

#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 14, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Subject: Golden LivingCenter - Walker - Informal Dispute Resolution (IDR)

CMS Certification Number (CCN): 24 5323

Project Number: S5323025

Dear Ms. Hendrickx:

This is in response to your letter of August 8, 2016, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency cited at F250, issued pursuant to the survey completed on July 15, 2016.

The information presented with your letter, the CMS 2567 dated July 15, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F250 G 42 CFR §483.15 (g) Social Services 483.15 (g) (1) The facility must provide medically related social services to attain and maintain the highest practicable physical, mental and psychosocial being of each resident.

#### Summary of the facility's reason for IDR of this tag.

The facility alleges they provided medically related social services to R12 when R12 experienced mood and sleep changes following a roommate change. The facility further alleges they were in the process of supplying a wall mounted television for R12's roommate R18, because they were aware there was conflict between R12 and R18 regarding the television. Facility staff stated they felt adding a television to the room would be the least disruptive to the situation for both residents and would solve their conflict.

### Summary of facts.

R18 was moved into R12's room on 6/22/16. According to the record, and staff and resident interview, R12 and R18 experienced several conflicts between them related to television usage and daily routines such as choice of bed time and rising time routines. Various facility staff were aware of these conflicts including the SW, NA-A, NA-E and LPN-B. Due to the conflict which began between R12 and R18 after the roommate change, R12 began to demonstrate irritability, fatigue, sleepiness and spent less time in

Golden LivingCenter - Walker December 14, 2016 Page 2

his room which represented changes in his demeanor. The interpersonal conflicts continued and were observed by the surveyor on July 12, 2016 at 9:15 a.m. In addition, when interviewed, staff stated they were aware of R12's changes in demeanor, and verified R12 spent less time in his room because of R18's treatment of him. Staff acknowledged R12 had become irritable and was not sleeping well. When interviewed, the SW was aware R12 and R18 did not get along as roommates, and verified R12's family had expressed concern about R12 not sleeping well since the roommate change.

### Summary of findings:

There was no indication in R12's record the SW had comprehensively assessed the conflict between R12 and R18. Other than initiating the addition of another television to the room, there was no evidence the SW had considered other options to improve the relationship between R12 and R18. Multiple staff were aware of the conflict between the two residents and of the changes in R12's demeanor since R18 had become his roommate. The federal regulation guidance for psychosocial scope and severity at a level 3 (harm) includes: negative psychosocial outcome as a result of the facility's noncompliance may include but not be limited to persistent depressed mood, and may be manifested by verbal or nonverbal symptoms such as: social withdrawal, irritability, anxiety and hopelessness. R12 had displayed these types of mood changes which facility staff were aware of.

This is a valid deficiency cited at F250 and at the correct scope and severity of G, actual harm.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Brenda Fischer, Unit Supervisor

Brenda Liscler

Licensing and Certification Program Health Regulation Division

3333 West Division Street, Suite 212

St Cloud, MN 56301

Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care

Pam Kerssen, Assistant Program Manager

Licensing and Certification File

Lyla Burkman, Bemidji District Office Unit Supervisor

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	Z13 W
Fac	ility ID: 00995

1. MEDICARE/MEDICAID PROVID	ED NO	3. NAME AND AL	ODDESS OF EAC	TH ITV			4. TYPE OF ACT	ION: 7 (L8)
(L1) 245323	EK NO.	(L3) GOLDEN L			KER			(E0)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 209 BIRCHY	WOOD AVEN	UE WEST	PO BOX 700		1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) <b>677088600</b>		(L5) WALKER, N	MN		(L6)	56484	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) <b>04/01/2006</b>	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7)	) 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other ter Complaint
	<b>8/2016</b> (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF		FISCAL YEAR END	DING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
11. LTC PERIOD OF CERTIFICATION From (a):	N	10.THE FACILITY  X A. In Complia	ance With	AS:			The Following Require	
To (b):		_	equirements e Based On:		2. Tec.	hnical Personnel	6. Scope of 7. Medical I	
12.Total Facility Beds	<b>40</b> (L18)	1. A	cceptable POC			ay RN (Rural SN	<u> </u>	
13.Total Certified Beds	<b>40</b> (L18) <b>40</b> (L17)		pliance with Prog		5. Life * Code:	e Safety Code  A	9. Beds/Roo (L12)	m
14. LTC CERTIFIED BED BREAKDO	OWN		**		15. FACILITY			
18 SNF 18/19 SNF 40	19 SNF	ICF	IID		1861 (e) (1) o	or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	RVEY AGENCY	APPROVAL	Date:
Yvonne Switajewski	, HFE NEII		09/15/2016	(L19)	Mark	Weath	, Enforcement Spe	<u>cialist</u> 10/25/2016 (L20)
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#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245323

October 25, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Dear Ms. Hendrickx:

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

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

Effective August 16, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 15, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

RE: Project Number S5323025

Dear Ms. Hendrickx:

On July 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 15, 2016. 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.

On September 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 15, 2016, effective August 16, 2016 and therefore remedies outlined in our letter to you dated July 29, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

## Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER	A. Building			
245323 <sub>Y1</sub>	B. Wing	Y2	9/8/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALK	KER .	209 BIRCHWOOD AVENUE WEST PO BOX 700		
		WALKER, MN 56484		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			<b>Y</b> 5	Y4			<b>Y</b> 5	Y4			<b>Y</b> 5
ID Prefix Reg. #	F0247 483.15(e)(2)		Correction Completed	ID Prefix Reg. #	F0250 483.15(	g)(1)	Correction	ID Prefix Reg. #	F0280 483.20(d)(3), 483.1 (2)	0(k)	Correction Completed
LSC			08/16/2016	LSC			08/16/2016	LSC			08/16/2016
ID Prefix	F0309		Correction	ID Prefix	F0329		Correction	ID Prefix	F0356		Correction
Reg. #	483.25		Completed	Reg.#	483.25(	l) 	Completed	Reg. #	483.30(e)		Completed
LSC			08/16/2016	LSC			08/16/2016	LSC			08/16/2016
ID Prefix	F0387		Correction	ID Prefix	F0411		Correction	ID Prefix	F0425		Correction
Reg. #	483.40(c)(1)-(2)		Completed	Reg.#	483.55(	a)	Completed	Reg. #	483.60(a),(b)		Completed
LSC			08/16/2016	LSC			08/16/2016	LSC			08/16/2016
ID Prefix	F0431 483.60(b), (d), (e)		Correction	ID Prefix	F0441 483.65		Correction	ID Prefix	F0504 483.75(j)(2)(i)		Correction
Reg. #			Completed	Reg.#			Completed	Reg. #			Completed
LSC			08/16/2016	LSC			08/16/2016	LSC			08/16/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. # LSC			Completed	Reg. #			Completed	Reg. # LSC			Completed
REVIEWE		REVIEWE (INITIALS)	D BY ) LB/mm	<b>DATE</b> 09/15/201	16	SIGNATURE OF SL	JRVEYOR	18619		<b>DATE</b> 09/0	8/2016
REVIEWE	D ВҮ	REVIEWE (INITIALS)		DATE		TITLE				DATE	
<b>FOLLOW</b> L 7/15/2016	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE TED DEFICIENCIES (				YES	s 🔲 no



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 15, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

Re: Reinspection Results - Project Number S5323025

Dear Ms. Hendrickx:

On September 8, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 15, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

### **STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
00995 <sub>Y1</sub>	B. Wing	Y2	9/8/2016 <sub>Y</sub>	′3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN LIVINGCENTER - WALKER		209 BIRCHWOOD AVENUE WEST PO BOX 700				
		WALKER, MN 56484				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20302		Correction	ID Prefix	20435		Correction	ID Prefix	20570		Correction
Reg. #	MN State Statut 144.6503	te	Completed	Reg. #	MN Ru Subp. 2	le 4658.0210 2 A.B.	Completed	Reg. #	MN Rule 4658.04 Subp. 4	405	Completed
LSC			09/08/2016	LSC			09/08/2016	LSC			09/08/2016
ID Prefix	20830		Correction	ID Prefix	21290		Correction	ID Prefix	21325		Correction
Reg. #	MN Rule 4658.0 Subp. 1	0520	Completed	Reg. #	MN Ru Subp. 3	le 4658.0710	Completed	Reg. #	MN Rule 4658.07 Subp. 1	725	Completed
LSC			09/08/2016	LSC			09/08/2016	LSC			09/08/2016
ID Prefix	21200		Correction	ID Prefix	21/26		Correction	ID Prefix	21/05		Correction
Reg. #	MN Rule 4658.0	0800	Completed	Reg. #	MN St.	Statute 144A.04	Completed	Reg. #	MN Rule 4658.10	005	Completed
LSC	Subp. 4 A-I		09/08/2016	LSC	Subd. 3	3	09/08/2016	LSC	Subp. 5		09/08/2016
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ID Prefix	21530		Correction	ID Prefix	21550		Correction	ID Prefix	21615		Correction
Reg. #	MN Rule 4658.	1310	Completed	Reg. #	MN Ru Subp.	le 4658.1325 I	Completed	Reg. #	MN Rule 4658.13 Subp. 2	340	Completed
LSC			09/08/2016	LSC			09/08/2016	LSC			09/08/2016
ID Prefix	21942		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	MN St. Statute Subd. 8b	144A.10	Completed	Reg. #			Completed	Reg. #			Completed
LSC			09/08/2016	LSC			-	LSC			-
STATE A		REVIEW (INITIAL	VED BY .S) LB/mm	<b>DATE</b> 09/15/20	16	SIGNATURE OF	SURVEYOR 18619			<b>DATE</b> 09/08	3/2016
REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
<b>FOLLOW</b> 7/15/201	FOLLOWUP TO SURVEY COMPLETED ON					R ANY UNCORRECTED DEFICIENCI	-			 : 	s □ no

Page 1 of 1 EVENT ID: ZI3W12

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZI3W

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AC	GENCY	F	acility ID: 00995
MEDICARE/MEDICAID PROVIDER     (L1) 245323  2.STATE VENDOR OR MEDICAID No.     (L2) 677088600		3. NAME AND ADD (L3) GOLDEN LI (L4) 209 BIRCHV (L5) WALKER, M	VINGCENTER - VOOD AVENUE	WALKER	3OX 700 (L6) 56484		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9) <b>04/01/2006</b>		7. PROVIDER/SUI	05 HHA	09 ESRD	<u>02</u> (L7	22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other nplaint
6. DATE OF SURVEY <b>07</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Othe	/15/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 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  14. LTC CERTIFIED BED BREAKDON 18 SNF 18/19 SN 40 (L37) (L38)	40 (L18) 40 (L17) WN F 19 SNF (L39)	X B. Not in Com Requirements :  ICF  (L42)	nce With quirements Based On: Acceptable POC pliance with Program and/or Applied Waiv  IID  (L43)	n	2. Tec 3. 241 4. 7-D	hnical Personnel Hour RN lay RN (Rural SNF) e Safety Code  B*  MEETS	Following Requirements:  6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room  (L12)  (L15)	or
17. SURVEYOR SIGNATURE		Date :				RVEY AGENCY AP		Date:
Jana Bromenshe	,	BE COMPLETE	08/05/2016 	(L19)		-	ogram Specialist	08/16/2016 (L20)
DETERMINATION OF ELIGIBIL	TTY Participate	20. COM	IPLIANCE WITH C		21. 1. 2.	Statement of Financi	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE  OF PARTICIPATION  07/01/1986  (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		VOLUNTARY 01-Merger, Close		INVOLUNT. 05-Fail to Me	et Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	intary Termination for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	(L45) PARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (	OF APPROVAL DAT		DETERMIN	ATION A PPRO	VAI	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 29, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, Minnesota 56484

RE: Project Number S5323025, H5323015 and H5323016

Dear Ms. Hendrickx:

On July 15, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5323015 and H5323016.

