cook-A to look at. Cook-A touched the paper menus with gloved hands, then handled sandwiches in the same manner, cutting them and placing them on plates. At approximately 5:59 p.m. Cook-A walked to the refrigerator in the back of the kitchen, opened the door with gloved hands and removed a container of ice cream, set ice cream down on service shelf for dietary manager (DM)-D. Cook-A did not remove gloves or wash hands. At approximately 6:00 p.m. Cook-A resumed serving sandwiches in the same manner. At approximately 6:04 p.m. Cook-A walked to the dry storage room, removed a can of soup from the shelf, opened it, poured the soup into a bowl, walked to the microwave oven and heated the soup. Cook-A removed gloves while soup heated and did not wash hands. Cook-A blew air into new gloves on as

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soup heated and put gloves on hands. Cook-A brought bowl of soup to DA-A and resumed serving the meal. At approximately 6:06 p.m. Cook-A turned around, removed gloves, then used white cloth kitchen towel to wipe [his/her] nose, returning towel to table behind service table, did not wash hands, blows air into pair of clean gloves and puts them on, and then continued to serve sandwiches. At approximately 6:09 p.m. upon handling the sandwiches Cook-A gets some food on gloved hands, turns around and uses the white cloth kitchen towel to wipe gloved hands before returning to serving the meal. The meal service ended at approximately 6:20 p.m.

The DM-D was observed on 2/4/13 at approximately 5:43 p.m., 5:59 p.m., and 6:05 p.m. walking in and out of the food service/kitchen area without observing Cook-A handling food with contaminated gloves.

On 2/5/13, at 2:30 p.m. Cook-A stated hands were to be washed when gloves are removed and failed to do so the previous evening when serving the supper meal. Cook-A confirmed the gloves used were inflated with air prior to put them for ease in pulling them onto hands. Cook-A further confirmed [he/she] wiped [his/her] nose on the kitchen towel and did not wash hands after or discard the towel from further use for hand wiping. Cook-A stated meal menus were touched by gloved hands during the meal service on the evening of 2/4/13, and then the sandwiches were handled with those gloves. Cook-A reported usually the meal menus are handled by the DA or DM at the service table and not the server/cook and should not have been handled by gloved

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F 441	Continued From page 23 hands then food touched with those gloves. On 2/5/13, at 2:45 p.m. the DM-D stated gloves should be changed and hands washed with all breaks in assigned kitchen duties when food is being touched by gloved hands. The DM further stated all dietary workers should be using disposable tissues for wiping nose, sneezing, coughing, etc and then hands should be washed before new gloves are applied and duties resumed. The DM confirmed Cook-A should not have used [his/her] mouth to inflate gloves for ease of application. The registered dietician (RD) stated Cook-A had received food handling education through recent inservicing. The Disposable Gloves policy for food service handlers dated 2011, directed single-use gloves must be worn when touching any food item and discarded when damaged or soiled, or when interruption occurs in the operation. The policy further directed gloves were to be changed after obtaining additional supplies, equipment or utensils, after touching items, equipment, utensils, trash can lids, or soiled work areas; when gloves are damaged or soiled; after sneezing, coughing or touching the face or hair; and after doing anything that would contaminate the gloves resulting in possible cross-contamination. The Hand Washing policy for dining service employees dated 2011, directed hands must be kept clean by washing vigorously for a minimum of 20 seconds. The policy further directed hand washing was to be done before putting on and removing of disposable gloves; after touching bare human body parts such as face or mouth; after blowing nose, sneezing, coughing or using a handkerchief or disposable	F 441		3/19/2013

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F 441	Continued From page 24 tissue; after handling any soiled or contaminated equipment, cleaning cloths, utensils, dishes trays, soiled aprons or trash can lids, after obtaining food supplies for preparation, and before handling cooked or ready-to-eat foods.	F 441		

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

(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 Living Center-Rush City 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. Golden Living Center-Rush City is a 1-story building with a partial basement. The building was constructed in 1967. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5907

February 22, 2013

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5348022

Dear Mr. Gershone:

The above facility was surveyed on February 4, 2013 through February 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rule. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 11 East Superior Street, Suite 290, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

