DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DICARE/MEDICAID CERTIFICATION A		ID: ZGKC11 Facility ID: 00945
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245394 STATE VENDOR OR MEDICAID NO. (L2) 914342400 	 3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - LYNNHU (L4) 471 LYNNHURST AVENUE WEST (L5) SAINT PAUL, MN 	URST (L6) 55104	4. TYPE OF ACTION: 9 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 03/08/2016 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 72 (L18) 13. Total Certified Beds 72 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 72 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLI See Attached Remarks	(L42) (L43)	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	 6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY AP	
Magdalene Jares, HFE N	(L19)	Kate JohnsTon, Pr	(L20)
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 1. Statement of Financi 2. Ownership/Control I 	
1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		3. Both of the Above :	
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN	G DATE ENDING DATE	26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety
A. Suspensio	(L25) VE SANCTIONS n of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27) B. Rescind S	uspension Date: (L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	00000 (L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	-	
(L32)	(L33)	DETERMINATION APPRO	VAL

CCN: 24-5394

On March 8, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2939 March 29, 2016

This letter redacts and replaces the letter dated March 25, 2016.

Mr. Michael Carlson, Administrator Golden Livingcenter - Lynnhurst 471 Lynnhurst Avenue West Saint Paul, Minnesota 55104

RE: Project Number S5394028

Dear Mr. Carlson:

On March 8, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0970 Telephone: (651) 201-3792 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 17, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that the following remedy will be imposed:

• Per instance civil money penalty for the deficiency cited at F 314. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Golden Livingcenter - Lynnhurst March 25, 2016 Page 4

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 8, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

ate Johnston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		· · ·	/ <i>P</i> \OI	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245394	B. WING	Sec. Sec.	an and a second and a	03/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		NNUI IDET		4	71 LYNNHURST AVENUE WEST		
GULDEN		NNNUNSI		S	AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000			F(000	F 000		
		et (MDS) 3.0/Staffing Focused			Submission of this Response and P	lan of	
	Survey was conductive were issued.	ted. The following deficiencies			Correction is not a legal admission t	hat a	
F 272			E /	272	deficiency exists or that this Statem	ent of	
SS=D				12	Deficiency was correctly cited, and	s also	
					not to be construed as an admission	n of	
		onduct initially and periodically	P		fault by the facility, the Executive Di	rector	
		accurate, standardized sment of each resident's	5		or any employees, agents or other		
	functional capacity.		Z		individuals who draft or may be disc	ussed	
	ranonan aupuany.		Ð		in this Response and Plan of Correct		
	A facility must make		,		In addition, preparation and submise		
		sident's needs, using the	5		of this Plan of Correction does not	510(1	
		nt instrument (RAI) specified	C'			nt of	
	least the following:	assessment must include at	Ľ		constitute an admission or agreeme		
		emographic information;	T		any kind by the facility of the truth of	•	
	Customary routine;	•		P	facts alleged or the correctness of a	-	
	Cognitive patterns;		\circ .	T	conclusions set forth in the allegatio	ns.	
	Communication; Vision:		30	>			
	Mood and behavior	r patterns:	1 -	\leftarrow	Accordingly, the Facility has prepare		
	Psychosocial well-t		12	l	and submitted this Plan of Correction	n	
		g and structural problems;	3		prior to the resolution of any appeal	which	
	Continence;		15		may be filed solely because of the		
	Disease diagnosis Dental and nutritior	and health conditions;	K		requirements under state and federa	al law	
	Skin conditions;		R		that mandate submission of a Plan	of	
	Activity pursuit;				Correction within ten (10) days of th	e	
	Medications;				survey as a condition to participate		
	Special treatments				Title 18 and Title 19 programs. This		
	Discharge potentia	i; summary information regarding			of Correction is submitted as the fac	•	
		ssment performed on the care			credible allegation of compliance.		
		the completion of the Minimum			second and gallon of complication.		
	Data Set (MDS); a	nd					
	Documentation of p	participation in assessment.					
LABORATOR	I Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
Y	hOL					4	lal.
A gu allalan		and starisk (*) denotes a deficiency wh	inte aten inc		EXECUTIVE DIRECTOR	<u> </u>	18/16

Any deficiency statement ending will 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.

PRINTED: 03/25/2016

FORM APPROVED

PRINTED: 03/25/2016 FORM APPROVED

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY
		245394	B. WING			03/0	8/2016
NAME OF F	ROVIDER OR SUPPLIER		[TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 1	F 2	72	F 272 •R9 no longer resides in facility R5 R10 have had triggered CAA's comprehensively assessed.	and	
	by: Based on interview facility failed to con assessment for 3 c	NT is not met as evidenced w and document review, the nplete a comprehensive of 10 residents (R9, R10, R5) in ad a comprehensive completed.			•All residents have potential to be affected if triggered CAA's are not comprehensively assessed. RNAC assure that RAI is used in accordar with resident's comprehensive assessment as part of ongoing pro- identify resident's functional capaci health status.	nce cess to	
	completed on 10/6 Area Assessments reviewed and the f - The Delirium CAJ with pain frequenc that could be indica decrease in eating checklist and failed specifically impact eating. - The Cognitive Lo had delirium, Alzhe indications of pain the resident had pain	Minimum Data Set (MDS) /15. The corresponding Care (CAAs) dated 10/14/15, were ollowing was noted: A indicated R9 had pain along y, intensity, and characteristics ative of delirium, and a recent habits. The CAA was a d to evaluate how these factors ed R9's pain and decrease in ess/Dementia CAA indicated R9 eimer's disease, confusion, , a decline in continence, noted otential for more independence			 •RNAC has been educated on comprehensive assessment of trigg CAA's. •DNS/designee to complete randor weekly audits on 10 comprehensive MDS's for accuracy of CAA notes in MDS. Results of these audits will b reviewed by QAPI. •DNS/designee is responsible. •Completion date is 4-17-16 	n e n	
	with cueing, restor task segmentation failed to evaluate h impacted R9's cog the care planning indications of pain	ative nursing program, and /or . The CAA was a checklist and how these factors specifically philive status or the rationale for decision especially with the , the decline in ability to make otential for more independence			•Completion date is 4-17-16		

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES				T	0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				DATE SURVEY COMPLETED	
		245394	B, WING			03/08/2016		
NAME OF F	ROVIDER OR SUPPLIER			-	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - LY				SAINT PAUL, MN 55104		·y····	
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F 272	 The Activities of C indicated R9 had c daily behavior sym loss, depression at care plan decision decline and mainta However, there wa the facility was goil was not a referral fi to assist R9 in maile. The Behavioral S description that im the resident or the decision. For all of R9's CA/ to proceed to care objective was left II CAA. The objectiv or minimize decline maintain current lear risks, and sympton The Care Plan con any documentation the problem/need rationale for care if documentation of CAAs also failed to the assessment, we observed and par- non-licensed staff R10 had an annual The CAAs dated following was note - The Cognitive Lo R10 had Alzheimed 	Daily Living (ADL) CAA hanging cognitive status, pain, ptoms, mood decline, weight nd a recent hospitalization. The was to slow or minimize the all current functioning. us no documentation as to how ng to meet R9's need and there to another discipline if needed ntaining function. symptoms CAA was void of any pacted the problem/need for facility's rationale for care plan As the care plan decision was plan however, the overall blank with the exception of ADL es included improvement, slow e, avoid complications, avel of functioning, minimize m relief or palliative measure. hsiderations section was void of n that described the impact of on the resident and the facility's plan decision. The CAAs lacked assessment information. The o identify who participated in whether the resident was ticipated, and if licensed and participated as well.		272				

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Facility ID: 00945

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1		ECONSTRUCTION		SURVEY PLETED
		245394	B. WING	xd-Oktheorem		03/0	08/2016
NAME OF F	ROVIDER OR SUPPLIER			57	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	/NNHURST			11 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	potential for more i restorative nursing segmentation. The failed to evaluate h impacted R10's co for the care planning indications of pain, self-understood, pe and decline in inco - The Psychosocia R10 had 'other der was noted under C checked for that C a change in comm checklist and failed specifically impact rationale for the ca with the change in dementia'. - The Activities CA were void of any d problem/need on t rationale for care p For all of R10's CA to proceed to care objectives were le included improven avoid complication functioning, minim palliative measure section was void c described the imp resident and the fa decision. The CAA	nence, noted the resident had ndependence with cueing, program, and /or task CAA was a checklist and now these factors specifically gnitive status or the rationale ng decision especially with the the decline in ability to make otential for more independence ontinence. Well-being CAA indicated mentia' (although Alzheimer's Cognitive Loss, it was not AA), aphasia, depression, and unication. The CAA was a d to evaluate how these factors ed R10's cognitive status or the are planning decision especially communication and the 'other A and Pressure Ulcer CAA escription that impacted of the he resident and the facility's		272			

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Event ID:ZGKC11 Facility ID: 00945

If continuation sheet Page 4 of 46

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES				<u>)MB NO.</u>	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	SURVEY PLETED
		245394	B. WING		2012/04/21/04/2012/2010/07/04/2012/2010/2012/2012/04/2012/2012/04/2012/02/2012/04/2012/02/2012/04/2012/04/2012/	03/0	8/2016
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	71 LYNNHURST AVENUE WEST		
GOLDEN	LIVINGCENTER - LY	INNHURST		S	AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 272	identify who had pay whether the reside participated, and w non-licensed staff R5's annual MDS of reference date) of 1/12/16, were revise noted: - The Delirium, Co daily living), Urinar Catheter, Falls, De Psychotropic drug additional review h description facility! decision. Furtherm left blank, the CAA assessment inform where the informal be located. The C/ participated in the observed and part non-licensed staff According to the L Resident Assessm version 3.0 dated of CAA process as for "Documentation for describe: The nature of include presence of subjective compla problem for this reside Risk factors th presence of the co	articipated in the assessment, int was observed and thether licensed and participated as well. with ARD (assessment 12/29/15. The CAAs dated awed and the following was mmunication, ADL (activities of y Incontinence and Indwelling ontal, Pressure Ulcer and use CAAs had all triggered for iowever they were void of any is rationale for care plan fore, the overall objectives were as lacked documentation of nation, and documentation tion relating to the CAAs could AAs also lacked who assessment if the resident was icipated and if licensed and participated as well. ong Term Care Facility tent Instrument User's Manual October 2015, described the ollows: or each triggered CAA should the issue or condition (may or lack of objective data and ints). In other words, what is the sident? ontributing factors. affecting or caused by the care ent. nat arise because of the ondition that affect the staff 's		272			
		oceed to care planning.					