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. In addition, at the time of the July 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5323015, H5323016 that were found to be unsubstantiated.

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

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

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

<u>Electronic 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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

### **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 August 24, 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 if your facility has not achieved substantial compliance by August 24, 2016 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

### 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 October 15, 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 January 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 08/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION (X3	3) DATE SURVEY COMPLETED
		245323	B. WING _		07/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	ΓS	F 00	00	
	as your allegation of Department's accepenrolled in ePOC, y at the bottom of the form. Your electron be used as verification	·			
	Upon receipt of an acceptable electronic POC, ar on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.				
F 247 SS=D	H5323016 were consubstantiated. 483.15(e)(2) RIGH	complaints H5323015 and mpleted and found not to be  T TO NOTICE BEFORE E CHANGE	F 24	17	8/22/16
		right to receive notice before or roommate in the facility is			
	by: Based on interview facility failed to prov	NT is not met as evidenced v and document review, the vide 1 of 2 residents (R12) with ification of a roommate		Submission of this Response and Pla Correction is not a legal admission that deficiency exists or that this Statement Deficiency was correctly cited, and is not to be construed as an admission of fault by the facility, the Executive Director any employees, agents or other	at a nt of also of
	_	a.m. R12 stated R18 had		individuals who draft or may be discus in this Response and Plan of Correcti In addition, preparation and submission	on.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed** 

(X6) DATE

08/04/2016

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			<b>07</b> /1	15/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	09 BIRCHWOOD AVENUE WEST PO BOX 7	00	
GOLDEN	I LIVINGCENTER - W	ALKER			ALKER, MN 56484		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 247	moved in with R12 had not been notification that the roommate. SW states move, then the However, if one of the move, then the period before then R12 (resident who had not been proving Getting A Roommate hand so had not been proving and SW was through on the notion of the move had not been proving and SW was through on the notion of the move had not been proving the move had not been proving and SW was through on the notion of the move hands in the confirmed any time regarding a room/reconversation should residents' medical medical record lack notification of R12 verified R12 had to been made aware	m about a month ago (R18 on 6/22/16). R12 stated he ed of the roommate change	F 2	247	this Plan of Correction does not cor an admission or agreement of any the facility of the truth of any facts a or the correctness of any conclusion forth in the allegations.  Accordingly, the Facility has prepare submitted this Plan of Correction provided the resolution of any appeal which refiled solely because of the requirement under state and federal law that massubmission of a Plan of Correction ten (10) days of the survey as a corto participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.  F247  -Room changes have been comple R12 and R18. Proper notice of room change has been completed and documented.  -All residents with a change of room roommate have the potential to be affected if proper notification of said change is not communicated and documented.  -SSD has been re-educated on requirements for notification of room/roommate change and necess follow-up following change in room/roommate.  -Audits will be completed after each or roommate change for the next 30 to insure proper notice and follow-up follo	ed and rior to may be nents undate within ndition of sary	
	been made aware roommate prior to R18 had been give on 6/15/16. R18 ha	that he would be getting a			or roommate change for the next 30	0 days p has will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245323	B. WING		07/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	<u> </u>
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIC
F 247	On 7/14/16, at 10:2 confirmed prior to a roommate change should be provided potential roommate consideration prior she expected all coroom/roommate chithe appropriate me administrator confirmade sure the app given and signed a conversations in the R12's nursing prog through 7/13/16, la appropriate notifical	29 a.m. the administrator a resident room change and/or the appropriate notification. The administrator stated a compatibility was taken into to a roommate change and proversations regarding langes to be documented in	F 24	recommendations and to deter continued need for auditsThe ED/Designee is the responsityCorrective action will be comp August 22, 2016.	onsible
	Resident Room Relocation policy dated 2/26/15, indicated the social service staff would be involved with any resident room relocations. The resident's social, emotional and cognitive needs would be assessed and considered prior to relocation of the resident. The impact of room relocation on the resident's psychosocial status would be assessed by the social service staff. The social service staff would work with the interdisciplinary team to consider roommate compatibility to arrive at the most appropriate location for a resident. In addition, a plan would be developed by the social service staff to assure the needs and concerns related to the residents' ability to cope and adjust to the relocation would				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/	/15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 247	resident or family the this would be docurted and a roommate.  - The resident and/informed that they wroommate.  - The identified soon need related to the addressed.  - A follow up visit wrooial service staff move.  - Social service staff	yould be provided to the nat was being relocated and mented in the medical record. Uld be given when possible. It introduced to their new or their family would be were receiving a new ial, emotional, and cognitive room relocation would be ould made as needed by the to aid in the adjustment to the fit would document the eto the move in the medical	F 2	47			
F 250 SS=G	within the Facility p the residents or the notified in advance affected by the tran change of room or provided. In additio tolerated the move 483.15(g)(1) PROV RELATED SOCIAL The facility must pr services to attain or	ovide medically-related social r maintain the highest I, mental, and psychosocial	F 2	50		8/22/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING		07/	15/2016
	PROVIDER OR SUPPLIER	ALKER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	•	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 250	by: Based on observareview, the facility frelated social servipsychosocial well-kright who had unrered for the facility frelated social servipsychosocial well-kright for the facility supports the findings include:  R12's physician project identified R12's dia attack, heart failures sleep apnea (a discrepeatedly stops at the throat muscles accident (stroke) with the facility of th	NT is not met as evidenced tion, interview and document failed to provide medically ces to promote the peing for 2 of 2 residents (R12, esolved roommate conflicts. esychosocial harm due to sturbance and decline in mood.  Orgress note dated 6/14/16, egnoses as history of a heart es, hypertension, obstructive order where breathing and starts which occurs when relax), cerebral vascular with left-sided weakness.  Inimum Data Set (MDS) dated R12's cognition was intact, had toms of a mood disorder, no towards self or others during eriod. R12 required extensive bility, transferring, toileting and R12 was independent with unit. R12 was always er.	F 250	F250 -SSD has assessed psychosocial well-being of R12 and R18. R12 a are no longer roommatesAll residents with unresolved conf have the potential to be affected if provided social services to promot psychosocial well-beingSSD was re-educated on provision psychosocial services for residents unresolved conflicts. IDT was proveducation on identification and resof resident conflictAudits will be completed on 3 resin weekly to determine if there are unresolved room/roommate conflict Negative results will be reviewed/resident by IDT immediately. Audit results reviewed at QAPI for recommendationand to determine continued need for auditsThe ED/Designee is the responsitionartyCorrective action will be completed August 22, 2016.	licts not e n of s with vided olution dents ets. esolved will be ations or	
	abuse due to R12's	R12's safety and potential for s decreased physical mobility. ded not having R12 near others				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		245323	B. WING _		07/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	ODE
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTI
F 250	removed from any situations. In addition R12 was at risk for and directed staff to	and that R12 should be potentially dangerous on, R12's care plan indicated sleep pattern disturbances o maintain an environment (quiet, comfortable	F 25	50	
	indicated R12 rece	dministration Record (MAR) ived Lasix (a diuretic) 20 ily. In addition, melatonin 10 nia.			
	R18's diagnoses as	eport dated 7/14/16, identified s obstructive sleep apnea, end e, dependent on renal dialysis, ion.			
	R18 had intact cog received a daily an symptoms of a mod	DS dated 5/12/16, indicated nition, was on dialysis, tidepressant, had no signs and od disorder, and no behavior self or others during the initial.			
	interview with R18, knocked on the resif he could come in bathroom. R18 lou seated in his motor the open door, "tell always has to use twas granted and R	is a.m. during the initial resident R12 (R18's roommate), ident's room door. R12 asked as he (R12) had to go to the dly responded, with R12 ized wheelchair right outside him to stay out he [R12] he bathroom." R12's request 12 entered the room, made his ne room, used the urinal and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING		····	07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	exited the room. Casked if she could	age 6 on R12's way out, the surveyor talk to him later. R12 stated and that he (R12) would be in	F 2	50			
	resumed. R18 state p.m. and wanted to stated he [R18] nor 10:00 p.m. and did breakfast at 8:00 a want R18 to watch watches it anyway. was an "ass." R18 time out of the roor stated, "It has been moved in." R18 state roommate situated offered a room chawords had been ex R12. R18 stated h	ed a.m. the interview with R18 and the R12 went to bed at 7:30 aget up at 5:00 a.m. R18 and went to bed around in the get up until right before a.m. R18 stated R12 didn't the television but "he [R18]" R18 stated his roommate stated R12 spent most of his in and down by the desk. R18 at this way since he [R18] had ated the staff were aware of ation, but the facility hadn't ange. R18 confirmed that changed between himself and it is did not feel threatened by "would beat the hell out of him threaten me."					
	into his [R12] room stated R18 always stated R18 "tells m stated R18 was no R12 stated R18 like on all night long an that he [R12] could all night. R12 state times to "get off my like it because he [bathroom frequent]	a.m. R12 stated R18 moved about a month ago. R12 wanted to dominate him. R12 e what to do all the time." R12 thappy with him [R12] at all. ed to sit up with the television d that R18 didn't understand n't sleep with the television on ed he had told R18 a couple of back." R12 stated R18 didn't R12] had to go to the y. R12 stated R18 dominated 12 stated he spent most of his					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING			07/	15/2016	
	PROVIDER OR SUPPLIER	ALKER		209 BIRCHWOOD	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 250	in the facility family said anything to an assistants were aw R12 stated when R "sneaks back in the stated he was not a had not been notific prior to R18 moving -On 7/12/16, at 1:1 motorized wheelch and not seated in his motor room. R18 was lay sleeping with the te-At 7:50 a.m. R12 aroom and used the exited their room at the urinal on R12's proceeded to go bar -At 7:56 a.m. R12 awheelchair in the fadangled down onto positioned on the fotogether and legs be in bed sleeping in the At 8:08 a.m. R12 aroom and his chin was do -At 8:19 a.m. R12 aroand his chin was do -At 8:19 a.m. R12 aroand his motorized wheelch had positioned a Ustan and his chin was do -At 8:19 a.m. R12 aroand his motorized wheelch had positioned and po	m and watched television down room. R12 stated he hadn't yone, however, the nursing are of his roommate situation. It went to dialysis, he [R12] to room as much as I can." R12 afraid of R18. R12 stated he ed of the roommate change ginto the room.  4 p.m. R12 was seated in his air in the family room.  0 a.m. R12 was observed rized wheelchair in the family ring in his bed in their room elevision off. Entered their (R12 and R18's) urinal. R12 immediately fter using the urinal, leaving bed side table. R12 ack into the family room. was seated in his motorized amily room. R12's left arm R12's lap and both feet bot rest with R12's heels rowed outward. R18 remained heir room. The family room. R12 remained seated in his air in the family room. R12 remained sheer. R12's eyes were closed own towards his chest. The family ad woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and woken up and had been served to the family and the fam	F 2	50				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	ODE	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 250	motorized wheelch stated he would rat than in the family ro take a nap. R12 st times a week, but h dialysis schedule. was gone to dialysis room. R12 stated h not comfortable to too small for him (Finew wheelchair and was on order).  -At 9:05 a.m. R12 whis motorized wheels slightly moved off to the root of the state	emained seated in his air in the family room. R12 her spend time in his room oom, so he could lay down and ated R18 went to dialysis three he [R12] wasn't aware of R18's R12 stated when he knew R18 s, he spent more time in their his motorized wheelchair was sleep in as the wheelchair was R12 had been measured for a d a new motorized wheelchair was sleeping while seated in elchair. R12's neck pillow had		50		
	(LPN)-B confirmed along. LPN-B state made the statemer continue to be mea way. LPN-B confirmed out of his room now observed R18 beinhad heard from oth R12.  On 7/13/16, at 12:5 (NA)-E stated R12 water" and were "p R12 was in the roo R18 had moved in sleep at night and I	2 a.m. licensed practical nurse R12 and R18 did not get ed she had heard that R18 had at that he was going to an to R12 until he [R18] got his med R12 spent a lot of time v. LPN-B stated she had not g mean to R12, however, she er staff that R18 was mean to go provided in the stated and R18 got along like "oil and olar opposites." NA-E stated in first and about a month ago NA-E stated R12 liked to R18 was more of a night owl. and R18's sleep hours did not				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 250	the family room sin R12 didn't want to I she was aware of t "F-off" and R12 had business. NA-E cooccurred between physical. NA-E stademeanor had cha R12's roommate. I become more host stated she had info couple of weeks agtreating R12 and the been the worst dechad changed though the administrator's nursing assistants input with potential NA-E state it was here was aware and the state it was here.	ated R12 spent more time in ce R18 moved in because on around R18. NA-E stated imes when R18 told R12 to did told R18 to mind his own of irmed verbal exchanges had R12 and R18, but nothing ted R12's mood and onged since R18 had become NA-E stated R12's mood had dile towards the staff. NA-E remed the administrator a so about how R18 had been at putting them together had ision. NA-E stated nothing the since she had brought it to attention. NA-E stated the were not asked to provide room or roommate changes. ard to see someone (R12) appy to now go to being a total	F 25	50		
	and R18 did not ge stated R18 liked to to go to bed earlier at R12 when R12 h NA-A stated she ha R12 since R12 and NA-A stated R12 whe (R12) used to bused to get up in th 5:30 a.m. and now around 6:30 a.m. thought R12 still we now just lied awake	p.m. NA-A confirmed R12 t along as roommates. NA-A be up at night and R12 liked. NA-A stated R18 had sworn ad to use the urinal so much. Id noticed a difference with R18 had become roommates. as shorter with staff now and a happier. NA-A stated R12 e morning around 5:00 a.mR12 doesn't get up until 7:00 a.m. NA-A stated she oke up around 5:00 a.m., but a until 6:30 - 7:00 a.m. when okay to get up and not disturb				