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
	00994	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, February 4-7, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column	

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2 000	Continued From page 1 Certification Program; 11 East Superior St., #290, Duluth, MN 55802.	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's	2 540		

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2 540	Continued From page 2 comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 4 residents in the sample (R24) reviewed for dental services. Findings included: R24's diagnoses included Alzheimer's disease. The significant change minimum data set (MDS) dated 9/11/12, noted R24 had severe cognitive impairment, short- and long-term memory deficits, occasional behaviors directed towards others, required extensive assistance of one person with personal hygiene and eating, and noted no dental problems.	2 540		

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2 540	Continued From page 3 On 2/4/13, at 4:21 p.m. R24 was observed to have one lower broken off tooth and two upper front teeth broken off. Review of R24's medical record noted R24 had fallen on 9/19/11, striking her head and knocking out two teeth. On 2/7/13, at 2:00 p.m. registered nurse (RN-C) confirmed R24's significant change MDS dated 9/11/12, lacked assessment of the dental problems and further verified the comprehensive assessment should have included R24's dental status. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses (DON) could review and revise policies and procedures for conducting comprehensive assessments and provide additional training to involved staff. A designated staff could monitor the system to assure assessments are complete and accurate. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not provide grooming as	2 565		

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2 565	Continued From page 4 directed by the plan of care for 2 of 5 residents (R15, R26) reviewed for grooming needs Findings include: R15 did not receive nail care as directed by his current plan of care. R15's diagnoses include dementia, spastic paraplegia and aphasia (impaired ability to use and comprehend language). F15 was observed, on 2/5/13, at 8:31 a.m., with long, jagged, dirty fingernails on both hands. R15 stated he was bothered by the unkept fingernails as he was unable to trim them on his own. R15 was interviewed again on 2/6/13, at approximately 8:45 a.m., and stated he had a shower that morning, however, the fingernails remained dirty, jagged and untrimmed. The bath schedule located in the shower room indicated R15 had his bath/shower on Wednesdays in the a.m. The care plan with a print dated of 12/13/12, indicated R15 had physical functioning deficits and staff were to provide nail care as needed (prn). Nursing assistant (NA)C, interviewed on 2/7/13, at 9:20 a.m., stated residents fingernails are to be trimmed and cleaned on bath days and more frequently if needed. An interview with the Director of Nursing (DON) on 2/7/13, at 1:23 p.m. verified R15's nails had not been trimmed or cleaned. The DON also stated she expected R15's nails to be trimmed on his bath day.	2 565		

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2 565	Continued From page 5 The bath policy dated 2006, indicated fingernail and toenail care was part of the bath. Be certain nails are clean. R26 was observed to have long facial hair on all 3 days of the survey. R26's diagnoses included depression, anxiety, macular degeneration, dementia and shoulder and neck pain. The physical functioning care plan dated 12/9/11, indicated R26 had self care and mobility impairment and directed staff set up and assist as needed with personal hygiene. The bedtime care plan dated 12/13/11, indicated R26 did not always state what she wanted even when upset and would not share complaints unless asked directly. On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and stated she cared about her appearance and did not like to have facial hair. R26 continued to have long facial hair on 2/6/13 through 2/7/13. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could schedule an in service to discuss the importance of following the plans of care for residents. The quality assurance committee could randomly audit resident records to ensure compliance.	2 565		

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2 565	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility did not ensure grooming services were provided as assessed for 2 of 4 residents in the sample (R26 and R15) who were reviewed for grooming needs. Findings include: R15 was observed to have long, jagged, dirty fingernails for all 3 days of the survey. R15's diagnoses include dementia, spastic paraplegia and aphasia (impaired ability to use and comprehend language). The quarterly Minimal Data Set (MDS) dated 11/29/12, indicated R15 had moderate cognitive impairment and needed extensive assist with activities of daily living (ADL's) including personal hygiene. The quarterly assessment dated 12/19/12, indicated R15 required assistance of one staff for grooming and bathing.	2 920		