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Facility ID: 00945

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					e survey Pleted
		245394	B. WING	2004704(AP		03/	08/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST			47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
	developing individu including appro- the decision to plar the individual resid Need for referr appropriate health What research tool(s) were used in source(s) need onl cited as the standa CAA by facility polid 483.20(g) - (j) ASS ACCURACY/COOI The assessment m resident's status. A registered nurse each assessment to participation of hea A registered nurse assessment is com Each individual wh assessment must that portion of the a Under Medicare ar willfully and knowir false statement in subject to a civil m \$1,000 for each as willfully and knowir to certify a materia resident assessment	ust be considered in alized care plan interventions, opriate documentation to justify a care or not to plan care for ent. als or further evaluation by professionals. , resource(s), or assessment n performing the CAA. A y be cited if it is not already rd source(s) used for this cy." ESSMENT RDINATION/CERTIFIED nust accurately reflect the must conduct or coordinate with the appropriate lith professionals. must sign and certify that the npleted. o completes a portion of the sign and certify the accuracy of			F 278 •R 1, and R10 MDS updated to refl changes not accurately coded. •All residents have potential to be affected if MDS is not accurately coded. •RNAC has been educated on RAI criteria for coding of UTI's and catheters. •Random audits of 10 MDS's of se "H" will be completed. Results of to audits will be reviewed by QAPI. •DNS/designee is responsible. Completion date is 4-17-16	oded. ection	

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

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FORM	APPROVE	J

CENTERS FOR MEDICARE & MEDICAID SERVICES					Q	<u>MB NO.</u>	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		245394	B. WING	Vicence de la		. 03/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES WINST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PAEFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	material and false a This REQUIREME by: Based on interview facility failed to acc Data Set (MDS) for reviewed for indwe tract infection (UTI Findings include: Indwelling catheter R1's quarterly MDS had an active diag however, did not id catheter. A Physician's Order required use of a F which should be ch included, "dx: (diag bladder dysfunctio condition)." R1's Comprehensi 2/24/16, identified catheter related to R1 had a diagnosi On 3/8/16, at 7:30 stated R1 had utilit	ent does not constitute a statement. NT is not met as evidenced v and document review, the surately code the Minimum r 2 of 10 residents (R1, R10) lling catheter and/or urinary). S dated 1/28/16, reflected R1 noses of neurogenic bladder lentify R1's use of an indwelling or dated 2/2/16, indicated R1 Foley (indwelling) catheter hanged every month. The order gnosis) neurogenic bladder (a n caused by a neurological ive Assessment Note dated the use of an indwelling urinary retention, and indicated s of neurogenic bladder. p.m. nursing assistant (NA)-A zed an indwelling catheter "for					
	catheter care in th	A indicated R1 received e morning and evening, and stance with switching from a				and the second	

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

Facility ID: 00945

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FORM	APPROVED
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STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE	U938-0391 SURVEY PLETED
		245394				03/08/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST			4	STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	used during the da On 3/8/16, at 11:24 stated R1's indwell 8/17/15. RN-B ack the MDS and had catheter use. RN-f actually losing mod On 3/8/16, at 1:13 services stated sh assessments to be each resident's cu According to the L Resident Assessm Version 3.0 dated the intent of the ite to gather informati bladder appliance: urinary toileting pr continence, bowel patterns. "Each re at risk of developin identified, assesses individualized trea non-medicinal trea services to achiev elimination function facility was follow which included: "1. Examine the re any urinary or bow 2. Review the met and bowel records	ag used at night, to a leg bag y. A a.m. registered nurse (RN)-B ling catheter had been initiated nowledged she had mis-coded not included R1's indwelling B further stated, "We are ney from my not coding it right." p.m. the director of nursing e expected all resident MDS a coded accurately to reflect rrent status and needs. ong Term Care Facility nent Instrument User's Manual last revised on October 2015, ams in the bladder section was ion on the use of bowel and s, the use of and response to ograms, urinary and bowel training programs, and bowel sident who was incontinent or ng incontinence should be ad, and provided with tment (medications, atments and/or devices) and re or maintain as normal on as possible." In addition the the Steps for Assessment	F	278			

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Facility ID: 00945

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CENTERS FOR MEDICARE & MEDICAID SERVICES					U	<u>MB NO.</u>	<u>0938-0391</u>
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	8. WING	Annadara	anna an ann an an an an an an an an an a	03/08/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN LIVINGCENTER - LYNNHURST				11 LYNNHURST AVENUE WEST AINT PAUL, MN 55104			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	R10's annual MDS coded for UTI. The R10 had experience days. The Progress Note going back 30 days - On 1/5/16, R10 w room to have a gas tube changed and hospital also change catheter. - On 1/7/16, the ho informed the facility started on an antib updated R10's prin medical record lac assessment for sig the UTI to determin necessary. R10's r of any signs or syn such as a fever, or status. On 3/8/16, at 11:05 was interviewed ar medical record lac symptoms of a UT expect staff to follo physician to deterr clinically indicated or symptoms of inf change in status. On 3/8/16, at 11:33 record with the sur had been inaccura	age 8 dated 1/7/16, was inaccurately 1/7/16 annual MDS indicated ed an UTI within the last 30 as were reviewed from 1/7/16, s and the following was noted: as sent to the emergency strostomy/jejunosotmy (G/J) while R10 was there, the ged the resident's indwelling spital called the facility and y R10 had an UTI and R10 on iotic. Although the facility mary physician on that day, the ked evidence of any ms and symptoms reflecting he whether the antibiotic was nedical record lacked evidence optoms of a documented UTI change in the resident's 5 a.m. the director of nursing hd she acknowlegded the ked evidence of signs and 1. The DON stated she would ow up with the primary nine whether the antibiotic was since R10 displayed no signs ection including fever or B a.m. RN-D reviewed R10's veyor and verified the MDS itely coded. RN-D stated the ye been coded on the MDS.		278			
	Sne further stated	she came from the "old school"					

PRINTED:	03/25/2016
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STATEMENT OF DEPICERUIS AND PLAN OF CORRECTION (V2) MUTUPLE CONSTRUCTION A BULDING DEVITICATION INIGHT: 245394 (V2) MUTUPLE CONSTRUCTION A BULDING STREET ADDRESS, CITY, STATE, 2P CODE 31 UNHURST (V2) MUTUPLE CONSTRUCTION A BULDING STREET ADDRESS, CITY, STATE, 2P CODE 31 UNHURST AVENUE WEST SAINT PAUL, MN 55104 MME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS, CITY, STATE, 2P CODE 47 LIVINHURST AVENUE WEST SAINT PAUL, MN 55104 On PROVIDER STATE (CORRECTION ECAIL DEPICTION NOT SEE PRECEDED BY FULL REGULTORY OR LSC DESTIFYING INFORMATION) D PREFX TAG PREFX CAOSS REPERENCED TO THE APPROPRIATE CAOSS REPERENCED TO TH	CENTERS FOR MEDICARE & MEDICAID SERVICES					<u> </u>	<u>MB NO.</u>	0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDENT LIVING STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDENT GOLDENT LIVING STREET ADDRESS. OTTY. STATE. ZIP CODE GOLDENT F 278 Continued From page 9 F 278 Where nurses cid not question the doctors, although she was aware of the potential for overuse of antibulots. F 278 The facility spolicy for UT1s dated XI14, directed the statil and practitioner to identify residents with signs and symptoms, lab data and the clinical furges of the borner Care Facility Head. F 278 According to the Long Term Care Facility Facility Facilita to other authorized license statil as permitted by state law di	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·				
GOLDEN LIVINGCENTER - LYNNHURST 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 PRETX TAG SUMMARY STATEMENT OF DEFIDIENCIES (EACH ODEROIENT MAIN STATEMENT OF DEFIDIENCIES TAG D PRETX TAG F 278 Continued From page 9 where nurses did not guestion the doctors, although she was avare of the potential for overuse of antibiotics. F 278 The facility's policy for UTIs dated 8/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The staff were to follow the Surveillance definitions of Infections of Long Term Care for criteria that defines UTIs. "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team." According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licenses in flank, contision or change in mental status, change in character of unine (og., pyuria), 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained, and 4. Current medication or treatment for a UTI in			245394	B. WING	Seitzzboten	acconstrainty (1) 21 4 4 4 Februaries warman warman a fan	03/0	08/2016
GOLDEN LIVINGCENTER - LYNNHURST SAINT PAUL, MN 55104 (M)ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROEDED BY FULL FREEULTORY OR LSC IDENTIFYING INFORMATION) D PROVICER'S PAUL OF CORRECTIVE ACTORN SHOLD BE (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) Comil and the comil status of the property (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) Comil status (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278 Continued From page 9 where nurses did not question the doctors, although she was aware of the potential for overuse of antibiotics. F 278 The facility s policy for UTIs dated 8/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The statift were to tollow the Surveillance definitions of Intections of Long Term Care for criteria that defines UTIs. "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team." According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnose a UTI in last 30 days, 2. Sign or symptoms attributed to UTI, may or may not include but are not be limited to: lever, unrary symptoms (e.g., peri-urbtra site burning sensation, frequent urination of small amounts), pain or tendenses in flank, confusion or change in mental status, change in character of urine (e.g., puria), 3. "Significant laboratory findings	NAME OF F	PROVIDER OR SUPPLIER						
PREFX TAG CEACH CORRECTION OR LSC IDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS REPERENCE OT NHE APPROPRIATE F 278 Continued From page 9 where nurses did not question the doctors, although she was aware of the potential for overuse of antibiotics. F 278 The facility's policy for UTIs dated &/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The staff were to follow the Surveillance definitions of Intections of Long Term Care for criteria that defines UTIs, "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team." According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnose a UTI in last 30 days, 2. Signs or symptoms attributed to UTI, may or may not include but are not be limited to: tever, unary symptoms (e.g., peri-terthral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., puria), 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 4. Current medication or treatment for a UTI in	GOLDEN	GOLDEN LIVINGCENTER - LYNNHURST						:
 where nurses did not question the doctors, although she was aware of the potential for overuse of antibiotics. The facility's policy for UTIs dated 8/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The staff were to follow the Surveillance definitions of Infections of Long Term Care for criteria that defines UTIs. "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team." According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnose a UTI in last 30 days, 2. Signs or symptoms entributed to UTI, may or may not include but are not be limited to: fever, urinary symptoms (e.g., perfure that list burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., puria). 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 278	where nurses did m although she was a overuse of antibioti The facility's policy the stalf and practi signs and symptom UTIs. The staff were definitions of Infect criteria that defines UTI are resident-sp aggregation of sign the clinical judgme team." According to the Lo Resident Assessm version 3.0 dated 0 coded on the MDS criteria are met: 1. Physician, nurse assistant, or clinical authorized licensed diagnose a UTI in 2. Signs or symptom may not include bu urinary symptoms sensation, frequen pain or tenderness in mental status, cl (e.g., pyuria), 3. "Significant labo physician should d laboratory findings should be obtained 4. Current medical	avare of the potential for ics. for UTIs dated 8/14, directed tioner to identify residents with its suggesting the possibility of re to follow the Surveillance tions of Long Term Care for a UTIs. "Clinical definitions of a becific and require the its and symptoms, lab data and int of the interdisciplinary ong Term Care Facility ent Instrument User's Manual October 2015, UTIs can only be when all of the following e practitioner, physician al nurse specialist or other d staff as permitted by state law last 30 days, ims attributed to UTI, may or at are not be limited to: fever, (e.g., peri-urethral site burning it urination of small amounts), in flank, confusion or change hange in character of urine tratory findings" (The attending letermine the level of significant and whether or not a culture d), and		278			

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Facility ID: 00945

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PRINTED: 03/25/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	DMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245394	B. WING	B. WING			08/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOLDEN	I LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
1	A facility must use to develop, review comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are ider assessment. The care plan mus to be furnished to a highest practicable psychosocial well-t §483.25; and any s be required under due to the resident	(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's in of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment		279	 F279 Resident 8 care plan reviewed an updated to include antipsychotic u All residents on antipsychotics hapotential to be affected if care plan not developed to address antipsycuse. RNAC has been Educated on developing plan of care for resider receiving antipsychotic medication DNS/designee to complete rando weekly audits of care plan to ensure antipsychotic usage is addressed proper monitoring. Results of the audits will be reviewed by QAPI Completion date is 4-17-16 	sage. nve the hs are chotic nts n. nts n. ym for		
	This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care related to antipsychotic medication for 1 of 2 residents (R8) reviewed for psychotic medications Findings include: R8's care plan dated 9/25/15, identified R8 received an antidepressant medication related to depression. The care plan did not identify olanzapine as an antipsychotic medication and lacked direction for staff to monitor for side							