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(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	and R18 became r down a lot more ar room or would just and watch television now R12 spent more and in the family rowhen R18 was at croom and laid dow hollered at R12, Ridoesn't respond to trying to ignore R15 to provide input regroommate changes been asked in a lostated it wasn't a g together. NA-A sta	age 10 B). NA-A stated before R12 commates, R12 would lay and usually took a nap in his kick back in his wheelchair on in his room. NA-A stated lest of his time out of his room from. NA-A stated sometimes dialysis, R12 would go into his an. NA-A stated when R18 ale just put his head down and and R18, it's like he [R12] was just and R18, it's like he NAs used agarding potential room or and stated the NAs hadn't and time to provide input. NA-A and idea to put R12 and R18 ated she thought this move had and R12 more than R18, and in a	F 25	0		
	R18 argued about stated R12 used to and now R12 does p.m. (staying up at past preference/ro to go into his room nap, but now R12 if R12 noticed that stated she thought wheelchair in the fadytime. NA-F stawatched television with the television most evenings the the night because	7 p.m. NA-F stated R12 and the television a lot. NA-F go to bed right after dinner in t go to bed until about 8:00 pout two hours later than R12's utine). NA-F stated R12 used around 3:00 p.m. and took a conly went into his room to nap R18 was at dialysis. NA-F R12 now napped in his amily room a lot during the ted R18 stayed up late and and that R18 liked to sleep on. NA-F stated she thought television was left on during that was how R18 liked it. ppeared more moody since R12's roommate				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 250	Continued From page 11		F 2	50				
		a.m. R12 was observed ized wheelchair in the activity vision.						
	R18 should never had not need to get up a R12 this, NA-C state of paper that R12 co (R12) wanted to an NA-C stated R12 "showever, NA-C state until around 7:00 a. past preference/routold R12 "if you did wouldn't have to us stated R12 had told R18 one. NA-C state television on all the the facility was goin the room. However that would resolve to confirmed R12 spesince R18 became stated R12 used to now R12 spent the family room. NA-C two different occasi regarding R12 and NA-C stated the first around 6/23/16. No change in R12 since roommate. R12 used to smile and now	a.m. NA-C stated R12 and lave become roommates. and told R12 that he [R12] did at 5:00 a.m. When R18 told led she had written on a piece ould get up whenever he dishowed the note to R12. Shook his head yes." Ited now R12 stayed in bed led m. (two hours later than R12's latine). NA-C stated R18 had led have to drink so much you led that urinal so much." NA-C I her that he was ready to poputed R18 liked to have the time and NA-C had thought light to get another television in r., NA-C stated she didn't think the roommate problem. NA-C in more time out his room R12's roommate. NA-C take a nap in R12's room, but majority of the time in the stated she had expressed on ons to the nurse in charge R18's roommate situation. St time she brought it up was A-C stated she had seen a le R18 became R12's led to get up and be bubbly R12 was more withdrawn and NA-C confirmed it was a daily						

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_	PROVIDER OR SUPPLIER	ALKER		2	STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			BE	(X5) COMPLETION DATE
F 250	Continued From page 12 occurrence on how R18 treated R12.		F 2	250			
	verbal interactions	a.m. NA-E confirmed the from R18 to R12 happened if it didn't happen then that ay".					
	On 7/14/16, at 9:24 a.m. NA-A confirmed the verbal interactions from R18 to R12 happened daily. NA-A stated for example this morning R12 was in the bathroom being assisted with cares by NA-A, and R12 told NA-A that he [R12] was just being smart. NA-A stated R18 hollered "you are always a smart ass." NA-A stated it was stuff like this that happened daily.						
	seated in his wheel he didn't sleep as w became his roomm	a.m. R12 was observed chair on the patio. R12 stated vell as he used to since R18 ate and he was always tired didn't want to talk about R18					
	by another surveyo member of the residual this surveyor that the working on getting stated R18 always had the television on, R12 j R18 kept the television caused flawake. R12 stated	0 a.m. R12 was interviewed r as R12 was an active dent council. R12 confided to be facility was currently R18 away from R12. R12 yelled at him. R12 stated R18 emote, so when R18 had the lust rolled over. R12 stated sion on and R12 felt the ashes of light which kept him he was just going to keep his [R12] could be moved.					

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 250	Continued From pa	ge 13	F 2	250				
	7/12/16, indicated used ment section the following: - having R18 in R12 - R18 thought he was R18 had the televistic complained continuation the room and have R18's nursing programmer and the room and r	ision on at night and R18 lously about R12 making noise ving to use the urinal.  ress note (PN) from 6/15/16, cked documentation regarding frommate conflict with R12.  6/16, through 7/13/16, lacked arding R12's unresolved in addition, R12's medical						
		mentation of appropriate mmate change or a follow up roommate change.						
	confirmed the facilit which was 40 and t residents. SW state a room change a for a resident moved in resident already occording were to be consumed to make a completed by the being asked to make second form was corresident as notificat	O a.m. social worker (SW) by was not at full capacity he current census was 26 ed when a resident requested orm was completed and when not a room which had a cupying that room, then two competed. SW stated one form he resident requesting or the the room change and the completed and given to the cition that they would be commate. SW stated if both						

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		245323	B. WING		07	7/15/2016	
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GOLDEN	I LIVINGCENTER - V	VALNER		WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 250	could occur right a residents hadn't a was a seven day a move occurred. S received a new ro or signed the Noti as required. SW vacation when R1 of who followed the roommate and/or absence. SW cor conversation regard that conversation regard that conversation residents' medical medical record lad notification of R12 verified R12 had the made aware that a prior to R18 moving been given notice R18 had refused the day adjustment per moving into R12's confirmed R12 and roommates. SW care conference walong with R12. Seconference, R12 desing roommates main concern focus R18 liked to have and because the the directly at the foot bright lights from the night. In addition, always wanted to always complaine	age 14 to the move, then the move away. However, if one of the greed to the move, then there adjustment period before the W verified R12 (resident who commate) had not been provided be Getting A Roommate form, stated she had been on 8 moved and SW was unsure rough on the notification of room changes in the SW's affirmed any time there was a riding a room/roommate change should be documented in the record. SW confirmed R12's exed documentation regarding getting a roommate. SW cold her that he had not been ne would be getting a roommate ag in. SW confirmed R18 had of the room change on 6/15/16. The sign of the seven eriod was provided with R18 room on 6/22/16. SW d R18 did not get along well as stated on 7/12/16, R12 held a which R12's son also attended the stated at the care expressed his displeasure of with R18. SW stated R12's used on the television and how the television was positioned of R12's bed the flickering he television kept R12 awake at R12 voiced concerns that R18 be the boss and that R18 d of the noise that R12 made. pressed at the care conference	F 2	250			