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2 920	Continued From page 7 During an observation on 2/5/13, at 8:31 a.m. R15 was noted to have long, jagged, dirty fingernails. R15 stated he was bothered by the unkept fingernails as he was unable to trim them on his own. R15 was interviewed again on 2/6/13, at approximately 8:45 a.m. R15 was asked if he had a shower that morning and he replied, "yes". R15's fingernails were observed to still be dirty, jagged and untrimmed. The bath schedule which was located in the shower room, indicated R15 had his bath/shower on Wednesdays in the a.m. Nursing assistant (NA)C was interviewed on 2/7/13, at 9:20 a.m. stated residents fingernails are to be trimmed and cleaned during bath days and more frequently if needed. NA-C also stated, she was not sure why R15's nails were not trimmed yesterday as she did not have R15 on her slip,, The care plan with a print dated of 12/13/12, indicated R15 had physical functioning deficits and staff were to provide nail care as needed (prn). An interview with the Director of Nursing (DON) on 2/7/13, at 1:23 p.m. verified R15's nails had not been trimmed or cleaned. The DON also stated she would expect R15's nails to be trimmed on his bath day. The bath,bed policy dated 2006, indicated fingernails and toe nails is part of the bath. Be certain nails are clean. R26 was observed to have long facial hair on her chin during all 3 days of the survey. R26's diagnoses included depression, anxiety,	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 920	Continued From page 8 macular degeneration, dementia and shoulder and neck pain. The annual Minimum Data Set (MDS) dated 11/26/13, indicated R26 had moderate cognitive impairment. R26 required extensive assistance of one staff with personal hygiene and R26 had not rejected cares. The annual comprehensive assessment dated 11/26/12, indicated R26 had moderate cognitive impairment and required the assistance of one staff for dressing, grooming and bathing. The physical functioning care plan dated 12/9/11, indicated R26 had a deficit related to self care and mobility impairment. The care plan directed staff to set up R26 and assist as needed with personal hygiene. The bedtime care plan dated 12/13/11, indicated R26 did not always state what she wanted even when upset and would not share complaints unless asked directly. On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and indicated she not like it and she cared about her appearance. R26 continued to have the long facial hair on 2/6/13 through 2/7/13. On 2/7/13, at 10:30 a.m. R26 was observed coming out of the main dining room and no facial hair was noted. On 2/7/13, at 8:43 a.m. during an interview with	2 920		

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2 920	Continued From page 9 nursing assistant (NA)-B, the NA indicated the night shift got R26 up in the morning. The NA stated, "all the day shift does for her is toilet her and lay her down on the bed. R26's razor has been broke and she just got a new razor. I think there is another razor somewhere to use for residents whose razors are broken." At 9:40 a.m. the director of nursing (DON) indicated she would expect shaving to be done on the bath day. The staff set up R26 and go back as needed. The DON would expect residents to be shaved. R26's razor was broken and she just got a new razor yesterday. There were electric razors in the social services office for residents to use if residents did not have a razor or their razor was broken. The facility's Shaving the Resident procedure dated 2006, indicated the purpose was to remove facial hair and improve the resident's appearance and morale. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise policies and procedures for care delivery systems and provide education for all involved staff. A designated staff member could monitor the system to assure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 920		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services	21325		

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21325	Continued From page 10 include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide dental services for 1 of 4 residents in the sample (R24). Findings included: R24 was observed, on 2/4/13, at 4:21 p.m., to have one lower front tooth and two upper front teeth broken off. R24's diagnoses included Alzheimer's disease. The quarterly minimum data set (MDS) dated 12/4/12, indicated R24 had severe cognitive impairment with both short- and long term memory deficits, displayed occasional behaviors directed towards others, and required extensive assistance of one for personal hygiene and eating. Both the significant change MDS dated 9/11/12, and the quarterly MDS dated 12/4/12, noted R24 had no dental problems and no behaviors of resisting cares. The Care Conference Review Sheet (CCRS) dated 1/11/12, indicated R24 had missing teeth with average meal intake at 3% and a significant weight loss with R24 weighing 102 pounds. The CCRS dated 4/4/12, noted R24's dental area as "0 no apt"[appointment]. Another CCRS (undated) noted R24's dental status as adequate. The CCRS dated 9/5/12, noted R24's dental	21325		