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Facility ID: 00945

PRINTED: 03/25/2016 FORM APPROVED

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>		0838-0381
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B, WING		an management of the state of the	03/0	8/2016
	ROVIDER OR SUPPLIER	NNHURST		4	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	,D BE	(X5) COMPLETION DATE
F 279	effects, orthostatic behaviors. The car non-pharmacologic The Physician Ord had an order for ol mouth two a day. R8's Medication Ac December 2015, a March 2016, indica On 3/8/16, at 9:17 confirmed the care monitoring, orthos non-pharmacologi behavior monitorin medication. RN-C would expect use be included on the On 3/8/16, at 9:17 plan lacked interve monitoring, orthos non-pharmacologi behavior monitorir antipsychotic med acknowledged R8 the assessment re 1/26/16. RN-D sta plan, my expectati updated as neces The facility's polic Interdisciplinary C "The social servic and psychosocial to the interdisciplinary C	blood pressure and/or target e plan also failed to identify cal interventions to be utilized. ers dated 3/8/16, indicated R8 anzapine 5 milligrams (mg) by dministration Record (MAR) for and January, February and ated R8 received olanzapine. a.m. registered nurse (RN)-C e plan lacked side effect tatic blood pressure, cal interventions and target ig for use of antipsychotic indicated further verified she of antipsychotic medications to care plan. a.m. RN-D verified the care entions for side effect tatic blood pressure, cal interventions and target indicated further verified she of antipsychotic medications to care plan. a.m. RN-D verified the care entions for side effect tatic blood pressure, cal interventions and target ing related to the use of the lication. RN-D further had received olanzapine during efference dates of 1/5/16 and ated, "I will update the care ion is care plans should be		279			

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Facility ID: 00945

If continuation sheet Page 12 of 46

PRINTED: 03/25/2016 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					E CONTRACTOR OF THE OWNER	DMB NO. 0938-0391		
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
		245394	B, WING _	หลายสามารถการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกระบบการกร	03/	08/2016		
NAME OF F	PROVIDER OR SUPPLIER	Anna 1999 - Anna		STREET ADDRESS, CITY, STATE, Z	CIP CODE			
GOLDEN	LIVINGCENTER - LY	NNHURST		471 LYNNHURST AVENUE WES SAINT PAUL, MN 55104	т			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
	the RAP (Resident Summary as proce	Data Set) and identified on Assessment Protocol) ed to the care plan"	F 21					
F 282 SS=D	PERSONS/PER C. The services provide must be provided t accordance with ea care.	.20(k)(3)(ii) SERVICES BY QUALIFIED RSONS/PER CARE PLAN services provided or arranged by the facility st be provided by qualified persons in ordance with each resident's written plan of		B.20(k)(3)(ii) SERVICES BY QUALIFIED RSONS/PER CARE PLAN e services provided or arranged by the facility ist be provided by qualified persons in cordance with each resident's written plan of		 Resident 2 and resident repositioned according to of care All residents at risk for p have the potential to be repositioning does not o 	o individual plan pressure ulcers affected if	
	by: Based on observa review, the facility f according to each	tion, interview and document failed to provide repositioning resident's individualized plan of dents (R2, R4) in the sample		 care plan Education to staff on care plan and importance plan and importance plan and importance positioning to prevent DNS/designee to comp weekly audits of repositi provided according to care 	rtance of breakdown. lete random oning being			
	at 7:46 a.m., licens	v regarding R2's skin, on 3/8/16 ed practical nurse (LPN)-A am dressing in place over a		•Results of these audits by QAPI Completion dat				
	RN-A and LPN-A e care to the residen he had last measu 3/4/16, at which tin RN-A measured th centimeters (cm) x described it as an bed covered by 90 10% granulating tis	tion on 3/8/16 at 8:04 a.m., ontered R2's room to provide it's coccyx wound. RN-A stated red the wound on Friday ne R2 had only one wound. ie original wound as 2.3 : 2.0 cm x 0.2 cm and irregular stage II with a wound % yellow necrotic tissue with ssue. RN-A then went on to y acquired stage II pressure						

Facility ID: 00945

(a MEDICAID SERVICES				1	0300-0331
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED	
		245394	B. WING	committants	tan manakanan kan katan kanan kan	03/0	8/2016
	PROVIDER OR SUPPLIER	'NNHURST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	area located on the new area was mea cm. RN-A describe covered with yellow edges. RN-A and L unaware of the new reported the prese Consequently, the assessed. At 8:25 R2 to his back and On 3/8/16, at 8:27 the nursing assista immediately report so that an assess again acknowledge the existing coccyx assessed and iden total physical assis incontinence cares he would have exp the concern and re On 3/8/16, at 9:00 in a wheelchair at t wheel R2 to the be 10:38 a.m. NA-C a leave R2's room a her bed, where she During interview w 3/8/16, he stated h down in bed at abo interviewed immed did not work with F	a inferior of the coccyx. The sured as 0.4 cm x 0.8 cm x 0.1 ad the wound bed as being v necrotic tissue with defined .PN-A verified they had been v wound and that no staff had nce of the second wound. new wound had not been a.m. the nurses repositioned left the room. a.m. RN-A stated he expected ints who provided daily care, to all skin concerns to the nurse nent could be done. RN-A ad the new open area next to a wound had not been stilled. RN-A stated R2 required tance with all cares including a, turning and repositioning so pected someone to have seen		282			

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

Facility ID: 00945

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	PRINTED: 03/25/2016 FORM APPROVED OMB NO. 0938-0391
TRUCTION	(X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
		245394	B. WING	enematurinensis umo bita 42040 kielanitaisis osis dalamen dusi kun da 42040 kielan		3/08/2016
	PROVIDER OR SUPPLIER	NNHURST		STREET ADDRESS, CITY, ST 471 LYNNHURST AVENUE SAINT PAUL, MN 5510	E WEST	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE (CIENCY)	(X5) COMPLETION DATE
F 282	During interview wi 3/8/16, LPN-A state a.m" (Indicating res 55 minutes without how often resident repositioned, LPN- verified R2 had bee pressure ulcers and on the coccyx. LPN received assistance 10:48 a.m. LPN-A to follow all resident concerns about resident concerns about residents. LPN-A to follow all resident concerns about resident concerns about resident concerns about resident concerns about resident concerns about resident about the state of the residents. LPN-A report issues with r she could get help an open area. R2's pressure ulce (CAA) dated 10/8/1 potential for impair incontinence of bou on staff for changin requiring extensive turning, repositioni also indicated R2 wide development per the R2's Minimum Datt identified diagnose hemiparesis, type peripheral neuropa indicated R2 did no ulcers and identified pressure ulcers. R2's care plan date potential for impair	th LPN-A at 10:44 a.m. on ad, "We got her up around 8: sident had been up 1 hour an repositioning). When asked was supposed to be A stated every hour. LPN-A en identified at risk for d had an actual pressure ulce I-A also verified R2 had not e to reposition as required. A stated she expected the NA's atted she expected the NA's tated she expected the NA's ning late with repositioning also stated the NA's needed to running late immediately so to reposition R2 since she hat r Care Area Assessment 15, identified R2 as having a ed skin integrity related to wel and bladder, dependence ing and pericare, and as e assistance with bed mobility ng and off-loading. The CAA was at risk for pressure ulcer he Braden Score. a Set (MDS) dated 12/23/15, is including hemiplegia, II diabetes, idiopathic athy, and dementia. The MDS of have any unhealed pressure ad R2 as at risk for developing ed 1/4/16, indicated R2 had the red skin integrity related to tot	a a a a a a a a a a a a a a a a a a a			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:ZG	NGTT	Facility ID: 00945	If continuation she	et Page 15 of 46

PRINTED: 03/25/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•••		ECONSTRUCTION	(X3) DATE SURVE COMPLETED	
	245394	8. WING		xxpxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	03/0	8/2016
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST				71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
PREFIX (EACH DEFICIENCY ML	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
included: "Skin will ren Care plan intervention daily observation of R2 report alterations to nu weekly skin inspection and to turn and reposi and as needed due to During review of the P through 3/7/16, reveal - On 1/16/16, indicated pink, scar tissue area - On 2/13/16, indicated compromised area on slightly red and cream - On 2/27/16, indicated assessed, the compro open, area measured bed was 100% granul and peri-wound was p indicated pink areas h buttocks with potentia further indicated the o cleansed and a foam - On 3/7/16, indicated on the coccyx measur cm. Wound bed was were undefined and m An undated nursing as group B assignment s plan of care, directed one hour until buttock On 3/8/16, at 11:16 a. (DON) pulled up an as	ability, turning and ing and transfers. The goal main free from breakdown." is directed staff to conduct 2's skin with all cares, urse, nurse to conduct n, treatments as ordered, ition the resident every hour open area. Progress Notes from 1/16/16 led the following: d resident had ongoing on coccyx d resident had ongoing on coccyx d resident had ongoing on coccyx which was n was applied as ordered. d resident skin was prised area on coccyx was 1.0 cm x 1.4 cm, wound lated with macerated edges pink. In addition, the note had been noted to both 1 for opening. The note open wound had been dressing had been applied. I the pressure related wound red 3.0 cm x 2.0 cm x 0.0 100% yellow slough, edges nacerated. ssistant Second Floor sheet, a component of the staff to "Reposition every	F	282			

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Facility ID: 00945

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CENTERS FOR MEDICARE & MEDICAID SERVICES					<u> </u>	MR NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245394	B. WING	100-000 -0007	ดการสุดสารทั้งการการสุดสารทั้งสารที่ เสียง เสียงการเกมสารที่สารที่ เสียงการเกมสารที่ เหตุการสารการการการการการ 	03/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST				71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	coccyx. The DON s to conduct weekly s ensure the assess stated she expecte accordance with in and to report any c to the nurse who w conduct an assess On 3/8/16, at 12:14 coordinator, was in watch her (R2) close the area re-openin supposed to be rep directed by the car On 3/8/16, at 4:13 the coccyx wound 2/27/16 to 3/4/16. R4 was continuous 7:36 a.m. to 9:38 a with the bead eleve R4 was interviewed whether staff had cares, R4 nodded At 9:40 a.m. on 3/8 stated he was assi asked when R4 ha stated NA-A had re a.m. At 9:50 a.m. on 3/8 R4's room, and as get up, R4 decline At 9:52 a.m. on 3/8	stated she expected the nurse skin assessments and to ments were accurate. She also d staff to provide care in dividual resident's care plans, oncerns including skin issues, rould then be expected to ment. 4 p.m. RN-B, the MDS iterviewed and stated "we sely because of the history of g." RN-B also verified R2 was bositioned every hour as e plan. p.m. RN-A stated he'd verified had increased in size from sly observed on 3/8/16, from i.m. lying in bed on his back ated approximately 45 degrees. d at 9:38 a.m. and was asked assisted him with morning and stated "yes." B/16, NA-B was interviewed and igned to R4 for the shift. When id last been repositioned, NA-B epositioned R4 around 7:30 B/16, NA-A and NA-B entered ked the resident if he wanted to d. B/16, the NA's were observed to		282			
		pillows were observed to have					