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F 250	sleep and felt since not slept as well. Sielt the roommate shad negatively imposed well-being, especial brought up at the coshe expressed to the stand up meetings concerns regarding situation. SW states move R18, however R12 should be the had requested to most recent mood conducted 5/17/16, behavioral concern expect if R12's moon, it would be dif R12's mood. SW states which was stated to most recent mood conducted 5/17/16, behavioral concerned expect if R12's moon, it would be dif R12's mood. SW states which was stated to the state of the state	age 15 If about R12 getting enough R18 had moved in, R12 had W stated "most definitely" she situation between R12 and R18 acted R12's psychosocial Illy after what had been are conference. SW stated the leadership team at their these last couple of days, her and R18's roommate and she thought they should for, the leadership team thought cone that moved because R12 and behavior assessment addentified no mood or s. SW stated she would and devaluation was completed ferent and show a decline in stated overall she felt R12 was R12's current situation.	F2	50		
	(DON) and adminish ad open resident is confirmed prior to a roommate change was to be provided had spoken to both (7/13/16) and had a temporary room. Troommate had bee facility would again the new roommate declined the tempo move twice. R12 owas provided to his	erg a.m. the director of nursing strator confirmed the facility rooms. The administrator a resident room change and/or the appropriate notification. The administrator stated she R12 and R18 yesterday offered to move R12 to a then when R12's potential new in provided proper notice, the move R12 into that room with the administrator stated R12 rary move as he didn't want to pted to wait until proper notice is potential new roommate and The administrator stated R12				

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F 250	request to be move potential roommat consideration prior the nurse manage other staff which ir resident and family the safety with the residents liked the definitely sleep routhe NAs had mad that R12 and R18 last Friday (7/8/16) NAs had made he television and that television on all the confirmed some teand R18. The adression psychosocial well-negative manners roommates. In ad she was aware R1 current roommate that R12 was frust R18's medical rece 2:32 p.m. R18 had On 7/15/16, at 8:5 so nice and quiet is on nice to be able he wanted.  Resident Room Reindicated the social involved with any resident's social, early and r	because R12 had made the ed. The administrator stated e compatibility was taken into to a roommate change and rs also gathered input from the heluded the NAs and the y. Other things considered were equipment in the room, if the television on, and most utines. The administrator stated e her aware today (7/14/16) had argued last evening, and y. The administrator stated the r aware of the conflicts with the R18 liked to have the etime. The administrator ension existed between R12 ministrator verfied R12's being had been affected in a since R18 and R12 became dition, the administrator stated 2 was not comfortable with the arrangement and was aware	F 250				

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - WALKER				STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484		
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F 250	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 250			
	the residents or the notified in advance affected by the tran	olicy dated 5/3/16, indicated ir responsible parties would be of the transfer. All roommates sfer would be notified. In he resident tolerated the move nted.				

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F 280 F 280 SS=D	The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive of within 7 days after the comprehensive associated interdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident interdisciplinary teaphysician.	0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or		280			8/22/16
	by: Based on interview facility failed to revi plan to include intermanagement for 1 acquired a pressure. Findings include: R19's quarterly Min	NT is not met as evidenced and document review, the se the comprehensive care rventions for pressure ulcer of 1 resident (R19) who had e ulcer.			F280 -R19's comprehensive care plan have revised to include interventions for pressure ulcer managementResidents with a change in skin interventions for alterations in skin interventions for alterations in skin integrity are not identified and care-plannedLicensed staff has been educated of updating care plans to reflect current interventions.	egrity	

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		245323	B. WING		07/	15/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - WALKER			STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page 19  Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living, and was at risk for pressure ulcers and had developed an unstageable pressure ulcer.  R19's weekly skin review, dated 6/4/16, indicated R19 had developed and area of eschar to her left heel. R19 was seen by the physician's on 6/6/19 for left heel pressure ulcer, with referral to the wound clinic and cushion device to help relieve pressure.  F 280  -Audits will be completed we residents with pressure ulcer ensure care plan is revised interventions. Negative find immediately corrected and exprovided as needed. Audit reviewed at QAPI for recommendated audits.  -DNS/Designee is the responsance of the prelieve pressure.		rs/wounds to with current ngs will be ducation esults will be mendations need for				
	for a Mepilex borde	visit, 6/9/16, indicated orders or heel dressing, staff to very other day and to wear a boot.					
	dressing change: A to left heel, ok to sh	der dated, 7/6/16, indicated Apply wet to dry dressing daily nower, wound should be and water with each dressing					
	revision to include I	int date 7/14/16, lacked R19's pressure ulcer and d to R19's unstageable left					
	(DON) stated, R19'	p.m. the director of nursing s care plan should have been he needed interventions when developed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/15/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - WALKER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 280	indicated the interd address problems, directed toward pre	Care Protocol, undated, isciplinary plan of care would goals and interventions evention of pressure ulcers	F 280			
F 309 SS=D	The facility procedudated 2/4/16, identify guidelines, directing appropriate problem dressing change as goals, list responsituation unique to resident, and preventive mea 483.25 PROVIDE OF HIGHEST WELL BEACH resident must provide the necess or maintain the high mental, and psychological procedures.	CARE/SERVICES FOR	F 309		8/22/16	
	by: Based on observareview the facility	NT is not met as evidenced tion, interview and document ailed to ensure physician ed for 1 of 1 resident (R19) ture ulcer wound care.		F309 -R19 is receiving wound care per Morders. UA has been completed, Moreviewed, and treatment has been completed per MD orders for R5All residents have the potential to Mathematical in MD orders are not follow -Licensed staff was educated on fo	ID has be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245323	B. WING			07/ <sup>-</sup>	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	R19's quarterly Min 6/6/16, indicated R: Alzheimer's disease cognition, was total activities of daily liv assist with positioni ulcers and had deversesure ulcer.  R19's physician ordindicated: Apply we heel, ok to shower, soap and water with date 7/6/16).  On 7/14/16, at 3:06 (LPN)-C was obserpressure ulcer dressure uneasured 1.5 centil LPN-C removed he gauze dressing pactape, applied saline 4 and washed the videous and regloved gauze 4 X 4 and applied saline quared 4 X 4 and applied 5 X 4 A A A A A A A A A A A A A A A A A A	pressure ulcer wound care as	F3	09	MD orders and following up on ordereceived.  -Audits will be completed 3 times won new orders to insure orders and needed follow up are completed as written. Negative findings will be corrected immediately and education provided as needed. Audit results reviewed at QAPI for recommenda and need for continued audits.  -DNS/Designee is the responsible.  - Corrective action will be complete August 22, 2016.	veekly I s on will be tions party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484		.0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	kerlix gauze to secremoved her gloves sock and pressure washed her hands.	by wrapping the left heel with ure the dressing. LPN-C s and applied R19's slipper relief boot, LPN-C then	F3	309			
	dressing change, a indicated to wash the LPN-C verified she order, and should he	nd stated the physician order ne wound with soap and water. did not follow the physician's nave washed the wound with or to applying the dressing.					
	(DON) stated, it was follows the physicial	p.m. the director of nursing s her expectation the nurse and order as directed. The nould have been completed as ed.					
	A facility policy for f physicians orders v	ollowing/implementing vas not provided.					
	R5's physician orde urinary incontinenc	ers were not followed regarding e needs.					
	was diagnosed with disorders of the bla						
	R5's Urinary Incont	inence Care Area Assessment					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245323	B. WING _		07	//15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DDE D BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	urgency, required a	6, indicated R5 had urinary ssistance in toileting, had nce and the overall objective	F 30	09		
	(treats overactive b was to try Vesicare	on 3/25/16, indicated Ditropan ladder) was ineffective, so R5 10 milligrams (mg) (treats . Could consider Botox sical.				
	recommended phys (urine test) which w home facility when results to physician infection, R5 would infection (UTI) until Botox treatment the	n 5/27/16, indicated a sician's order to get a UA rould be easier done at the R5 was in bed, then fax and if the UA was positive for be treated for a urinary tract clear and then arrange for creafter. The report indicated with that approach would like her management.				
	completed and resu	lacked indication the UA was ults faxed to the physician, or p related to R5's urology visit.				
	stated R5 needed to sometimes 15-30 ti	p.m. nursing assistant (NA)-A o go to the bathroom a lot, mes in an 8 hour shift. NA-A sted R5 to the commode 12 o far.				
		a.m. R5 stated the girls came				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE COMP	
		245323	B. WING _		07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX  WALKER, MN 56484	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 309	R5 stated she was see what they can different medicine in thought is had helpophysician was going she didn't know who can attempt to schedwas completed as corder on 5/27/16, at 1:19 (DON) verified R5's have been address	and my urine just comes out. going to see a specialist to do for her urinary frequency as had been attempted which R5 ed. R5 also stated the g to do something else, but en.  a.m. registered nurse (RN)-A know who was responsible for sician orders and did not know the done about R5's urology  8 a.m. the facilities clinical stated she had reviewed R5's confirmed there was noth indicated labs, follow up, or dule the Botox appointment directed by R5's physician's	F 30			
F 329 SS=D	physician's orders v 483.25(I) DRUG RE UNNECESSARY D	GIMEN IS FREE FROM	F 32	29		8/22/16