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21325	Continued From page 11 status as "N/A" [not applicable]. The CCRS dated 11/28/12, noted R24's dental status was blank. The Quarterly Interdisciplinary Resident Review dated 11/20/12, indicated R24 had broken, loose or carious teeth. R24's care plan dated 1/4/12, noted R24 was at risk for dental problems related to some or all natural teeth loss with goal R24 would be free of complications related to dental/oral issues. R24's care plan interventions for dental problems included assistance with oral care as resident allows and medication and/or treatment as ordered. A Social Services electronic progress note dated 1/11/13, indicated R24 had no dental, hearing or vision appointments needed at this time; social services will continue to follow. Medical record review indicated R24 had fallen on 9/19/11, striking her head and knocking out two teeth. There was no evidence of dental services offered or discussion with R24's family regarding the need for dental services. On 2/6/13, at 2:00 p.m. nursing assistant (NA-D) stated R24 was totally dependent in all activities of daily living (ADLs). NA-D further reported R24 will resist help with oral cares, and when NA-D is able to complete oral cares, R24's gums will bleed. On 2/7/13, at 9:05 a.m. NA-C confirmed R24 often resists oral cares when approached, verified R24's gums will bleed with gentle brushing or use of toothette oral sponges, and stated this has been reported to the registered nurse (RN). SUGGESTED METHOD OF CORRECTION: The administrator with the director of nursing	21325		

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21325	Continued From page 12 could determine a system to ensure residents in need of dental care and/or dental follow up receive those services in a timely manner. An auditing system to ensure the plan was being followed could be instituted and the quality committee could monitor the effectiveness of those measures. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure meals were served in a sanitary manner to reduce potential of food born illnesses. This had the potential to effect 28 of 34 residents residing in the facility. Findings included: During observation of the supper meal on 2/4/13, cook-A was observed touching sandwiches after handling menu request papers, touching the refrigerator door handles, wiping his nose and gloved hands on a cloth kitchen towel without changing gloves or washing hands. Cook-A was also observed to blow up the gloves with [his/her] mouth and then put them on to serve the sandwiches to the residents. The meal served on 2/4/13, was turkey club sandwiches with potato	21375		

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21375	Continued From page 13 salad and coleslaw with the alternate as goulash. On 2/4/13, at 5:43 p.m. in the kitchen food serving line Cook-A was observed to blow into each glove with [his/her] mouth and put the gloves on, beginning to serve sandwiches to the residents out in the dining room. Cook-A served several sandwiches by taking them out of the service table with gloved hands, placing them on a cutting board, cutting them diagonally, and then picking up the sandwich and placing it on a plate. At 5:46 p.m. Cook-A was observed to be sniffling while food was being prepared for service, touched paper menus with gloves hands, reading the resident's request for dinner meal, then touched the sandwiches in the service table, to prepare the sandwiches for serving. At approximately 5:52 p.m. Cook-A turned around, with gloved hands touched a piece of paper on counter, then turned back and again touched several paper menus on upper shelf of service table, and began handling the sandwiches again for service to the residents. At approximately 5:57 p.m. dietary aide (DA)-A place paper menus on upper shelf of service table for Cook-A to look at. Cook-A touched the paper menus with gloved hands, then handled sandwiches in the same manner, cutting them and placing them on plates. At approximately 5:59 p.m. Cook-A walked to the refrigerator in the back of the kitchen, opened the door with gloved hands and removed a container of ice cream, set ice cream down on service shelf for dietary manager (DM)-D. Cook-A did not remove gloves or wash hands. At approximately 6:00 p.m. Cook-A resumed serving sandwiches in the same manner. At approximately 6:04 p.m. Cook-A walked to the dry storage room, removed a can of soup from the shelf, opened it, poured the soup into a bowl, walked to the microwave oven and heated the soup. Cook-A removed	21375		