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Facility ID: 00945

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PRINTED: 03/25/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 245394 8. WING 03/08/2016 NAME OF PROVIDER OR SUPPLIER 245394 8. WING 03/08/2016 GOLDEN LIVINGCENTER - LYNNHURST 30/08/2016 93/08/2016 93/08/2016 MALE OF PROVIDER OR SUPPLIER 30/08/2016 92/08/2016 93/08/2016 GOLDEN LIVINGCENTER - LYNNHURST SUMMARY STATEMENT OF DEFICIENCIES 93/08/2016 93/08/2016 MALE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES 92/07/08/07/2004/2016 93/08/2016 GOLDEN LIVINGCENTER - LYNNHURST SUMMARY STATEMENT OF DEFICIENCIES 92/07/07/07/07/07/07/07/07/07/07/07/07/07/	CENTERS FOR MEDICARE & MEDICAID SERVICES					Ç	MB NO.	0938-0391	
NAME OF PROVIDER OR SUPPLIER In the observed of the second part of the second	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA						
GOLDEN LIVINGCENTER - LYNNHURST 471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST SUMMARY STATEMENT OF DEFICIENCIES (EACH OPENDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In PAETK TAG PADULER IS LAN OF CORRECTION (EACH OPENTIFYING INFORMATION) COMPLETA (CAGSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 17 been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the back again. NA-8 elevated the bed at approximately 45 degrees. F 282 A 19:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, preakfast had been assisting residents who smoked in the smoking room. F R4 was observed on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated fA was supposed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to find an NA to thur R4 to his side. A 110:48 a.m., LPN-A stated she would have expected the NA's to follow R4's care plan and to have reported to her immediately if they were not able to reposition resident timely as resident was at a high risk for pressure ulcers. At 10:58 a.m. NA-A stated he was aware FA was supposed to be reposition resident timely as resident was at a high risk for pressure ulcers. At 10:58 a.m. NA-A stated he was aware FA was supposed to be reposition resident timely had hough NA-B.			245394	B. WING	,		03/0	03/08/2016	
SAINT PAUL, MN 55104 (M) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FEGULATIONY OR LSC DENTIFYING INFORMATION) ID PREFX TAG PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CAROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 17 been in place behind F4's back. The NAs slid Fl4 up in the bed and turned the resident from the right to the left, and then positioned Fl4 on the back again. NA-B elevated the bed at approximately 45 degrees. F 282 At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been served late that morning, and that he had been assisting residents who smoked in the smoking room. F 4 was observed on 3/8/16 again from 9:57 a.m. to 10:39 a.m. on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated R4 was at posed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to ind an NA to that he ywer not able to reposition resident timely as resident was at a high risk for pressure ulcers. At 10:53 a.m. NA-A stated he was aware F4 was supposed to be turned from side to side but had though NA-B was going to the offlow R4's care plan and to have reported to her immediately if they were not able to repositioned side to side but had though NA-B was going to the offlow R4's care plan and to have reported to her immediately if they were not able to repositioned side to side but had though NA-B was going to	NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
White PREER/ TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING NFORMATION) PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CAROSS-REFERENCE OT OTHE APPROPRIATE DEFICIENCY) F 282 Continued From page 17 been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the right to the loft, and then positioned R4 on the back again. NA-8 elevated the bed at approximately 45 degrees. F 282 At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been assisting residents who smoked in the smoking room. F 4 was observed on 3/8/16 again from 9:57 a.m. to 10:39 a.m. on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated R4 was supposed to be turned from side to side as the resident was at high risk for pressure ulcers. LPN-A stated she was going to ind an NA to turn R4 to his side. At 10:48 a.m. LPN-A stated she was at high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware FA was supposed to be turned from side to side but had though NA-B. was agoing to binder NA to turn R4 to have expected the NA's to follow R4's care plan and to have exported to her immediately if they were not able to repositioned side to side but had though NA-B. was agoing to the side to side but had though NA-B. was agoing to the construction.	GOLDEN	LIVINGCENTER - LY	(NNHURST						
PAGE/IX TAG IEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC DENTIFYING INCOMATION) PAGE/IX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY) F 282 Continued From page 17 been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the back again. NA-B elevated the bed at approximately 45 degrees. F 282 At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been assisting residents who smoked in the smoking room. R4 was observed on 3/8/16 again from 9:57 a.m. to 10:39 a.m., on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated R4 was supposed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to find an NA to turn R4 to his side. At 10:48 a.m. LPN-A stated she would have expected the NA's to follow R4's care plan and to have reported to her immediately if they were not able to repositioned was aware R4 was supposed to be threpositioned side to side at the devident Was at a high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware R4 was supposed to be threpositioned side to side tha thad holy NA-M stated he was aware R4 was supposed to be threpositioned side to side that the othol NA-M was going to find as that that the resident was at a high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware R4 was supposed to be repositioned side to side but had thought NA-M was going to find to that head the was othe torepositioned side to side but had thought NA-M was going to find to		12. martin							
 been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the right to the left, and then positioned R4 on the back again. NA-B elevated the bed at approximately 45 degrees. At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been olfered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been served late that morning, and that he had been assisting residents who smoked in the smoking room. R4 was observed on 3/8/16 again from 9:57 a.m. to 10:39 a.m., R4 remained on his back as he slept. At 10:39 a.m. on 3/8/16, LPN-A verified R4 was lying on his back and verified H6 Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated R4 was supposed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to find an NA to turn R4 to his side. At 10:48 a.m. LPN-A stated she word thave expected the NA's to follow R4's care plan and to have reported to her immediately if they were not able to reposition resident timely as resident was at risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware R4 was supposed to be turposition resident timely as resident was at high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was going to her immediately if they were not able to reposition 	PREFIX	(EACH DEFICIENC'	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	COMPLETION	
put a pillow behind the resident after he had assisted NA-B to reposition R4 at 9:52 a.m. R4's Pressure Ulcer CAA dated 1/8/16, indicated R4 was at risk for the development of pressure ulcers due to multiple sclerosis,	F 282	been in place behir up in the bed and t right to the left, and back again. NA-B e approximately 45 c At 9:57 a.m. on 3/8 R4 had not been o a.m., for a total of NA-B stated NA-A had been served la had been assisting smoking room. R4 was observed o to 10:39 a.m., R4 r slept. At 10:39 a.m. on 3 lying on his back a Group C assignment plan of care, direct LPN-A stated R4 v side to side as the pressure ulcers. L find an NA to turn LPN-A stated she to follow R4's care her immediately if resident timely as pressure ulcers. A was aware R4 was side to side but ha put a pillow behind assisted NA-B to r R4's Pressure Ulc R4 was at risk for	hd R4's back. The NAs slid R4 urned the resident from the d then positioned R4 on the elevated the bed at legrees. 3/16, NA-A and NA-B verified ffered repositioning since 7:30 two hours and 22 minutes. had been on break, breakfast ate that morning, and that he residents who smoked in the on 3/8/16 again from 9:57 a.m. remained on his back as he /8/16, LPN-A verified R4 was ind verified the Second Floor ant sheet, a component of the ted "Keep pressure off coccyx." vas supposed to be turned from resident was at risk for PN-A stated she was going to R4 to his side. At 10:48 a.m. would have expected the NA's e plan and to have reported to they were not able to reposition resident was at a high risk for At 10:55 a.m. NA-A stated he is supposed to be repositioned id thought NA-B was going to 1 the resident after he had reposition R4 at 9:52 a.m. er CAA dated 1/8/16, indicated the development of pressure		282				

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Facility ID: 00945

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FORM APPROVED	PRINTED:	03/25/2	2016
	FORM	APPRO	VED

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245394	8, WING	No. of Contraction		03/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	hemiplegia/hemipa cognitive loss, and R4's care plan revit had potential for im risk for pressure ul extensive assist wi repositioning and b and bladder. The c a history of open al diagnoses for traur sclerosis and left s directed "Nurse to inspection, turn and and as needed whe R4's Physician Orc resident wound orc coccyx, denuded (epidermis (the out surface area). Cha During review of th notes, and Weekly 3/7/16, it was revea 3/7/16, documenta ongoing denuded a the Wound Evalua indicated the denu identified as a Stag On 3/8/16, at 1:15 expected the NA's of care to provide i	resis, incontinence, immobility, delirium that limited mobility. sed 3/7/16, identified resident opaired skin integrity, was at cers related to requiring th bed mobility, turning and being incontinent of both bowel ware plan identified also R4 had reas, had confounding matic brain injury, multiple ided hemiplegia. The care plan conduct weekly skin d reposition every two hours en in bed." der dated 3/8/16, indicated ders as "Foam dressing to a loss of some or all of the er layer) leaving a denuded ange daily and when soiled." he interdisciplinary progress y Skin Reviews dated 2/1 to aled that on 2/14, 2/28 and ation indicated R4 had an area on the coccyx. In addition, tion Flow sheet dated 3/7/16, ded coccyx area had been ge 2 pressure ulcer. p.m. the DON stated she to follow each resident's plan		282			
	supposed to check RN-A stated, "they	k each resident's skin weekly. y are supposed to do it and R [Medication Administration					

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Event ID:ZGKC11

Facility ID: 00945

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PRINTED:	03/25/2016
FORM A	PPROVED
OMB NO, (938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245394	B. WING		108/A-10-10/1-7-A	03/0	8/2016
1	PROVIDER OR SUPPLIER I LIVINGCENTER - LY	INNHURST		STREET ADDRESS, CITY, 471 LYNNHURST AVEN SAINT PAUL, MN 551	JE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROP EFICIENCY)	86	(X5) COMPLETION DATE
F 282	denuded area, RN- skin was gone and covering/coat. The undated Skin I treatment protocol and denuded areas pressure, moisture guideline indicated responsible for per evaluation/observa Weekly Skin Revie indicated if a reside	A stated the top layer of the A stated the top layer of the was covered with a white Integrity Guideline indicated the goals for stage I, reddened s were to protect from and prevent further injury. The licensed nurses were forming a skin tion weekly utilizing the w. In addition, the guideline ent had been identified with a grity the care plan was to be		282			
	treatment protocol and denuded areas pressure, moisture guideline indicated responsible for per evaluation/observa Weekly Skin Revie addition, the guide	ation weekly utilizing the w UDA (facility wound form). In line indicated if a resident had h a decline in skin interity the		Facility ID: 00945			Page 20 of 46

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			O	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245394	B, WING	www.wines	AD ANY TELEVISYON AND ANY	03/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	nge 20	F	282			
		e implemented and followed.					
F 314 SS=G	483.25(c) TREATM		F:	314	F314 •R 9 no longer resides in the facilit and R4 have been comprehensive		
	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores rec	prehensive assessment of a y must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having seives necessary treatment and e healing, prevent infection and from developing.			assessed and risk factors identified prevent further breakdown. Woun system and interventions to monito in place to assure issues are timel recognized, assessed, and reporte practitioner, nurse, and physician f addressed. Weekly wound rounds done per facility protocol.	d UDA or skin y od to o be s to be	
	by: Based on observa review, the facility reassess and iden prevent further skii identification of pre residents (R2, R4, facility failed to pro determine whether effective to promot pressure ulcers (p involving epidermis superficial and pre blister, or shallow R2 sustained actu	NT is not met as evidenced ation, interview and document failed to comprehensively tify risk factors in order to in breakdown following essure ulcers for 3 of 4 R9) reviewed. In addition, the ovide care, and failed to r current treatment was the healing, for current stage II artial thickness skin loss is, dermis, or both. The ulcer is issents clinically as an abrasion, crater) for 1 of 4 residents (R2). al harm when the resident e and/or recurring stage II the coccyx.			 All residents at risk for skin break have the potential to be affected if assessed, risk factors identified, a interventions implemented to prev further breakdown Education completed to nursing s identifying residents at risk for skin breakdown and interventions for prevention and healing. DNS/designee to complete rando weekly audits to ensure skin check wound documentation are complet care is being provided per care plate DNS is responsible. Results of these audits will be revented to the state of the second se	not nd ent taff on n m ks and ted, an.	
		а.т., пursing assistant (NA)-C е assisting R2 with morning			by QAPI •Completion date is 4-17-16		
	Ec7/02.00) Provious Version	e Obcolata Evant ID: 7GKC	· ·	Ľ-	cility ID: 00945	tion sheet	Page 21 of 4F