	OF DEFICIENCIES OF CORRECTION			TE SURVEY MPLETED		
		245323	B. WING		07	/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP 209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 329	drug when used in duplicate therapy); without adequate mindications for its usadverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs us therapy is necessal as diagnosed and crecord; and resider drugs receive gradiobehavioral interven	An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 3	329		
	by: Based on interview facilty failed to act upharmacist's recommesidents (R18) which pharmacist recommended upon, as required. Finding include:	nmendations for 1 of 5 o had ongoing consulting nendations which were not		F329 -Pharmacy recommendati have been reviewed and a the MD responsibleAll residents have the pot affected if pharmacy recor are not addressed by MDADNS has been educated up on pharmacy recomme the responsible MDPharmacy recommendati reviewed twice monthly to	ential to be mmendations d on following endations with ons will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING			07/ <sup>-</sup>	15/2016
	PROVIDER OR SUPPLIER	ALKER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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 329	R18's diagnoses as disease (GERD-heapnea (a sleep discrepeatedly stops are the throat muscles disease, dependent heart failure, hypert R18's admission M 5/12/16, indicated Freceived a daily dosantidepressant.  R18's Psychotropic Assessment (CAA) had not been taking R18's Order Summ directed staff to adrected staff to adrected staff to adrected short term to a cid production) temazepam 15 mg (medication used to R18's Pharmacy R6/13/16, and 7/11/1 the consulting phar recommended a grabe considered for p	gastro-esophageal reflux art burn), obstructive sleep order when breathing and starts which occurs when relaxes), end stage renal at on renal dialysis, diabetes, ension and major depression.  Inimum Data Set (MDS) dated R18 was on dialysis and se of insulin and an  Drug Use Care Area dated 5/20/16, indicated R18 as a sedative/hypnotic.  ary Report dated 7/14/16, minister: ium delayed release 40 be a day (medication usually treat GERD and excessive as every evening as needed of treat insomnia)  eview notes dated 5/16/16, 6, repeatedly indicated that	F3	229	recommendations have been addreby MD responsible. Negative finding be addressed with MD responsible immediately. Audit results will be reviewed at QAPI for recommendation and need for continued audits.  -DNS/Designee is the responsible perceptive action will be completed August 22, 2016.	ngs will tions oarty.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION			
		245323	B. WING			07/	15/2016	
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	BOX 700  ECTION (X5 HOULD BE COMPLE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 329	R18's medication a for May, June and one taken the tema:	age 27 dministration records (MAR) July 2016, indicated R18 had zepam at all and had on dose of R18's scheduled	FS	329				
		gress note dated 7/14/16, ement of the CP's above ations.						
	(LPN)-B confirmed when needed at be	a.m. licensed practical nurse R18 had temazepam ordered dtime for sleep, however, R18 nistered the temazepam for						
	(DON) confirmed F had received panto 40 mg twice a day. confirmed R18 had as needed at night temazepam since tordered (5/12/16). above noted CP ref6/13/16, and 7/11/1 considerations for 0 temazepam and paher expectation that followed up upon in assistant director of e-mail was sent earincluded the CP's resident in which stemals into the physical street and the control of the con	2 p.m. director of nursing 118 had current orders for and prazole delayed release (DR) In addition, the DON temazepam 15 mg ordered and had not taken the he medication had been The DON also confirmed the commendations dated 5/16/16 6, regarding the GDR's for both R18's antoprazole and stated it was at these recommendations be a timely manner. The f nursing (ADON) stated an ch month by the CP which ecommendations for each ne placed a copy of these vsician's mailbox for the when the physician came for	3					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245323	B. WING _		07/	/15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	never reviewed the review note in the of CP's monthly reconconfirmed she had day prior (7/14/16), physician had receifrom the pharmacistor May, June or June On 7/15/16, at 2:56 documented each rhis recommendation the CP's monthly review. In addition, e-mail each month recommendations he pharmacy review notes available in the resist CP verified he had GDR's for R18's terfor the last three makes expectation that	e. The ADON confirmed she CP's monthly pharmacy omputer which included the mendations. The ADON rounded with the physician the however, was unsure if the ved R18's recommendations its monthly drug regime review	F 32	29			
	Requirements policy would review the mare resident at least mondocumented in the readily retrievable frommunicate montoprescriber and the from the second reservable from the second re	cist Services Provider y dated 5/12, indicated the CP edication regimen of each onthly and this review would be resident's medical record or a ormat. The CP would hly to the responsible facility leadership or changes in medication					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		245323	B. WING _		07/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX  WALKER, MN 56484	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION
F 356 F 356 SS=C	483.30(e) POSTED INFORMATION  The facility must post a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per single - Registered nurses of the current date. The facility must pospecified above on of each shift. Data o Clear and readables.	on NURSE STAFFING  and the actual hours worked egories of licensed and staff directly responsible for hift:  rses.  tical nurses or licensed as defined under State law).  e aides.  ast the nurse staffing data a daily basis at the beginning must be posted as follows:	F 35 F 35		8/22/16
	make nurse staffing for review at a cost standard.  The facility must m staffing data for a n required by State la This REQUIREMED by: Based on interview facility failed to mai	pon oral or written request, g data available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.  NT is not met as evidenced and document review, the ntain the posted daily nurse ninimum of 18 months, as		F356 -Daily posting of staff hours is being retained to meet the required 18 recognitions.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		SURVEY PLETED
		245323	B. WING _		07/ <sup>-</sup>	15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVINGOENTED W	AL KED		209 BIRCHWOOD AVENUE WEST PO BOX 7	00	
GOLDEN	LIVINGCENTER - WA	ALKER		WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	residents, family or this information.  Findings include:  On 7/14/16, at 2:00 nurse staffing data 7/14/16, were revie staffing data sheets 7/2/16, 7/3/16, 7/4/missing.  Further review of th data sheets for 201 data sheets were m 1/10/16, 1/15/16, 2/3/6/16, 3/17/16, 3/2	the potential to affect all visitors who wished to review p.m. the facility posted daily sheets from 6/27/16, to wed. The facility daily nurse for 6/28/16, 6/29/16, 7/1/16, 16, and 7/8/16, were not re facility's daily nurse staffing 6, indicated the following staff hissing: 1/8/16, 1/9/16, 6/16, 2/7/16, 2/14/16, 2/20/16, 17/16, 5/27/16, 6/1/16, 6/2/16, 16, 6/6/16, 6/7/16, and	F 35	retentionAll residents and visitors have the potential to be affected if daily postistaff hours is not maintained and avoid for reviewEducation has been provided to morecords on requirement to retain 18 months of daily posting of staff hourally maintained. Negative findings will be corrected and education provided a necessary. Audit results will be revat QAPI for recommendations and for continued auditsED/Designee is the responsible parally complete august 22, 2016.	vailable edical s rs. kly to s be as riewed need	
	if the daily nurse sta	5 a.m. the administrator stated affing data sheets were not in ty did not have them.				
F 387 SS=D	however, no policy 483.40(c)(1)-(2) FR	EQUENCY & TIMELINESS	F 38	37		8/22/16
	once every 30 days	pe seen by a physician at least for the first 90 days after east once every 60 days				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		E SURVEY PLETED
		245323	B. WING _		07/	15/2016
	PROVIDER OR SUPPLIER  I LIVINGCENTER - WA	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 387	not later than 10 darequired.  This REQUIREMENT by: Based on interview facility failed to ensure was reviewed for tirreceived a physicia first three months.  Findings include:  R18's admission MI 5/12/16, indicated Facility on 5/12/16, vanemia, coronary and hypertension, gastr renal disease, diaboth surgeon on 6/28/16, went to a foundary medical downward many medical downward.	considered timely if it occurs ys after the date the visit was NT is not met as evidenced and document review, the ure 1 of 1 resident (R18) who nely physician visits had n visit every 30 days for the with diagnoses which included retry disease, heart failure, oesophageal reflux, end stage etes, and depression.  Indicated R18 had been sician's assistant (PA)-A on ollow up appointment with a , and was evaluated by R18's eter (MD)-A on 7/14/16.	F 38	F387 -R18 is receiving timely MD visits intervals per regulationAll residents have the potential taffected if MD visits are not compintervals per regulationADNS has been educated on requirement for timely MD visits tregulatory guidelinesAudits will be completed twice moreview that residents are receiving visits timely. Negative findings with addressed immediately. Audit residents and need for cauditsDNS/Designee is the responsible. Corrective action will be completed August 22, 2016.	o be pleted at o meet onthly to g MD l be sults will ontinued e party.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COMP		E SURVEY IPLETED				
		245323	B. WING _		07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 387		ge 32 e dated 6/30/16, indicated 118 when MD-A rounded at the	F 38	37		
	(LPN)-A stated she missed evaluating I she had contacted	1 a.m. licensed practical nurse was unsure why MD-AR18 in June. LPN-A confirmed R18's primary clinic and the ead not been seen by MD-A, eduled.				
	(DON) and assistar confirmed R18 shor physician once a m following admission 60, and 90 day eva physician could eva	p.m. director of nursing nt director of nursing (ADON) uld have been seen by a onth for the first three months to the facility. After the 30, luations by a physician, then a cluate R18 every other month. N confirmed R18's 60 day visit ed by 6/21/16.				
F 411 SS=D	not provided.	hysician visit schedules was E/EMERGENCY DENTAL S	F 41	1		8/22/16
	A facility must provi resource, in accord part, routine and en meet the needs of e Medicare resident a	de or obtain from an outside ance with §483.75(h) of this nergency dental services to each resident; may charge a an additional amount for ency dental services; must if				

	CORRECTION	IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		245323	B. WING		07/15/2016
	ROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION
-	appointments; and to and from the der residents with lost of dentist.  This REQUIREMED by:	ne resident in making by arranging for transportation ntist's office; and promptly refer or damaged dentures to a	F 41		
	review, the facility f services for 1 of 3 r dental services.  Findings include:  R14's undated Facility f audited Facility for and multiple for all f	imum Data Set (MDS) dated R14 had not issues with nd R14 required extensive cares and was  Daily Living Care Area 12/8/15, indicated R14 assist with dressing secondary motion, poor balance, and ess as related to MS and a ted 5/13/16, directed staff to e two times a day and refer to		F411 -R14 has had dental issues additional residents have the potential affected if dental needs are not addressedLicensed staff has been educat providing and following up on de recommendationsAudits will be completed on 4 reweekly to ensure dental needs a addressed. Dental referrals will completed if dental needs are id Audit results will be reviewed at recommendations and need for auditsDNS/Designee is the responsib-Corrective action will be complex August 22, 2016.	ed on ental esidents are be entified. QAPI for continued le party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07	//15/2016	
	PROVIDER OR SUPPLIER	ALKER	A. BUILDING O7/15/2  STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 411  d ce, ed l ftor on n, on is, call I				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE	
F 411	the staff would not because she had M and added "I am not R14's faxed order so R14 had been com appointment had be addition, the faxed and asked if R14 re Tylenol and Tramac and R14's family we antibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment. The 2/19/2016, Quantibiotic for oral pa 2/23/16. The physic directed staff to "ho if worse." No other issue was noted in dental appointment.	is losing her teeth. R14 stated help her with dental visits and the pher with dental	F 41				