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21375	Continued From page 14 gloves while soup heated and did not wash hands. Cook-A blew air into new gloves on as soup heated and put gloves on hands. Cook-A brought bowl of soup to DA-A and resumed serving the meal. At approximately 6:06 p.m. Cook-A turned around, removed gloves, then used white cloth kitchen towel to wipe [his/her] nose, returning towel to table behind service table, did not wash hands, blows air into pair of clean gloves and puts them on, and then continued to serve sandwiches. At approximately 6:09 p.m. upon handling the sandwiches Cook-A gets some food on gloved hands, turns around and uses the white cloth kitchen towel to wipe gloved hands before returning to serving the meal. The meal service ended at approximately 6:20 p.m. The DM-D was observed on 2/4/13 at approximately 5:43 p.m., 5:59 p.m., and 6:05 p.m. walking in and out of the food service/kitchen area without observing Cook-A handling food with contaminated gloves. On 2/5/13, at 2:30 p.m. Cook-A stated hands were to be washed when gloves are removed and failed to do so the previous evening when serving the supper meal. Cook-A confirmed the gloves used were inflated with air prior to put them for ease in pulling them onto hands. Cook-A further confirmed [he/she] wiped [his/her] nose on the kitchen towel and did not wash hands after or discard the towel from further use for hand wiping. Cook-A stated meal menus were touched by gloved hands during the meal service on the evening of 2/4/13, and then the sandwiches were handled with those gloves. Cook-A reported usually the meal menus are handled by the DA or DM at the service table and not the server/cook and should not have been handled by gloved	21375		

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21375	Continued From page 15 hands then food touched with those gloves. On 2/5/13, at 2:45 p.m. the DM-D stated gloves should be changed and hands washed with all breaks in assigned kitchen duties when food is being touched by gloved hands. The DM further stated all dietary workers should be using disposable tissues for wiping nose, sneezing, coughing, etc and then hands should be washed before new gloves are applied and duties resumed. The DM confirmed Cook-A should not have used [his/her] mouth to inflate gloves for ease of application. The registered dietician (RD) stated Cook-A had received food handling education through recent inservicing. The Disposable Gloves policy for food service handlers dated 2011, directed single-use gloves must be worn when touching any food item and discarded when damaged or soiled, or when interruption occurs in the operation. The policy further directed gloves were to be changed after obtaining additional supplies, equipment or utensils, after touching items, equipment, utensils, trash can lids, or soiled work areas; when gloves are damaged or soiled; after sneezing, coughing or touching the face or hair; and after doing anything that would contaminate the gloves resulting in possible cross-contamination. The Hand Washing policy for dining service employees dated 2011, directed hands must be kept clean by washing vigorously for a minimum of 20 seconds. The policy further directed hand washing was to be done before putting on and removing of disposable gloves; after touching bare human body parts such as face or mouth; after blowing nose, sneezing, coughing or using a handkerchief or disposable tissue; after handling any soiled or contaminated equipment, cleaning cloths, utensils, dishes trays,	21375		

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21375	Continued From page 16 soiled aprons or trash can lids, after obtaining food supplies for preparation, and before handling cooked or ready-to-eat foods. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding handwashing and infection control and provide additional education to all involved staff. A designated staff member could perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to administer medications according to physician orders for 1 of 10 residents in the sample (R27) whose medications were reviewed. Findings included:	21525		

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21525	Continued From page 17 R27's diagnoses included Alzheimer's disease, depression, hypothyroidism, hypertension, dementia, insomnia, and anxiety The annual minimum data set (MDS) dated 11/20/12, indicated R27 had severe cognitive impairment, short and long-term memory deficits, exhibited no behaviors, and was not assessed for mood due to the severe cognitive impairment. R27's Physician Orders dated 6/29/12, directed Seroquel (an antipsychotic medication) 12.5 mg twice daily. Another Physician's Order handwritten dated 10/2/12, directed R27's morning dose of Seroquel be discontinued. Review of R27's Medication Administration Records (MAR) dated 10/1/12, through 2/7/13, noted R27 had been receiving 12.5 mg of Seroquel twice daily. On 2/7/13, at 1:30 p.m. licensed practical nurse (LPN)-B stated either LPN's or registered nurses (RNs) would transcribe a telephone or handwritten order for a medication change and confirmed R27 was receiving the Seroquel twice daily. On 2/7/13, at 2:00 p.m. the director of nursing (DON) stated [he/she] is ultimately responsible for all transcribed physician orders and R27's physician order for Seroquel was incorrect. SUGGESTED METHOD OF CORRECTION: The director of nursing and the consulting pharmacist could review and revise the policy regarding the monthly pharmacy reviews. The director of nursing could then establish a system to ensure that all residents receive adequate	21525		