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Facility ID: 00945

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	03/25/2016
FORM	APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245394 B. WING 03/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 471 LYNNHURST AVENUE WEST	CENTER	S FOR MEDICARE	& MEDICAID SERV					0938-0391
INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P COOE 47 LYNHURST APPLICENT SURMARY STATEMENT OF DEFICIENCIES (CAD) ESPICIANCY USET EF PRACEED BY FULL (EAD) ESPICIANCY USET EFFORMATION (EAD) ESPICANCH USET EFFORMATION (EAD) ESPICIANCY USET EFFORMATION	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA (X2) N				
IMME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STREE_P2 CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS. CITY. STREE_P2 CODE (M) D SUMMARY STREMENT OF DEFICIENCIES PARTY FAD SUMMARY STREMENT OF DEFICIENCIES PARTY TAG STREET ADDRESS CITY, STREE_PIC CORRECTON COROS STREET ADDLOS E Continued From page 21 Cares F 314 Cares On 3/8/16 at 7.46 a.m., Ilconsed practical nurse F 314 Wereday and Fiday) but that she had placed a call to the nurse practitioner (NP) to get orders F 314 Care on the unit. During an observation on 3/8/16 at 8:04 a.m., RN-A and LPN-A and streament. LPN-A stated the decase she felt the wound care on the unit. During an observation on 3/8/16 at 8:04 a.m., RN-A and LPN-A was then incoccyx, tw			245394	8. WI	NG	an a	03/	08/2016
PARE/K TAG LEACH CORRECTS ADDITION SHOLLO BE EQULATORY OR LISC IDENTIFYING INFORMATION) PREV TAG CEACH CORRECTS ADTIVE ADTION SHOLLO BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY Converting and the appropriate DEFICIENCY <thconver< td=""><td></td><td></td><td>INNHURST</td><td><u></u></td><td>47</td><td>1 LYNNHURST AVENUE WEST</td><td></td><td></td></thconver<>			INNHURST	<u></u>	47	1 LYNNHURST AVENUE WEST		
cares. On 3/8/16 at 7:46 a.m., licensed practical nurse (LPN)-A stated R2 had a foam dressing in place over a pressure uicer. LPN-A stated the dressing was being changed three times a week (Monday, Wednesday and Friday) but that she had placed a call to the nurse practitioner (NP) to get orders to change the current treatment because she felt the wound, which was on the resident's coccyx, could use additional treatment. LPN-A also stated she was wailing for registered nurse (RN)-A, the nurse manager, to assess the wound's progress because RN-A was the nurse who provided wound care on the unit. During an observation on 3/8/16 at 8:04 a.m., RN-A and LPN-A entered R2's room to provide care to the resident's coccyx, wo wounds were gloves during the observation. When RN-A spread the skin around the coccyx, two wounds were observed. RN-A stated he had last measured the wound on Friday 3/4/16, at which time R2 had only one wound. RN-A measured the original wound as 2.3 centimeters (cm) x 2.0 cm x 0.2 cm and described it as an irregular stage II with a wound bed covered by 90% yellow necrotic tissue with 10% granulating tissue. RN-A also stated the wound edges were macareted. RN-A then went on to measure the newly acquired stated it wound deges were macareted. RN-A then wound on Fin-A described the stage II pressure area located on the inferior of the coccyx. The new area was measured as 0.4 cm 0.4 cm x 0.1 cm. RN-A described the wound bed as being covered with yellow necrotic tissue with defined edges. RN-A described the wound bed as being covered with yellow necrotic tissue with defined edges. RN-A described the wound bed as being covered with yellow necrotic tissue with defined edges. RN-A and LPN-A verified they had been nuaware of the new wound and that no staff had reported the presence of the second wound. Consequently, the new wound had not been assessed. At 8:16 a.m., LPN-A was	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	FULL PR	EFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
had not been assessed. At 8:16 a.m., LPN-A was	F 314	cares. On 3/8/16 at 7:46 at (LPN)-A stated R2 over a pressure ull was being changed Wednesday and F a call to the nurse to change the curre the wound, which to could use addition she was waiting fo nurse manager, to because RN-A way wound care on the During an observa RN-A and LPN-A at care to the resider wore gloves during spread the skin ar were observed. Rif measured the would time R2 had only of original wound as 0.2 cm and descrif with a wound bed tissue with 10% gastated the wound then went on to m stage II pressure at the coccyx. The r cm x 0.8 cm x 0.1 wound bed as bein tissue with defined verified they had to and that no staff h	a.m., licensed practic had a foam dressing cer. LPN-A stated the d three times a week riday) but that she ha practitioner (NP) to g ent treatment becaus was on the resident's al treatment. LPN-A a r registered nurse (R assess the wound's s the nurse who prove unit. tion on 3/8/16 at 8:04 entered R2's room to at's coccyx wound. B g the observation. W ound the coccyx, two N-A stated he had las and on Friday 3/4/16, one wound. RN-A me 2.3 centimeters (cm) bed it as an irregular covered by 90% yello ranulating tissue. RN- edges were macerate easure the newly acc area located on the irr new area was measure covered with yello d edges. RN-A and Lib peen unaware of the presentation.	al nurse in place e dressing (Monday, id placed et orders se she felt coccyx, also stated N)-A, the progress ided 4 a.m., provide oth staff hen RN-A wounds st at which asured the x 2.0 cm x stage II ow necrotic -A also ed. RN-A juired iferior of red as 0.4 if the w necrotic PN-A new wound ence of the	F 314			
	FORM CHS 2	had not been asse	essed. At 8:16 a.m., l	_PN-A was	Fa	Nity ID: 00945	onlinuation shoe	1 Pane 22 of 41

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A, BUILDING B. WING 245394 03/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST GOLDEN LIVINGCENTER - LYNNHURST** SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 **Continued From page 22** F 314 overheard indicating the nurse practitioner (NP) had ordered Hydrogel (a dressing that provides an ideal environment for cleaning the wound and allowing the body to rid itself of necrotic tissue) to be applied to the wound, and to cover it with a clear dressing, At 8:18 a.m. LPN-A left the room and RN-A was observed take the Q-tip (cotton tipped applicator) he had used to measure the wound depths, applied a pea size of Hydrogel to the wound bed and edges, then applied a clear dressing over the large wound. RN-A was not observed to have cleansed the wounds prior to the application of the Hydrogel. At 8:19 a.m. LPN-A returned to the room, applied a pair of gloves, removed the dressing RN-A had just applied, cleansed the wound with wound cleanser, applied a small amount of Hydrogel, then applied a new clear dressing over both wounds. At 8:25 a.m. the nurses repositioned R2 to his back and left the room. On 3/8/16, at 8:27 a.m. RN-A stated he expected the nursing assistants who provided daily care, to immediately report all skin concerns to the nurse so that an assessment could be done. RN-A again acknowledged the new open area next to the existing coccyx wound had not been assessed and identified. RN-A stated R2 required total physical assistance with all cares including incontinence cares, turning and repositioning so he would have expected someone to have seen the concern and reported it. On 3/8/16, at 9:00 a.m. R2 was observed seated in a wheelchair at the dining room. R2's wheelchair was observed to tilted slightly backwards. At 9:41 a.m. LPN-A was observed to wheel R2 to the bedroom and to leave again. At 10:38 a.m. NA-C and NA-B were observed to

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Facility ID: 00945

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245394	B, WING	tool man		03/0	8/2016
	ROVIDER OR SUPPLIER	INNHURST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
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F 314	leave R2's room all her bed, where she During interview w 3/8/16, he stated h down in bed at abo interviewed immed did not work with F was supposed to b During interview w 3/8/16, LPN-A stat a.m" (Indicating re 55 minutes withou how often resident repositioned, LPN- verified R2 had be pressure ulcers ar on the coccyx. LPI received assistand 10:48 a.m. LPN-A to follow all reside concerns about re when they were ru residents. LPN-A report issues with she could get help an open area. R2's pressure ulce (CAA) dated 10/8/ potential for impai incontinence of bo on staff for changi requiring extensiv turning, reposition	iter having transferred R2 to a was positioned on her back. Ith NA-A at 10:42 a.m. on the had assisted NA-C to lay R2 but 10:25 a.m. NA-B was liately after NA-A and stated he R2 however, NA-B stated R2 be repositioned every one hour. Ith LPN-A at 10:44 a.m. on ed, "We got her up around 8:30 sident had been up 1 hour and t repositioning). When asked t was supposed to be A stated every hour. LPN-A en identified at risk for id had an actual pressure ulcer N-A also verified R2 had not be to reposition as required. At stated she expected the NA's ints' care plans, to report any sidents' skin, and to report inning late with repositioning also stated the NA's needed to running late immediately so to reposition R2 since she had er Care Area Assessment 15, identified R2 as having a red skin integrity related to owel and bladder, dependence ing and pericare, and as e assistance with bed mobility, ing and off-loading. The CAA was at risk for pressure ulcer		314			

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNN	NHURST			RST AVENUE WEST L, MN 55104		
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identified diagnoses in hemiparesis, type II di peripheral neuropathy further indicated R2 h cognitive skills, and hi memory problems, re- physical assistance of activities of daily living toileting, personal hyg addition, the MDS ind unhealed pressure uk risk for developing pro- R2's care plan dated potential for impaired assistance with bed n repositioning, off-load included: "Skin will re Care plan intervention daily observation of R report alterations to n weekly skin inspection and to turn and repos and as needed due to During review of the R through 3/7/16, revea - On 1/16/16, indicate pink, scar tissue area - On 2/13/16, indicate compromised area or slightly red and cream - On 2/27/16, indicate assessed, the compro open, area measured bed was 100% granu and peri-wound was	Set (MDS) dated 12/23/15, including hemiplegia, diabetes, idiopathic y, and dementia. The MDS had severely impaired had both short and long term equiring total to extensive of one to two staff with all g including transferring, giene and bed mobility. In dicated R2 did not have any leers and identified R2 as at ressure ulcers. 1/4/16, indicated R2 had the d skin integrity related to total mobility, turning and ding and transfers. The goal emain free from breakdown." ins directed staff to conduct R2's skin with all cares, hurse, nurse to conduct on, treatments as ordered, sition the resident every hour o open area. Progress Notes from 1/16/16 aled the following: ed resident had ongoing a on coccyx ed resident had ongoing on the coccyx which was m was applied as ordered.	Fa	14			