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			
		245323	B. WING		0.	7/15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	AN OF CORRECTION (COMPED TO THE APPROPRIATE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE	
F 411	was noted in the m On 7/13/16, at 12:4 (LPN)-B stated R14 2/23/16, and was re Bemidji who could in Northern Dental ref in Fargo. LPN-B sta \$1000.00 in which in At the time of the a UCARE insurance. record lacked docu 2/23/16, Northern E recommendation for surgeon in Fargo or been informed of R of service.  On 7/14/16, at 10:5 interview, R14's da appointment had be Fargo and stated so her mother could no current physical/met too far for her moth she was told by the place that would ac R14 went to Fargo. was in Feb or Marc with her mother's te daughter stated her her mouth because extractions and it w nobody would take  On 7/14/16, at 2:45 in her mouth all the	nation on R14's dental issue edical record.  5 p.m. licensed practical nurse was seen by a dentist eferred to Northern Dental in not pull the teeth. At that time, ferred R14 to an oral surgeon ated that facility wanted R14's daughter was notified. ppointment, R14 utilized However, R14's medical mentation regarding the	F 4				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/	15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 411	had to periodically periodically periodically periodically periodically periodically periodical neutron someone should be dental needs.  On 7/15/16, at 8:35 (DON) and assistant were interviewed reflection as the medicated on 2/18/16 milligrams (mg) for The DON verified the regarding starting of the R14's complaints ADON verified staff medical record regarding appointments. The needs were not me working on getting lappointment to see issues. The DON a	tooth in her mouth that she bush down so it stayed in her again that she was under which was not welfare, and felt able to take care of her  a.m. the director of nursing (ADON) agarding R14's dental needs. cal record with the DON, 6, R14 was given Tramadol 50 oral pain which was effective. The doctor was contacted an an antibiotic on 2/18/16, due to of oral pain. The DON and and had not documented in the arding R14's dental DON verified R14's dental the facility would be ther an appropriate the dentist for her teeth lso stated the staff would be noting dental appointments in	F 4	.11			
	however no policy v 483.60(a),(b) PHAF ACCURATE PROC	RMACEUTICAL SVC - EDURES, RPH	F 4	25		8/22/16	
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn	ovide routine and emergency als to its residents, or obtain eement described in eart. The facility may permit nel to administer drugs if State by under the general					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			07/-	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE  09 BIRCHWOOD AVENUE WEST PO BOX 70  VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	(including procedur acquiring, receiving administering of all the needs of each r  The facility must en a licensed pharmac	de pharmaceutical services es that assure the accurate dispensing, and drugs and biologicals) to meet resident.  Inploy or obtain the services of cist who provides consultation e provision of pharmacy	F 4	125			
	by: Based on interview facility failed to ens available as prescriwho had an as nee prescribed.  Findings include:  R18's Diagnosis ReR18's diagnoses as disease (GERD-he apnea (a sleep discrepeatedly stops ar disease, dependen heart failure, and many R18's admission M	and document review, the ure a hypnotic medication was ibed for 1 of 1 resident (R18) ded (PRN) hypnotic  eport dated 7/14/16, identified a gastro-esophageal reflux art burn), obstructive sleep order when breathing and starts), end stage renal ton renal dialysis, diabetes, arajor depression.			F425 -All ordered medications have been obtained for R18. R18 has had a slassessment completed and reviewed MDAll residents have the potential to be affected if ordered medications are availableLicensed staff has been educated procedure for obtaining medications ordered and obtaining required prescription for controlled medication when orderedAudits will be completed twice ween medications and ministration record for medications not available. Pharmat MD will be notified immediately for an egative findings and education professional and recommendations and refor continued audits.	leep ed by  De not  on s as  DNS  Ekly on r cy and any Divided riewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		· · · · · · · · · · · · · · · · · · ·	07/·	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	-	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Continued From pareceived a daily do antidepressant.	age 38 se of insulin and an	F∠	125	-DNS/Designee is the responsible   - Corrective action will be complete August 22, 2016.		
	Assessment (CAA)	Drug Use Care Area dated 5/20/16, indicated R18 g a sedative/hypnotic.					
	directed staff to add milligrams (mg) evo (medication used to	nary Report dated 7/14/16, minister temazepam 15 ery evening as needed o treat insomnia). R18's tially been ordered on 5/12/16.					
	6/13/16, and 7/11/1 consulting pharmad gradual dose reduced	eview notes dated 5/16/16, 6, repeatedly indicated the cist (CP) had recommended a ction (GDR) be considered for 3 had not been using the					
	for May, June and	Idministration records (MAR) July 2016, indicated R18 had ired the temazepam 15 mg at d.					
	(LPN)-B confirmed when needed at be had not been admit the month of July. didn't know if the fain the medication crequested. LPN-B	a.m. licensed practical nurse R18 had temazepam ordered ditime for sleep, however, R18 nistered the temazepam for LPN-B commented that she will be used the medication art to give R18, if he had thought there may have been ere R18 would have used the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		
		245323	B. WING			07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	OOMPLET  O7/15/2  SS, CITY, STATE, ZIP CODE  OD AVENUE WEST PO BOX 700  56484  VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 425	medication.  On 7/15/16, at 2:06 nursing (ADON) ve	p.m. assistant director of rified the facility did not have ble for R18. Both the director	F 4	25			
	of nursing (DON) a expectation that the ordered medication confirmed the phar residents' medication articulate a reason	nd ADON confirmed it was the e facility have all of R18's is available for R18. The DON macy in town filled the ons. The ADON was unable to why R18's temazepam which on 5/12/16, was still					
	(CP) stated he was temazepam had no CP confirmed all or	p.m. consulting pharmacist unaware that R18's It been made available to R18. dered medications, including ould have been filled and R18.					
	(PT)-A (from the loc pharmacy supplied facility. PT-A confir temazepam which had not been filled a hard copy of the p ordered prescription confirmed the phar the facility either the	p.m. pharmacy technician cal pharmacy) verified their the medications for the med R18's prescription for had been ordered on 5/12/16, due to the pharmacy required prescription or an electronically n for the temazepam. PT-A macy had not received from the hard copy prescription or the d prescription for R18's					
	On 7/15/16, at 3:59	p.m. The ADON stated R18					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431 SS=F	usually the hospital submitted their presprescription with the obtained the hard of then be faxed to the the pharmacy brough be given the hard of confirmed when the medications to the signed off that they however, the facility reconciliation process medications had be ADON was unable temazepam order homological to the signed off that they however, the facility reconciliation process medications had be ADON was unable temazepam order homological to the signed of the signed o	e facility from the hospital and physicians' electronically scriptions or sent a hard copy e resident. When the facility opy prescription, this would e local pharmacy and when ght the medications they would opy prescription. LPN-B e pharmacy delivered facility, the medication nurse had received the medications, a had no medication ess in place to determine if all the en received as ordered. The to explain why R18's had not been followed through.  p.m. nurse consultant (NC) not had a sleep pattern eted.  Requirements policy dated allar and reliable vices would be available to with prescription and dications.	F 4			8/22/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		245323	B. WING		07/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
F 431	labeled in accordar professional princip appropriate access instructions, and th applicable.  In accordance with facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Dr. Control Act of 1976 abuse, except whe package drug districtions.	als used in the facility must be new with currently accepted oles, and include the ory and cautionary e expiration date when  State and Federal laws, the all drugs and biologicals in the new surface to only authorized personnel to keys.  Ovide separately locked, a compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the ninimal and a missing dose can	F 43		
	by: Based on observareview, the facility for monitoring and second medication kits, one medication. This has residents residing in	NT is not met as evidenced tion, interview and document ailed to ensure the proper urity for 5 of 5 emergency e which contained narcotic ad the potential to affect all 26 in the facility who could have medications/narcotics from .		F431 -E kits have been removed from the facility. All controlled medications remaining in the facility have been accounted forAll residents receiving medications in the potential to be affected if expired medications are administeredLicensed staff has been educated on checking expiration dates, monitoring/security of controlled medications, accountability for control	1