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21525	Continued From page 18 reviews. The quality assurance committee could complete chart audits to ensure all residents receive appropriate pharmacy reviews. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending	21530		

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21530	Continued From page 19 physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on record review and interview the consultant pharmacist failed to identify the lack of monitoring related to the use of Trazadone for insomnia for 1 of 10 residents (R14) reviewed for unnecessary medications. Findings include: Physician orders dated 2/9/12, included Trazodone (an antidepressant occasionally prescribed as a sleep aid) 50 mg every day at bedtime. The quarterly MDSs, dated 8/10/12 and 11/2/12, identified R14 had no trouble falling or staying asleep, or sleeping too much. A Sleep Hygiene Assessment, dated 2/27/12, established that R14 took over 15 minutes to fall asleep, never woke during the night, and had not ever taken sleeping pills, prior to admission on 2/9/12. The Sleep Monitoring Tool, dated February 2012, noted on 2/26/12, R14 received non-pharmacological interventions at 8:00 p.m. and was sleeping at 10:00 p.m.. On 2/27/12 and 2/29/2012, R14 received non-pharmacological interventions at 8:00 p.m. and was awake at 8:00 p.m.. R14 also received Trazodone 50 mg 8:00 p.m. and was noted to be sleeping at 9:00 p.m..	21530		

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21530	Continued From page 20 No other Sleep Monitoring Tools were completed since February 29, 2012, as of 2/6/13. The monthly pharmacy consultant review sheets dated 2/20/12, through 1/24/13, did not identify the lack of monitoring related to the use of Trazodone for sleep. The consultant pharmacist, interviewed on 2/8/13, at 12:51 p.m., stated the lack of monitoring was not addressed in the monthly consultant reports. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could collaborate with the consultant pharmacist to review the policies and procedures regarding monitoring medications,educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If	21540		

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21540	Continued From page 21 the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on record review, and interview, the facility failed to monitor the effectiveness of medications for 2 of 10 residents in the sample (R14 and R27) reviewed for unnecessary medications. Findings include: R14 received 50 mg of Trazodone for insomnia, however, the record lacked ongoing monitoring of the effectiveness of medication. Physician orders, dated 2/9/12, prescribed Trazodone (an antidepressant occasionally prescribed as a sleep aid,) 50 mg every day at bedtime. The quarterly MDSs, dated 8/10/12 and 11/2/12, identified R14 had no trouble falling or staying asleep, or sleeping too much. The care plan, dated 2/1/13, identified R14 was at risk for sleep pattern disturbance related to a history of insomnia or not being able to sleep. The care plan directed staff to assess for pain, assess usual sleep patterns, assist R14 to establish a daily routine, discourage physical activity and caffeine within 2 hours of bedtime, maintain an environment conducive to sleeping, offer warm milk and to encourage family to bring in comforting items from home.	21540		