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NAME OF PROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHUR	ST			71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 314 Continued From page 25 buttocks with potential for of further indicated the open vi- cleansed and a foam dress - On 3/7/16, indicated the p- on the coccyx measured 3. cm. Wound bed was 100% were undefined and macer. An undated nursing assista Group B assignment sheet "Reposition every one hour On 3/8/16, at 11:16 a.m. the (DON) pulled up an assess which indicated R2 had onl coccyx. The DON stated sh to conduct weekly skin ass ensure the assessments w stated she expected staff to accordance with individual and to report any concerns to the nurse who would the conduct an assessment. On 3/8/16, at 12:14 p.m. R coordinator, was interviewed watch her (R2) closely bec- the area re-opening." RN-E supposed to be repositioned directed by the care plan. On 3/8/16, at 2:51 p.m. RN assessed the wound on the 3/4/16. RN-A stated nurses assess the area as indicated dated 1/16/16, 2/13/16, and these progress notes had ia areas and did not include r information related to the s 	wound had been sing had been applied. Tressure related wound 0 cm x 2.0 cm x 0.0 yellow slough, edges ated. ant Second Floor , directed staff to until buttocks healed." e director of nursing sment dated 3/4/16, by one wound on the ne expected the nurse essments and to rere accurate. She also o provide care in resident's care plans, including skin issues, in be expected to N-B, the MDS ed and stated "we ause of the history of a also verified R2 was ed every hour as I-A stated he had last e coccyx on Friday s were supposed to ed in Progress Notes d 2/27/16. Each of identified redness/pink more specific	F	314			

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<u>_CENTE</u> F	IS FOR MEDICARE	& MEDICAID SERVICES				<u>JWR NO'</u>	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONST A. BUILDING				E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER				8	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST					171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)			(X5) COMPLETION DATE
F 314	Continued From page 26			314			
	On 3/8/16, at 4:13 the coccyx wound 2/27/16 to 3/4/16.	p.m. RN-A stated he'd verified had increased in size from					
	R4 was continuously observed on 3/8/16, from 7:36 a.m. to 9:38 a.m. lying in bed on his back with the bead elevated approximately 45 degrees. R4 was interviewed at 9:38 a.m. and was asked whether staff had assisted him with morning cares, R4 nodded and stated "yes." At 9:40 a.m. on 3/8/16, NA-B was interviewed and stated he was assigned to R4 for the shift. When asked when R4 had last been repositioned, NA-B stated NA-A had repositioned R4 around 7:30 a.m.						
		3/16, NA-A and NA-B entered ked the resident if he wanted to d.					
	reposition R4. No been in place behi up in the bed and right to the left, an	3/16, the NA's were observed to pillows were observed to have nd R4's back. The NAs slid R4 turned the resident from the d then positioned R4 on the elevated the bed at degrees.					
	R4 had not been of a.m., for a total of NA-B stated NA-A had been served I	B/16, NA-A and NA-B verified offered repositioning since 7:30 two hours and 22 minutes. had been on break, breakfast ate that morning, and that he g residents who smoked in the					
	R4 was observed	on 3/8/16 again from 9:57 a.m.				an a	

Facility ID: 00945

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST				4	TREET ADDRESS, CITY, STÄTE, ZIP CODE 71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
an a							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
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Facility ID: 00945

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	03/25/2016
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<u>CENIER</u>	IS FOR MEDICARE	A MEDICAID SE	HVILES					NO. 0936	<u>-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUP IDENTIFICATION		• •	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		24539	94					03/08/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST				47	REET ADDRESS, CITY, STATE, ZIP COD 1 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	E			
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F 314	 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 R4's Physician Order dated 3/8/16, indicated resident wound orders as "Foam dressing to coccyx, denuded (a loss of some or all of the epidermis (the outer layer) leaving a denuded surface area). Change daily and when soiled." During review of the interdisciplinary progress notes, and Weekly Skin Reviews dated 2/1 to 3/7/16, it was revealed that on 2/14, 2/28 and 3/7/16, documentation indicated R4 had an ongoing denuded area on the coccyx. In addition, the Wound Evaluation Flow sheet dated 3/7/16, indicated the denuded coccyx area had been identified as a Stage 2 pressure ulcer. On 3/8/16, at 1:15 p.m. the DON stated she expected the NA's to follow each resident's plan of care to provide resident care. On 3/8/16, at 2:23 p.m. RN-A stated staff were supposed to check each resident's skin weekly. RN-A stated, "they are supposed to do it and sign off on the MAR [Medication Administration Record]." When asked for a description of the denuded area, RN-A stated the top layer of the skin was gone and was covered with a white covering/coat. When asked if the nurses were supposed to measure the denuded area, RN-A stated he was going to check what the facility policy directed. When asked about R4's skin concern, RN-A verified again that R4 had a denuded area on his coccyx. When asked about the 3/7/16 wound documentation, RN-A stated he had assessed the area on 3/4/16, which was 			314	DEFICIENCY				
	Friday then compl Monday three day							out, and and the second s	
	On 3/8/16, at 2:49				E-		atinuation	haat Deet	20.06.4
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STATEMENT OF DEFICIENCIES (X	(1) PROVIDER/SUPPLIER/CLIA				¢	1
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER	<u></u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNI	NHURST			1 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
and thought he had n staging of the denude the facility policy. The facility's undated indicated the treatme reddened and denude from pressure, moist injury. The guideline i were responsible for evaluation/observatio Weekly Skin Review. indicated if a resident decline in skin integri implemented and foll R9 was not compreh- identify risk factors in further skin breakdow was identified by staf R9's plan of care initi potential for skin inte extensive assist for to mobility, and was inc be turned and reposi "Offload [prevention of re-distribute pressure able to reposition wh was updated on 3/8/ every one hour after identified. The pressure Ulcer O indicated R9 was at a pressure ulcers due	he wound documentation nade a mistake with the ed coccyx area and provided I Skin Integrity Guidelines, ent protocol goals for stage I, ed areas were to protect ure and prevent further indicated licensed nurses performing a skin on weekly utilizing the . In addition, the guideline t had been identified with a ity the care plan was to be lowed. The servent potential wn, after a pressure ulcer if on R9's buttocks on 3/8/16. iated on 11/12/14, for ordinent of bowel. R9 was to itioned per assessment. of skin breakdown - to e] on rounds when in chair, iile in bed." The care plan 16, to turn and reposition the Stage 2 ulcer was	Fa	314			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	B, WING		nin under start war war with the interval of the additional and a start and a	03/08/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST					71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 30	F	314			
		e Skin Assessment dated could sit in a chair and lie in					
		g assistant assignment sheet ted the staff to off load the					-
		l on the afternoon on 3/7/16, at 3/9/16, at 7:37 a.m. lying on					
	On 3/8/16, at 8:23 and stated R9 had	a.m. the DON was interviewed no open areas.					
	and stated R9 had she had informed a.m. LPN-B was in looked at R9's bott	5 a.m. NA-E was interviewed a reddened bottom and the LPN-B of that today. At 10:50 terviewed and stated she'd om and the resident had a hat was blanchable.					
	a.m. with the DON the resident had a coccyx. The wound cm. The wound be slough and 20% g resident's room du she had been in th	bserved on 3/8/16, at 11:15 . At that time, the DON stated Stage 2 pressure ulcer on the d measured 0.8 cm x 0.3 x 0.1 id was described as 80% ranulation. NA-E, present in the ring the observation, stated e room earlier, but she had not R9 over to look at the coccyx.					
	effective 7/8/15, di resident with a pre services to promo Staff were to asse	for Pressure Ulcer Review rected staff to ensure that a ssure ulcer received care and the healing of the pressure ulcer. ss the resident if the resident wn and were to develop				normaliyah data jung taka jung kan	

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Facility ID: 00945

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CENTERS FOR MEDICARE & MEDICAID SERVICES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	• •	G	COM	PLETED
		B. WING		03/	08/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	'NNHURST		471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		Aurolan da Bayr May Printernation
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314 F 323 SS=D	Interventions to pro 483.25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents. This REQUIREME by: Based on observa review, the facility f	T is not met as evidenced NT is not met as evidenced tion, interview and document tailed to ensure fall intervention	F 31 F 32		been d as to be to be r ms per	
	and prevention techniques were implemented for 1 of 3 residents (R10) reviewed for accidents. Findings include: R10 was observed on 3/7/16, continuously from 11:40 a.m. through 12:10 p.m. R10's door to the room was wide open from the hallway. R10's bed was in the low position, the head of bed and knee was slightly elevated and R10 was pushing on the footboard with both feet. The right side of the footboard had swung away from the bed at an approximately 25 to 30 degree angle. Nursing assistant (NA)-D placed R9's tray in the room and did not notice R10's ill-repaired footboard. The administrator was walking passed the room and was notified of the bed in need of repair. NA-D was interviewed on 3/7/16, at 12:15 p.m. NA-D indicated they had been working for here for years and when asked if he knew R10's bed			completed. Quarterly room cher inspect beds and other furnishin proper operation and repair as •ED/designee is responsible •Negative results of these audit inspections will be reviewed at QAPI meeting for further recommendation.	ngs for needed. s/	4-17-11