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		245323	B. WING		07/	15/2016		
	PROVIDER OR SUPPLIER	DENTIFICATION NUMBER:  245323  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484  MARY STATEMENT OF DEFICIENCIES  IFFICIENCY MUST BE PRECEDED BY PULL  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  From page 42  A 1:31 p.m. during the medication of the main medication room with citical nurse (LPN)-A, five emergency (ekit) storage boxes were observed. torage boxes were composed of a with a clear plastic lid and measured tely 18 inches by 24 inches, and three pth. There were labels on the lids of ve ekits which identified the contents vidual ekit (one of the ekits lacked a e of the ekits, one which contained dications were found stored on top of ed medication dispensing machine. vo ekits were in a cabinet with a the door handles. LPN-A stated she e of the facility's policy for medication monitoring of the ekits which refreshed to the ekits refreshed				STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	(X5) COMPLETION DATE		
F 431	storage tour of the licensed practical remedication (ekit) so These ekit storage grey plastic with a approprimately 18 inches in depth. The four of the five ekit of each individual elabel). Three of the narcotic medication an automated medication an automated medication an automated medication and the other two ekits padlock on the door was unaware of the storage and monitorincluded the narcotic pharmacy which in was no longer provided the ekits on this paran order for an anticontained the antible LPN-A contacted the provided the facility verified she would the ekit if it had been on 7/15/16, at 2:35 nursing (ADON) stabout the ekits. The not know if anyone medications for exsecurity of the seal	I p.m. during the medication main medication room with nurse (LPN)-A, five emergency torage boxes were observed. boxes were composed of a clear plastic lid and measured inches by 24 inches, and three here were labels on the lids of s which identified the contents exit (one of the exits lacked a exits, one which contained as were found stored on top of lication dispensing machine. If we were in a cabinet with a per handles. LPN-A stated she are facility's policy for medication oring of the exits which tic exit. LPN-A verified the itially had provided the exits widing pharmacy services to the ead she had recently accessed ast Monday, as a resident had ibiotic. The exits had not biotic the resident required, so the pharmacy which currently with it's medications. LPN-A have used the medication from	F 431	medications, and reconciliation controlled medications every solution. Random audits will be perform medication carts weekly to che expired and/or undated medical Negative findings will be corresponded. Audit results will be reached. Audit results will be recontinued audits.  -DNS/Designee is the responsacion-	chift.  med on eck for ations. cted ovided as eviewed at ad need for sible party.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3	(X3) DATE SURVEY COMPLETED	
		245323	B. WING			07/15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CO 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		
F 431	The contents of the verified by the direct Injectable Emerger -Adrenalin (Epineph (mg) (used in life-th quantity (QTY) 2 -Benadryl 50 mg (a -Decadron 4 mg (c -Glucagon Emerge levels) QTY 2 -Haldol 5 mg (antip -Heparin-5000 units -Lasix-10 mg (diure -Lovenox 40 mg (a -Lovenox 100 mg (s -Narcan 0.4 mg (op -Reglan 5mg (gastr -Solu-Medrol 125 mg -Visteril 25 mg (antip -Vitamin K 10 mg (s -Zofran 2 mg (s -Zofran 2 mg (antip -Vitamin K 10 mg (s -Zofran 2 m	een she started which was o.  e ekits were as followed and ctor of nursing (DON):  ncy Supply Kit -  nrine) 1:1000 1 milligrams reatening-allergic reactions)  ntihistamine) QTY 4  corticosteriod) QTY 2  ncy Kit-(controls blood sugar sychotic) QTY 2  s (blood thinner) QTY 10  etic) QTY 4  nticoagulant) QTY 2  anticoagulant) QTY 2  coesophogeal reflux) QTY 4  ng (corticosteriod) QTY 2  thistamine) QTY 2  (anticoagulant) QTY 3  (anticoagulant) QTY 3  (anticoagulant) QTY 4  (antico	F 4	.31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/	15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFUL  DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 431	-Augmentin 875 mg -Avelox 400 mg (ar -Avelox 400 mg (ar -Bactrim 800 mg (ar -Catapres 0.1 mg (ar -Ceftin 250 mg (and -Cipro 250 mg (and -Compazine supposed -Coumadin 1 mg (ar -Coumadin 1 mg (ar -Instaglucose 31 gr QTY 2 -Kayexalate 15 gm -Keflex 250 mg (arr -Lasix 20 mg (diure -Levaquin 250 mg -Macrobid 100 mg -Nitroquick 0.4 mg -Proventil/Ventolin (QTY 6 -Vitamin K 5 mg (us QTY 2 -Zithromax 250 mg  The DON verified the broken, the medicate four doses of the Praccounted for and the kit, and no medication contained seals with Contents included:  -Amoxil 250 mg (ar 11/30/15)	g (antibiotic) QTY 10 g (antibiotic) QTY 10 ntibiotic) QTY 4 antibiotic) QTY 10 antibiotic) QTY 10 antihypertensions) QTY 2 tibiotic) QTY 10 ibiotic) QTY 10 sitory 25 mg (antiemetic) QTY nticoagulant) QTY 1 ams (gm) (boosts glucose) (treats hyperkalemia) QTY 2 ntibiotic) QTY 20 tic) QTY 10 (antibiotic) QTY 10 (antibiotic) QTY 10 (antibiotic) QTY 10 (nitrate) QTY 25 0.083% (nebulizer solution) sed for blood coagulation)	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07	//15/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	8/6/14) -Avelox 400 mg (a 3/2015) -Bactrim 800 mg 4/2015) -Catapres 0.1 mg -Ceftin 250 mg (a 12/16/14) -Cipro 250 mg (a 8/30/14) -Compazine support 4 -Coumadin 1 mg (1/31/15) -Instaglucose 31 g QTY 2 -Kayexalate 15 gm-Keflex 250 mg (a 8/3/14) -Lasix 20 mg (diur-Levaquin 250 mg 9/2014) -Macrobid 100 mg 8/2014) -Nitroquick 0.4 mg 6/2015) -Proventil/Ventolin QTY 6 -Vitamin K 5 mg (u QTY 2 (expired 10 -Zithromax 250 mg 10/11/14)  The DON verified exception of the Count of	antibiotic) QTY 10 (expired antibiotic) QTY 4 (expired (antibiotic) QTY 10 (expired (antibiotic) QTY 10 (expired (antihypertensions) QTY 2 (expired ntibiotic) QTY 10 (expired exitory 25 mg (antiemetic) QTY anticoagulant) QTY 20 (expired expired expired (antibiotic) QTY 10 (expired expired expired expired expired (antibiotic) QTY 10 (expired expired (antibiotic) QTY 10 (expired (antibiotic) QTY 25 (expired (antibiotic) QTY 25 (expired (antibiotic) QTY 25 (expired (antibiotic) QTY 10 (expired (antibiotic) QTY 25 (expired (antibiotic)	F 4	131			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING _	·····	07	/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP COI 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	of the Macrobid 100 contained nine dos unaccounted for).  Medication Ekit sea	s should have been 10 doses of mg and the ekit only es (one dose of Macrobid al tags #368213/368279 did	F 43	1		
	contained:  -Benadryl 50 mg (a -Decadron 4 mg (c -Adrenalin (Epineph (mg) (used in life-thi QTY 2 vials -Haldol 5 mg (antip -Heparin-5000 units -Lasix-10 mg (diure -Narcan 0.4 mg (op -Reglan 5mg (gastr vials -Solu-Medrol 125 m -Visteril 25 mg (anti (expired 5/2016) -Vitamin K 10 mg ((expired 5/1/16) -Zofran 2 mg (antie -Lovenox 40 mg (a -Lovenox 100 mg (a -Glucagon Emerge levels) QTY 2 kits  The DON verified the content label on the not able to verify if accurate. In adidtio	plate antidote) QTY 2 vials roesophogeal reflux) QTY 4 ang (corticosteriod) QTY 2 vials tihistamine) QTY 2 vials anticoagulant) QTY 2 vials				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245323	B. WING		<del></del>	07/-	15/2016
	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE
The Narcotic Emery 429430/429436 cordivan 0.5mg QTN-Ativan 2 mg injecticibilaudid 2 mg QT-Morphine sulfate in Morphine sulfate	gency Supply ekit- seal # Intents included:  (6 In QTY 2 Y 6 Injection 10 mg QTY 4 Impository 5 mg. QTY 4 Impository 5 mg. QTY 4 Impository 5 mg. QTY 6 Impository 6 Import 2 Impository 6 Import 2 Impository 6 Import 2 Impository 6 Import 6 Import 6 Import 7 Import 8 Impository 7 Import 9 Impository 8 Impository 9 Im	F	131			
	Continued From particles of the Narcotic Emer 429430/429436 color-Ativan 0.5mg QTV-Ativan 2 mg injection - Dilaudid 2 mg QTV-Morphine sulfate in - Morphine sulfate in - Morphine sulfate in - Morphine sulfate in - Tylenol # 3 300mg - Valium Injection 5 mg - Vicodin tablets 5/5 The DON verified the narcotic medication count was inaccural unaccounted for included:)  - Vicodin tablets 5/5 - Valium Injection 5 mg - Morphine sulfate in - Morphine sulfate in - Vicodin tablets 5/5 - Valium Injection 5 mg - Morphine sulfate in - Mo	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  The Narcotic Emergency Supply ekit- seal # 429430/429436 contents included:  -Ativan 0.5mg QTY 6 -Ativan 2 mg injection QTY 2 -Dilaudid 2 mg QTY 6 -Morphine sulfate injection 10 mg QTY 4 -Morphine sulfate suppository 5 mg. QTY 4 -Oxycodone 5mg QTY 6 -Percocet 5/325 mg QTY 6 -Morphine sulfate oral solution 10 mg QTY 6 -Tylenol # 3 300mg/30 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6  The DON verified the narcotic ekit contained narcotic medications and the narcotic medication count was inaccurate. Medications which were unaccounted for included: (with discrepancies	PROVIDER OR SUPPLIER    LIVINGCENTER - WALKER	PROVIDER OR SUPPLIER  LIVINGCENTER - WALKER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  The Narcotic Emergency Supply ekit- seal # 429430/429436 contents included:  -Ativan 0.5mg QTY 6 -Ativan 2 mg injection QTY 2 -Dilaudid 2 mg QTY 6 -Morphine sulfate injection 10 mg QTY 4 -Morphine sulfate suppository 5 mg. QTY 4 -Oxycodone 5mg QTY 6 -Percocet 5/325 mg QTY 6 -Morphine sulfate oral solution 10 mg QTY 6 -Tylenol # 3 300mg/30 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium lostion 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Volodin tablets 5/500 mg	ROVIDER OR SUPPLIER  LIVINGCENTER - WALKER  SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47  The Narcotic Emergency Supply ekit-seal # 429430/429436 contents included:  -Ativan 0.5mg QTY 6 -Morphine sulfate injection 10 mg QTY 4 -Morphine sulfate oral solution 10 mg QTY 6 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate injection 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 4 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 5/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 6/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Morphine sulfate oral solution 10 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 6/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 6/500 mg QTY 6 -Valium Injection 5mg QTY 2 -Vicodin tablets 6/500 mg QTY 6 -Valium Injection 5mg QTY	A BUILDING COM  245323 B. WING  245023 B. WING  245023 B. WING  2770000000000000000000000000000000000

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245323	B. WING _		07	7/15/2016	
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	TY, STATE, ZIP CODE ENUE WEST PO BOX 700		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	expiration dates and the ekit storage systems a concern and monitoring them dates	age 48 If have been monitored for an area of reconciled. The DON stated astem and lack of monitoring a she would expect staff to be aily, and the narcotic of have been double locked.	F 43	31			
	pharmacist (CP) st medication storage The CP stated he varecommendations storage on his reported. The CP verified pro- ekits was something of ekit medications medications. The Cf facility to monitor the the seals on a daily controlled (narcotic he was unaware the room contained the confirmed he had re been something the	ated he checked the facility's a room on a quarterly basis. Would have included any regarding ekits monitoring and ort to the facility, but does not recommendations for the ekits. Oper monitoring and storage of any he looked for, including use and expiration dates of the CP stated he would expect the ne use of ekit medications and or basis, especially the expirations. The CP stated refacility's medication storage rese five ekits of medication. CP missed this and it would have at he should have included in edication storage process at					
	Kits policy, dated 5 supply was maintal along with a list of expirations dates, to medication use from medication form are color-coded lock to	acy Service and Emergency /12, indicated the emergency ined at a designated area, supply contents and the nurse records the m the emergency kit on the and flags the kit with a p indicate need for kits are monitored/inventoried					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED			
		245323	B. WING		07	7/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP COL 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431		narmacist/provider pharmacy sys for completeness and	F 4	31		
F 441 SS=D	the emergency kit is perpetual inventory separate sheet or a pages for each indirect Each dose given ar received from the pappropriate invento Remaining" adjuste and outgoing nurse controlled substance exchange of keys.	ontrolled substances stored in a maintained as follows: a system is used with a bound book with numbered vidual medication in the kit. In all replacement doses tharmacy are entered on the ry sheet with the "Amount ad accordingly. The incoming is verified the inventory of the es at each change of shift or I CONTROL, PREVENT	F 4	41		8/22/16
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under which (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	(b) Preventing Spre (1) When the Infect	ead of Infection ion Control Program				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		COMPLETED	
		245323	B. WING _		07/1	5/2016	
	PROVIDER OR SUPPLIER	ALKER	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484		DE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 441	prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dihand washing is incorprofessional practic (c) Linens Personnel must ha transport linens so infection.	esident needs isolation to of infection, the facility must the prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted ee.	F 44	11			
	by: Based on observareview, the facility f hygiene was impler (R19) observed for facility failed to ensproperly covered for ensure cleanable aprovided.  Findings Include: R19's wound care was review.	sion, interview and document ailed to ensure proper hand mented for 1 of 1 resident wound care. In addition, the ure wheelchair cushions were r 2 of 2 residents (R2, R28) to and sanitary surfaces were was observed and the facility proper hand hygiene during wound care.		F441 -Staff are utilizing proper hand between glove changes for R R28 have been provided with covers for their wheelchair cu-All residents have the potenti affected if infection control me not followedNursing staff has been educa infection control measures with on hand hygiene related to glo and maintaining cleanable, was surfaces for resident equipme -Audits of proper hand hygien dressing changes will be comweekly. Audits of resident equipme be completed weekly to ensurare cleanable. Negative finding	19. R2 and washable shions. ial to be easures are ated on the emphasis ove changes ashable ent. ee during pleted twice uipment will re surfaces		