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21540	Continued From page 22 A Sleep Hygiene Assessment, dated 2/27/12, established that R14 took over 15 minutes to fall asleep, never woke during the night, and had not ever taken sleeping pills, prior to admission on 2/9/12. The Sleep Monitoring Tool, dated February 2012, noted on 2/26/12, R14 received non-pharmacological interventions at 8:00 p.m. and was sleeping at 10:00 p.m.. On 2/27/12 and 2/29/2012, R14 received non-pharmacological interventions at 8:00 p.m. and was awake at 8:00 p.m.. R14 also received Trazodone 50 mg 8:00 p.m. and was noted to be sleeping at 9:00 p.m.. No other Sleep Monitoring Tools were completed since February 29, 2012, as of 2/6/13. RN-C stated on 2/7/13 at 12:45 p.m., stated that no other monitoring had been documented since since 2/29/12 because R14 had not had any trouble sleeping. She added that R14 was due for another Sleep Hygiene Assessment on 2/13/13, since they are completed annually. The executive director indicated, on 2/7/13 at approximately 2:00 p.m., Trazodone needed to be monitored for effectiveness on a routine basis when given as a sleep aid. R27's physician orders dated 1/11/12, directed Trazodone 50 mg at bedtime. A Sleep Hygiene Assessment dated 1/30/13, indicated R27 fell asleep in less than 15 minutes and woke 1 to 3 times during the night. The other assessment areas on this dated form were left blank. The annual MDS dated 11/20/12, indicated R27 had severe cognitive impairment, short- and long-term memory deficits, exhibited no behaviors, and rarely had problems falling or staying asleep.	21540		

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21540	Continued From page 23 R27's care plan dated 12/8/12, identified R27 was at risk for sleep pattern disturbance related to a history of insomnia or not being able to sleep. The care plan directed staff to assess for pain and offer pain medications and other interventions if needed, assess usual pattern of sleep, assist R27 in establishing a daily routine with periods of rest and activity, allow family to bring in personal items to increase R27's comfort, maintain a sleep-conducive environment, offer back rub and other relaxation techniques, and review R27's medication for sleep interference. Review of the Sleep Monitoring Tool (undated), noted R27 had received no pharmacological or non-pharmacological interventions. On 2/7/13, at 2:00 p.m. the director of nursing (DON) stated sleep monitoring could not be located in R27's medical record. The DON further stated the Sleep Monitoring Tool is filled out by exception, meaning only negative findings are recorded. The DON was able to locate one progress note in R27's electronic record dated 8/3012, indicating R27 was sleeping in bed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could review the policies and procedures regarding monitoring medications,educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		

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21805	Continued From page 24 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide grooming for dignity for 1 of 3 residents (R26) in the sample reviewed for grooming needs. Findings include: R26 was observed to have long hair on her chin during all 3 days of the survey. R26's diagnoses included depression, anxiety, macular degeneration, dementia and shoulder and neck pain. The annual Minimum Data Set (MDS) dated 11/26/13, indicated R26 had moderate cognitive impairment, did not reject cares, and required extensive assistance of one staff with personal hygiene. The physical functioning care plan dated 12/9/11, indicated R26 had selfcare and mobility deficits. The care plan directed staff to set up R26 and assist as needed with personal hygiene. The bedtime care plan dated 12/13/11, indicated R26 did not always state what she wanted even when upset and would not share complaints unless asked directly. On 2/5/13, at 1:36 p.m. R26 was observed to have several long dark and gray colored facial	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00994	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21805	Continued From page 25 hairs on chin, under chin and along the jaw line. The facial hair was approximately 1/4 of an inch long. R26 indicated she kept it shaved herself before coming to the facility. "Now the girls have to help me and I have to ask for help." R26 was well dressed and indicated she cared about her appearance and did not like it facial hair. R26 continued to have the long facial hair on 2/6/13 through 2/7/13. On 2/7/13, at 10:30 a.m. R26 was observed coming out of the main dining room and no facial hair was noted. On 2/7/13, at 8:43 a.m. nursing assistant (NA)-B was interviewed and stated the night shift got R26 up in the morning. NA-B stated, "All the day shift does for her [R26] is toilet her and lay her down on the bed. R26's razor has been broke and she just got a new razor. I think there is another razor somewhere to use for residents whose razors are broken." At 9:40 a.m. the director of nursing (DON) stated she expected shaving to be provided bath days and staff set up R26 and go back to check on her as needed. R26's razor was broken and she just got a new razor yesterday. There were electric razors in the social services office to use for residents that didn't have one. The facility's Shaving the Resident procedure dated 2006, indicated the purpose was to remove facial hair and improve the resident's appearance and morale. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and the Director of Social Services could educate the staff on how to care for residents in a dignified manner. The quality assurance committee could develop a monitoring	21805		

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21805	Continued From page 26 system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		