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BATEMENT OF DEPIDENCIES AND RANN OF CORRECTION (X) PROVIDERSUPPLIERLA IDENTIFICATION NUMBER: (X) AULTH-LE CONSTRUCTION A BUILDING (X) PROVIDER CONSTRUCTION CONSTRUCTION (X) PROVIDER CONSTRUCTION PROVIDER CONSTRUCTION FOR CONSTRUC	<u>CENTEP</u>	IS FOR MEDICARE	<u>& MEDICAID SERVICES</u>				<u>OMR NO.</u>	0938-0391
NAME OF PROVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AT LININHURST AVENUE WEST SUMMARY STREMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE AT LININHURST AVENUE WEST SUMMARY STREMENT OF DEFICIENCIES (EAC) DEFICIENCIES DUE NOT EXCLOSED BY FULL (EAC) DEFICIENCIES DUE NOT EXCLOSED BY FULL (EAC) DEFICIENCIES UND TO SCIENCIENCIES (EAC) DEFICIENCIES DUE NOT EXCLOSED BY FULL (EAC) DEFICIENCIES DUE NOT EXCLOSED BY FULL (EAC) DEFICIENCIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (EAC) DEFICIES (E				1				
GOLDEN LIVINGCENTER - LYNNHURST 471 LYNNHURST AVENUE WEST SANT PAUL, MN 55104 COLDEN LIVINGCENTER - LYNNHURST GAIN DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL TAG PRETX TAG REQUATORY OR LSC DENTIFYING INFORMATION) D PRETX TAG PRETX TAG PRETX TAG PRETX TAG PRETX TAG PRETX TAG COMPLETION (EACH OEFICIENCY MUST BE PRECEDED BY FULL TAG PRETX TAG PRETX TAG PRETX TAG COMPLETION (EACH OEFICIENCY) COMPLETION (EACH OEFIC	L		245394	B. WING		nya nyawa wakawa na na wakawa na	03/	08/2016
Philiping TAG reach deprication with the PRECEDED BY Full. PREX TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COUNTRY OR USE DENTIFYING NUMBER DEFICIENCY F 323 Continued From page 32 needed repair he indicated there were a "lot of beds here" that needed repair and he had reported them to corporate but the beds still did not get fixed. NA-D was unable to provide any more information on what beds were in need of repair when asked during the interview. F 323 R10's care plan dated 1/5/15, indicated R10 was at risk to risk to tails due to unsteady stilling and standing balance and was an assist of two to transfer using a mechanical lift. A one page typed note undated and untilled was provided which indicated R10 had fallen from the bed on 6/8/15 and 9/2/15. Both falls were from the side of the bed. The administrator was interviewed on 3/7/16, at 3:16 p.m., he indicated there was no work order that could be located for R10's bed. The administrator revealed a both had snapped of the lootboard allowing the footboard to swing away from the bed. The administrator went conto to note that the foot and head boards are to be checked by the maintenace department at least quarely. He commented R10's bed was last checked on 12/22/15. He acknowledged R10'b did side down in bed even with the knees elevated and put his feat n against the footboard. F 329 Staol Each resident's drug regimen must be free from unkneessary drug. An unnecessary drug is any drug when used in excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of F 329					47	1 LYNNHURST AVENUE WEST		
 needed repair he indicated there were a "lot of beds here" that needed repair and he had reported them to corporate but the beds still did not get fixed. NA-D was unable to provide any more information on what beds were in need of repair when asked during the interview. R10's care plan dated 1/5/15, indicated R10 was at risk for falls due to unsteady sitting and standing balance and was an assist of two to transfer using a mechanical lift. A one page typed note undated and untilled was provided which indicated R10 had fallen from the bed on 6/8/15 and 9/2/15. Both falls were from the side of the bed and not the foot of the bed. The administrator was interviewed on 3/7/16, at 3:16 p.m. he indicated there was no work order that could be located for R10's bed. The administrator revealed a bolt had snapped off the footboard allowing the footboard to swing away from the bed. The administrator was not to note that the foot and head boards are to be checked by the maintenance department at least quarterly. He commented R10's bed R10 distide down in bed even with the knees elevated and put his feet on against the footboard. F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNECESSARY DRUGS 	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	
without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	needed repair he in beds here" that neu reported them to c not get fixed. NA-E more information c repair when asked R10's care plan da at risk for falls due standing balance a transfer using a mo A one page typed in provided which indi- bed on 6/8/15 and the side of the bed The administrator 3:16 p.m. he indica that could be locat administrator reve footboard allowing from the bed. The that the foot and h by the maintenance He commented R 12/22/15. He ackn in bed even with th feet on against the 483.25(I) DRUG R UNNECESSARY I Each resident's dr unnecessary drug drug when used in	ndicated there were a "lot of eded repair and he had orporate but the beds still did b was unable to provide any on what beds were in need of during the interview. Atted 1/5/15, indicated R10 was to unsteady sitting and and was an assist of two to echanical lift. note undated and untitled was licated R10 had fallen from the 9/2/15. Both falls were from I and not the foot of the bed. was interviewed on 3/7/16, at ated there was no work order ed for R10's bed. The aled a bolt had snapped off the the footboard to swing away administrator went onto to note ead boards are to be checked be department at least quarterly. 10's bed was last checked on lowledged R10 did slide down he knees elevated and put his a footboard. EGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any texcessive dose (including					
	FORM CME 2	indications for its u	use; or in the presence of		Far	ility ID: 00945	uation choot	Rana 23 ol 44

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		enterende inner	0	<u>MB NO.</u>	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	B. WING	e-toopenet		03/	08/2016
	PROVIDER OR SUPPLIER	NNHURST		47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From page 33 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		F 329		 F329 Resident 5 orthostatic blood pressure monitoring has been implemented, and R10 is no longer receiving antibiotics. All resident receiving medications have the potential to be affected if proper monitoring and justifications for medications are not in place. Nursing staff have been educated on proper monitoring for residents receiving psychotropic, all nursing educated on surveillance criteria for antibiotic use. DNS/designee to complete random weekly audits of psychotropic monitoring and necessity of antibiotic usage 		
	by: Based on observa review, the facility monitoring of an a 5 residents (R5) w (antipsychotic). In ensure 1 of 3 resid asymptomatic did justification. Findings include: On 3/8/16, at 2:21 awake, seated in t approached and in medication, Seroq notice or experien	NT is not met as evidenced ation, interview and document failed to ensure appropriate ntipsychotic medication for 1 of ho used Seroquel addition, the facility failed to lents (R10) who was not receive anti-biotic with p.m. R5 was observed to be he wheelchair. When aterviewed regarding the uel, R5 indicated she did not ce any side effects from the irrently taking and R5 was			•DNS is responsible. •Negative results of these audits v reviewed by QAPI •Completion date is 4-17-16	vill be	

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UENTER	IS FUR MEDICARE	& MEDICAID SERVICES			U		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			03/0	08/2016
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST		3		71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	observed to be rela R5's Physician Ord diagnoses which in Bipolar disorder, m dementia. Furthern Seroquel 25 mg by mg by mouth at ber 12/1/14. R5's care plan date received an antipsy plan did address th and direction for sta that include postura behaviors. Howeve documentation of r pressure monitorin The MAR (Medicat December 2015, J 2016, indicated R5 mouth in the morni bedtime. MAR for f received Seroquel morning and 50 mg On 3/8/16, at 2:19 (LPN)-B confirmed documentation of r pressure monitorin have an order for it it has not been dor On 3/8/16, at 2:23 verify R5's medical of monthly orthosta	ers dated 2/2/16, R5 had cluded personality disorder, ajor depressive disorder, and nore, R5 had an order for mouth in the morning and 75 dtime, which was started on ad 1/19/16, identified R5 yohotic medication. The care the antipsychotic medication aff to monitor for side effects al hypotension, and observe for er, medical record lacked nonthly orthostatic blood g. ion Administration Record) for anuary 2016 and February received Seroquel 25 mg by ng and 75 mg by mouth at March 2016, indicated R5 25 mg by mouth in the g by mouth at bedtime. p.m. licensed practical nurse R5's medical record lacked nonthly orthostatic blood g and indicated, they do not t and that was the reason why		329			
	l blood pressure mo	nitoring should be done and it		deux-u-u-u			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·····		<u> </u>	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY PLETED
		245394	B. WING		กระการการกรุฐางหมะสารกระบานการการการการการการการการการการการการการก	03/0	08/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - LY	NNHURST			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	have not be done. I pharmacy consulta On 3/8/16, at 3:41 µ confirmed R5's me documentation of m pressure monitorin expectation orthost should be done." On 3/8/16 at 3:44 µ stated, monthly orth monitoring is includ monitoring and ass monthly, that was t recommend it. In a expectation is facili orthostatic blood pu Policy and procedu MEDICATION REV. "Review Nursing N side effect monitori effects." R10's Minimum Da indicated R10 had R10's Progress No going back 30 days - On 1/5/16, R10 w room to have a gas tube changed and hospital also change catheter. - On 1/7/16, the ho informed the facility	f it have not been done nt could have recommend it." p.m. director of nursing dical record lacked nonthly orthostatic blood g and mentioned, "My latic blood pressure monitoring b.m. the consultant pharmacist hostatic blood pressure ded in the side effect sume that staff is monitoring it he reason why he did not ddition, PC indicated, his ity staff should monitor		329			

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	8. WING	And a state of the		03/08/2016	
NAME OF F	ROVIDER OR SUPPLIER			Ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 329	updated R10's prim medical record lack assessment for sig the UTI to determin necessary. R10's m of any signs or sym such as a fever, or status. On 3/8/16, at 11:05 was interviewed an medical record lack symptoms of a UT expect staff to follo physician to determ clinically indicated or symptoms of inf change in status. On 3/8/16, at 11:33 from the "old school question the docto the potential for ov The facility's policy the staff and practi- signs and symptom UTIs. The staff we definitions of Infect criteria that defines UTI are resident-sp aggregation of sign the clinical judgme	age 36 hary physician on that day, the ked evidence of any ins and symptoms reflecting he whether the antibiotic was inedical record lacked evidence aptoms of a documented UTI change in the resident's 6 a.m. the director of nursing id she acknowlegded the ked evidence of signs and 1. The DON stated she would wup with the primary nine whether the antibiotic was since R10 displayed no signs ection including fever or 8 a.m. RN-D stated she came of where nurses did not rs, although she was aware of eruse of antibiotics. 9 for UTIs dated 8/14, directed tioner to identify residents with ins suggesting the possibility of re to follow the Surveillance tions of Long Term Care for a UTIs. "Clinical definitions of a pecific and require the ns and symptoms, lab data and int of the interdisciplinary	F	329			
F 356 SS=C	I see a second a second a second as a s	D NURSE STAFFING	F	356			
	The facility must p	ost the following information on					

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CENTERS	FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245394	8. WING	anner vetalannav	หลางกับการการการสารสารการการการการการการการการการการการการกา	03/0	08/2016
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LYNNHURST			47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	A construction and an approximate	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	by the following cat unlicensed nursing resident care per si - Registered nu - Licensed prace vocational nurses (- Certified nurses o Resident census The facility must per specified above on of each shift. Data o Clear and readat o In a prominent pl residents and visite The facility must, u make nurse staffin for review at a cost standard. The facility must m staffing data for a n required by State la This REQUIREME by: Based on observa review, the facility worked for nursing resident care per s addition, the staff p	and the actual hours worked regories of licensed and staff directly responsible for hift: inses. trical nurses or licensed as defined under State law). e aldes. bost the nurse staffing data a daily basis at the beginning must be posted as follows: ble format. ace readily accessible to	F3	356	F356 •Nursing staff hour's posted in accordance with regulations. •Education to staff on location and requirements of posting and maint the daily posted nursing hours. •ED is responsible. •ED/designee to do random week audits of hours posting. •Negative results of these audits v reviewed by QAPI •Completion date is 4-17-16	aining ly	

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Facility ID: 00945

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	03/25/2016
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OMP NO	1000.0001

CENTER	IS FUH MEDILARE	& MEDICAID SERVICES						0838-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL				(X3) DATE SURVEY COMPLETED	
		245394	B. WING	3	2/14/14/14/14/14/14/14/14/14/14/14/14/14/		03/08/2016	
	ROVIDER OR SUPPLIER	NNHURST		4	TREET AODRESS, CITY, STATE, ZIP C 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI	D PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		SHOULD	BE	(X5) COMPLETION DATE
F 356	Continued From pa	age 38	F	356				
	Findings include:							
	facility nursing staff observed on the be	ur on 3/7/16, at 8:05 a.m. the f posting on a wall was shind the nursing station. The ff information was dated census of 68.						
	staff posting forms nursing station des 3/3/16, and 3/4/16,	observations of the nursing posted on the wall behind the k on 2/29/16, 3/1/16, 3/2/16, however there was no nursin 5/16, 3/6/16 and 3/7/16.						
	director on 3/7/16, record director adn nursing staff hour p	with the medical record at 8:05 a.m. the medical ninistrator confirmed the posting was noted posted for 3/7/16 and stated, "It should						
	on 3/7/16, at 9:32 a indicated, "My expo should be posted of	w with the staffing coordinator a.m. the staffing coordinator ectation is nursing staff postin daily. The census was 68 whe ere was a new admit on	9 1					
	3/7/16, at 9:32 a.m	w with the executive director on the executive director on the executive director on the executive director of the expectation is nursing the posted daily."	n					
	review date 8/14/1 will be posted in ac federal regulations	URSING STAFF HOURS last 5, read, "Nursing staff hours ccordance with state and in all facilities. The posting and readable format and					 A standard and a standard an 	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: ZGI	C11	Fa	cliity ID: 00945	continuat	ion sheet F	age 39 of 4

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CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO.	0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		e Survey Pleted
	÷	245394	B. WING	๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛๛	03/	08/2016
	ROVIDER OR SUPPLIER	NNHURST		STREET ADDRESS, CITY, STATE, ZIP 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		<u>An an an Signara</u> A
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 356	••••••••••••••••••••••••••••••••••••••	ent place readily accessible to	F 3!	56		
	483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist muthe attending physi	EGIMEN REVIEW, REPORT	F 4	 28 F428 Resident 5 monthly phan completed. -All residents have the po affected if monthly pharma not completed per regulat •DNS/designee to completed audits to ensure residents monthly medication review 	tential to be acy reviews are ion. te random receive	
	by: Based on observa review, the facility i recommendations for appropriate mo medication for 1 of unnecessary medic Findings include: On 3/8/16, at 2:21 awake, seated in th approached and in medication, Seroqui notice or experience medication that cu observed to be related R5's Physician Orce	NT is not met as evidenced tion, interview and document ailed to act upon the of the consultant pharmacist nitoring of an antipsychotic 5 residents (R5) reviewed for cations. p.m. R5 was observed to be ne wheelchair. When terviewed regarding the uel, R5 indicated she did not the any side effects from the rrently taking and R5 was axed with no behaviors.		 •DNS/Designee/Consulting responsible. •Negative results of these reviewed by QAPI •Completion date is 4-17- 	audits will be	

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245394	B. WING	- Sheen de da	ดีวิธีที่เพื่อสาม คามในการการการการการการการการการการการการการก	03/0)8/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	*	
GOLDEN LIVINGCENTER - LYNNHURST				4	71 LYNNHURST AVENUE WEST		
GOLDEN LIVINGGEN IER - LYNNHUHS I				S	AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Bipolar disorder, m dementia. Furtherm Seroquel 25 mg by mg by mouth at ber 12/1/14. R5's care plan date received an antipsy plan did address th and direction for sta- that include postura behaviors. Howeve documentation of r pressure monitorin The MAR (Medicat December 2015, J 2016, indicated R5 mouth in the morni bedtime. MAR for f received Seroquel morning and 50 mg On 3/8/16, at 2:19 (LPN)-B confirmed documentation of r pressure monitorin have an order for if it has not been dor On 3/8/16, at 2:23 verify R5's medical of monthly orthosta and stated, "My ex blood pressure mon have not be done.	ajor depressive disorder, and hore, R5 had an order for mouth in the morning and 75 dtime, which was started on ad 1/19/16, identified R5 ychotic medication. The care is antipsychotic medication aff to monitor for side effects al hypotension, and observe for er, medical record lacked nonthly orthostatic blood g. ion Administration Record) for anuary 2016 and February received Seroquel 25 mg by ng and 75 mg by mouth at March 2016, indicated R5 25 mg by mouth in the g by mouth at bedtime. p.m. licensed practical nurse R5's medical record lacked nonthly orthostatic blood g and indicated, they do not and that was the reason why	F	128			
	,	p.m. director of nursing					
L	1		<u></u>				į

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Feetral Tag CROISS-REFERENCED TO THE APPROPRIATE DATE F 428 Continued From page 41 F 428 F 428 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." F 428 On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily	CENTER	& MEDICAID SERVICES			Q	<u>MB NO.</u>	0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - LYNNHURST STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 41 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring is included in the side effect monthly, that was the reason why he did not recommend it. In addition, PC Indicated, his expectation is facility staff should monitor orthostatic blood pressure monitoring should be done, "I F 4/28 On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring is included in the side effect monthly, that was the reason why he did not recommend it. In addition, PC Indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. F 4/2015, reads, "Review Nursing Notes for documentation of dally"	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
GOLDEN LIVINGCENTER - LYNNHURST 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 (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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 428 Continued From page 41 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." F 428 On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring and assume that staff is monitoring it monitoring and assume that staff is monitoring it monitoring and assume that staff is monitoring it monitoring and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily PREFIX			245394	B. WING			03/0	08/2016
GOLDEN LIVINGCENTER - LYNNHURST SAINT PAUL, MN 55104 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY 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) COMPLET ONTE DEFICIENCY F 428 Continued From page 41 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." F 428 F 428 On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatif blood pressure monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily Mit Augustan Motes for documentation of daily	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH OGRRECTWE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 428 Continued From page 41 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." F 428 On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monitoring Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily	GOLDEN		alan i shi a mana a sa ana ana ana ana ana ana ana ana			AINT PAUL, MN 55104		
 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	(X5) COMPLETION DATE
side effect monitoring and follow up to side effects." Policy and procedure title MEDICATION MONITORING MEDICATION REGIMEN REVIEW dated 5/12, read, "The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration records (MARs); prescriber's orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following: 17. Side effects, adverse reactions, and interactions (drug-drug, drug-diet, drug-lab test and drug-disease) are evaluated, and modifications or alternatives are	F 428	confirmed R5's me documentation of r pressure monitorin expectation orthos should be done." On 3/8/16 at 3:44 p stated, monthly ort monitoring is inclue monitoring and ass monthly, that was f recommend it. In a expectation is facil orthostatic blood p Policy and procedu MEDICATION REV "Review Nursing N side effect monitor effects." Policy and procedu MONITORING ME REVIEW dated 5/ pharmacist identifit variety of sources Administration rec orders; progress n and/or consultant instrument (RAI); results; behavior n facility staff; the at interviewing, asse- resident. The cons includes, but is no evaluating the follo adverse reactions drug-diet, drug-lab	dical record lacked nonthly orthostatic blood g and mentioned, "My tatic blood pressure monitoring o.m. consultant pharmacist hostatic blood pressure ded in the side effect sume that staff is monitoring it the reason why he did not iddition, PC indicated, his ity staff should monitor ressure monthly. Ure title ANTIPSYCHOTIC VIEW dated 5/4/2015, reads, lotes for documentation of daily ring and follow up to side ure title MEDICATION EDICATION REGIMEN 12, read, "The consultant es irregularities through a including: Medication ords (MARs); prescriber's lotes of prescriber, nurses, s; the Resident Assessment laboratory and diagnostic test nonitoring information; the tending physician, and from ssing, and/or observing the sultant pharmacist's evaluation t limited to reviewing and/or owing: 17. Side effects, , and interactions (drug-drug, o test and drug-disease) are		428			

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Event ID:ZGKC11

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			01	<u>MB NO.</u>	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVI AND PLAN OF CORRECTION IDENTI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245394	B, WING	Jacob Contractor		03/	08/2016
NAME OF 1	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - LY	NNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	considered." 483,65 INFECTION SPREAD, LINENS The facility must es Infection Control P safe, sanitary and e to help prevent the of disease and infe (a) Infection Contro The facility must es Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to in (b) Preventing Spre (1) When the Infection determines that a to prevent the spread isolate the residem (2) The facility must	N CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and development and transmission action. of Program stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to I of infection, the facility must t. st prohibit employees with a	F	128		ed be s are ne and ekly ring	
	from direct contact direct contact will t (3) The facility mus hands after each d hand washing is in professional practi (c) Linens Personnel must ha	ease or infected skin lesions t with residents or their food, if ransmit the disease. at require staff to wash their lirect resident contact for which dicated by accepted ce. andle, store, process and as to prevent the spread of					

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Facility ID: 00945

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PRINTED:	03/25/2016
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CENTER	<u>AS FOR MEDICAHE</u>	& MEDICAID SERVICES			0	ME NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245394	B. WING		NATE (NULL STREETED STOL (S) is an a sum of the server stol and the server stol stol (S) and (03/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			Ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	INNHURST			71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	uge 43	F	141			
	by: Based on observa review, the facility f provided personal i the risk of infection resident (R2) revie Findings include: R2's diagnoses inc hemiparesis, diabe disturbance, hyper quarterly Minimum 12/23/15, revealed ulcer however, the Multiple Weeks da one Stage 2 press of dermis presentir a red pink wound b On 3/8/16, at 8:04 (RN)-A and license entered R2's room bedside turned R2 was observed ass At 8:08 a.m. RN-A without washing has the nursing station was observed goin for supplies. At 8:1 never washed han gloves proceeded a.m. removed glow hands went to the	NT is not met as evidenced tion, interview and document ailed to ensure nursing staff and wound care to minimize of a pressure ulcer for 1 of 1 wed for pressure ulcers. Iuded hemiplegia and tes, dementia with behavioral tension, and anxiety. The Data Set (MDS) dated R2 did not have a pressure Wound Evaluation Flow Sheet ted 3/4/16, revealed R2 had ure ulcer (partial thickness loss ing as a shallow open ulcer with bed, without slough). a.m. both registered nurse ed practical nurse (LPN)-A donned gloves went to R2's to the side. At 8:06 a.m. RN-A ess and measure the wounds. removed gloves left the room ands, went out to the hallway by opened the treatment cart, ing through the drawers looking 0 a.m. came back to room ds applied another pair of to measure the depth. At 8:15 es left the room never washed hallway and was observed go ent cart again. At 8:16 a.m.					

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Facility (D: 00945

If continuation sheet Page 44 of 46

PRINTED:	03/25/2016
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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		245394	B. WING	i		03/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - LYNNHURST					471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	applied another pa overheard indicate changed. LPN-A re hands. RN-A was of used to measure th the wound bed and dressing on the lar area. At 8:19 a.m. applied a pair of gl removed the dress cleansed the wound a small amount of dressing lying on th wounds, never cha retrieved to the bai the room. RN-A wa R2's rectal area ar consistancy stool a changed gloves or continued to stand gloves touch R2's clothing, bedding/l control then remove both observed rep On 3/8/16, at 8:27 never washed han gloves during the facility policy was change, before lead wound cares. On 3/8/16, at 9:16 services (DNS) sta wash hands or use changes, before a	age 44 b room never washed hands ir of gloves. LPN-A was R2's wound treatment had emoved gloves never washed observed take the q-tip he had he depth, applied a pea size to d edges then applied a clear ge wound never cleansed the LPN-A came back to room, oves never washed hands, sing RN-A had just applied, then d with wound cleanser, applied hydrogel, then got a new clear he bed applied it to both anged gloves. LPN-A then throom washed hands and left as observed reach out with hd used a wipe to clean soft and after tossing the wipe never washed hands. RN-A l at R2's bedside with the same bare skin around the thighs, inen, call light and remote red the gloves. At 8:25 a.m. osition R2 and left the room. a.m. both acknowledged they ds before and after removing observation. Both indicated the to wash hands with each glove aving a room, and between a.m. the director of nursing ated she expected the staff to e hand sanitizer between glove nd after wound care, before and anytime staff hands were		441			

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PRINTED:	03/25/2016
FORMA	APPROVED
OMB NO	0938-0391

	NO FUR IVIEUIUARE	& MEDICAID SERVICES					0930-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(` '				E SURVEY PLETED
		245394	B. WING			03/	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - LY	/NNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
тад F 441	Continued From pa Handwashing/Hand August 2014, direc "7. Use an alcohol- least 62% alcohol, (antimicrobial or no the following situati a. Before and a residents; b. Before prepa medications; c. Before perfor invasive procedure f. Before handl gauze pads, etc.; g. After toileting toileting, handling of bedpans, wash cloths. f. Before and a g. After coughi nose and or assisti coughing, snea h. After handlir such as raw meat i. Before perfor	age 45 d Hygiene policy revised ted: based hand rub containing at or, alternately, soap on-antimicrobial) and water for ions: after direct contact with aring and handling orming any non-surgical s; ing clean or soiled dressings, g or assisting residents with of urinals, catheters, soiled linen, towels, after smoking or eating. ing, sneezing, or blowing of ing residents after ezing and blowing of nose. ng uncooked animal products, or fish. rming a resident care ADL ving] procedure and after		441	DEFICIENCY)		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:ZGKC	11	Fe	scility ID: 00945 If continue	tion sheet	Page 46 of 46
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