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	COMPLETED		
		245323	B. WING			<b>07</b> /-	15/2016
	PROVIDER OR SUPPLIER	ALKER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	6/6/16, indicated Rial Alzheimer's disease cognition, was total activities of daily liviassist with positioni ulcers and had deviron pressure ulcer.  R19's physician ordindicated: Apply we heel, ok to shower, soap and water with date 7/6/16).  On 7/14/16, at 3:06 (LPN)-C was obserpressure ulcer dressure u	imum Data Set (MDS) dated 19 was diagnosed with e, had severely impaired ly dependent on staff for all ing (ADLs), required extensive ng, was at risk for pressure eloped an unstageable  der report print date 7/14/16, to dry dressing daily to left wound should be washed with n each dressing change (order p.m. licensed practical nurse ved performing R19's left heel sing change. LPN-C gloved as pressure relief boot and er left foot. A gauze 4 X 4 was wound. LPN-C measured the loer and stated the wound meters (cm) by 1.9 cm. or gloves and opened two 4 X 4 ekages, obtained two pieces of a wound wash to the gauze 4 X wound using a circular motion. Debris was observed to be wound. LPN-C removed her d. LPN-C applied saline to a opplied it to R19's pressure ulcer a dry gauze 4 X 4 over the by wrapping the left heel with the dressing. LPN-C and applied R19's slipper relief boot, LPN-C then		41	corrected immediately with educati provided as needed. Audit results reviewed at QAPI for recommenda and need for continued audits.  -DNS/Designee is the responsible - Corrective action will be complete August 22, 2016.	will be tions oarty.	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245323	B. WING _		07	//15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP C 209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	ODE	, 10, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	her hands after ren the provision of wo treatment and shou	nge 52 C verified she did not wash noving her gloves throughout und dressing change ald have. LPN-S verified she ving and the dressing change	F 44	.1		
	(DON) stated, it was to wash her hands prior to donning cle change. The DON sure training was p	p.m. the director of nursing is her expectation for the nurse after removing gloves and an gloves during a dressing stated the facility would make rovided to all staff who perform o make sure the procedure owed.				
	dated 2/4/16, indicational hygiene the paper spread of infections	Handwashing/Hand Hygiene, ated the facility considered rimary means to prevent the s and all personnel shall follow and hygiene procedures to read of infections.				
		elchair positioning cushions ers to ensure sanitary and				
	diagnosis of edema	dated 7/15/16, identified a, muscle weakness ve bladder and epilepsy.				
	6/2/16, indicated R	mum data set (MDS) dated 2 was totally dependent on 5 wheelchair, was at risk for				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY IPLETED
		245323	B. WING			07/	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	bowel and bladder reducing device for On 7/13/16, at 12:3	s frequently incontinent of and utilized a pressure bed and chairs.  0 p.m. and during intermittent	F 4	41			
	approximately 8:00 and 7/15/16, R2's wheelchair with an	ghout the survey from a.m. to 4:30 p.m. on 7/14/16, was observed seated in a uncovered, yellow, foam at cushion. The foam was					
	diagnosis of indicat assist with transferr surfaces- bed-whee indicated, R28 was	S dated 4/27/16, identified ed R28 required extensive ring and position between elchair. The MDS further at risk for pressure ulcers and reducing device on his bed					
		e dated 7/9/16, indicated R28 ir for mobility which was					
	seated in the wheel	p.m. R28 was observed chair in own room. The was an uncovered, gray foam					
		1 p.m. R28 was observed in ated in the wheelchair on top d, foam cushion.					
		0 a.m. R28 was observed in in the wheelchair on top of a am cushion.					
	On 7/15/16, at 9:44	a.m. R28 was observed in					

-	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245323	B. WING	·····	07	/15/2016
	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa own room seated ir gray, uncovered for	the wheelchair on top of a	F 4	41		
	maintenance direct cushion which a who of the yellow for the cushion should cushion cover on it. wheelchair cushion cushion should also housekeeping clean cushions became coleaned. The MD so been replaced right verified the lack of confection control conwere not cleanable	I 5/16, at 9:59 a.m. the or (MD) observed R2's lite bath towel was placed on am cushion. The MD verified have a non-permeable. The MD also observed R28's and verified the grey foam to be covered. The MD stated the wheelchairs and if the lirty, they were removed to be tated the covers should have away prior to use. The MD cushion covers was an ancern as the foam cushions surfaces. The MD stated he facility had a policy regarding overs.				
F 504 SS=D	wheelchair pressur- have covers on the confirmed with the uncovered cushion issue. 483.75(j)(2)(i) LAB	p.m. the DON verified the e relieving cushions should m at all times. The DON also lack of cleanability, the s would be an infection control SVCS ONLY WHEN YSICIAN	F 5	04		8/22/16
		ovide or obtain laboratory ordered by the attending				
	This REQUIREMEN	NT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING		07/	15/2016	
-	PROVIDER OR SUPPLIER	ALKER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	•		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 504	by: Based on interview facility failed to ensurinalysis was acte who had an order f which was not complete which was not complete which was not complete was diagnosed with disorders of the blands as a cognitively assist with toileting incontinence of blands was to with the was to minimize rise.  R5's Urinary Incomplete was to minimize rise.  R5's Urology visit of the was to try Vesicare overactive bladder, instillation interaves.  R5's Urology visit of the was to try Vesicare overactive bladder, instillation interaves.	w and document review, the sure physician orders for a d upon for 1 of 1 resident (R5) for a urinalysis lab test for upleted.  Solution dated 4/18/16, indicated R5 in Diabetes, anxiety and adder. The MDS also indicated intact, required extensive, and had frequent dder.  Itinence Care Area Assessment 16, indicated R5 had urinary assistance in toileting, had ence and the overall objective sks.  In 3/25/16, indicated Ditropan oladder) was ineffective, so R5 in 0 milligrams (mg) (treats in toilet of the could consider Botox	F 504	F504 -UA has been obtained as ordered MD has reviewed results and sub orders are being completedAll residents have the potential to affected if labs are not completed ordered and/or follow up is not co as orderedLicensed staff has been educate following up on MD ordersAudits will be completed 3 times on new orders to insure orders an needed follow up are completed a written. Negative findings will be corrected immediately and educa provided as needed. Audit results reviewed at QAPI for recommend and need for continued auditsDNS/Designee is the responsible Corrective action will be complex August 22, 2016.	be as mpleted d on weekly id as tion s will be ations e party.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			07/ <sup>-</sup>	15/2016
	PROVIDER OR SUPPLIER	ALKER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 504	Botox treatment the	clear and then arrange for ereafter. The report indicated with that approach would like	F 5	04			
	completed and resu	lacked indication the UA was ults faxed to the physician, or p related to R5's urology visit.					
	stated R5 needed to sometimes 15-30 ti	p.m. nursing assistant (NA)-A o go to the bathroom a lot, mes in an 8 hour shift. NA-A isted R5 to the commode 12 o far.					
	and helped her but until they get here a R5 stated she was see what they can o different medicine h thought is had helpe	a.m. R5 stated the girls came sometimes she cannot wait and my urine just comes out. going to see a specialist to do for her urinary frequency as nad been attempted which R5 ed. R5 also stated the g to do something else, but en.					
	stated she did not keep following up on phy	a.m. registered nurse (RN)-A know who was responsible for sician orders and did not know t done about R5's urology					
	director consultant	8 a.m. the facilities clinical stated she had reviewed R5's confirmed there was no					

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

PRINTED: 08/05/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	(X3) DATE SURVEY COMPLETED	
245323 B. WING 07/	15/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - WALKER  STREET ADDRESS, CITY, STATE, ZIP CODE  209 BIRCHWOOD AVENUE WEST PO BOX 700  WALKER, MN 56484		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 57 documentation which indicated labs, follow up, or an attempt to schedule the Botox appointment was completed as directed by R5's physician's order on 5/27/16 urology visit.  On 7/15/16, at 1:19 p.m. the director of nursing (DON) verified R5's physician's orders should have been addressed and followed up on. The DON stated it was her expectation that all orders be followed.  A facility policy for following/implementing physician's orders was not provided.		

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

F5323025

Printed: 07/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245323

B. WING

07/12/2016

NAME OF PROVIDER OR SUPPLIER

**GOLDEN LIVINGCENTER - WALKER** 

STREET ADDRESS, CITY, STATE, ZIP CODE

209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

COLDEIN	OCEDEN EN MODERTER WALKER		R, MN 564	184	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL F OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000		
	FIRE SAFETY				
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Division. At the time of this Golden Living Center of Walker was four substantial compliance with the requirer participation in Medicare/Medicaid at 42 Subpart 483.70(a), Life Safety from Fire 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Code (LSC), Chapter 19 Existing Health	State survey, and in ments for CFR, and the Safety			
	This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones.				
	The building is protected by a complete fire sprinkler system installed in accordance NFPA 13 Standard for the Installation of Systems (1999 edition) with quick responseds. The facility has a fire alarm syst smoke detection in the corridors, space the corridor system and in common are installed in accordance with NFPA 72 "National Fire Alarm Code" (1999 edition monitored for automatic fire department notification.	ance with f Sprinkler conse em with es open to eas that is The n), which is			
	The facility has a capacity of 42 beds a	nd had a			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRES	ENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

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

Printed: 07/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
		245323		B. WING		07/1	2/2016	
1	ROVIDER OR SUPPLIER				TATE, ZIP CODE	•		
GOLDEN	LIVINGCENTER -	WALKER		RCHWOOD R, MN 564	AVENUE WEST PO BOX 70	U		
/V/\ \ID	SHMMARVST	ATEMENT OF DEFICIENCI	L	ID ID	PROVIDER'S PLAN OF CORE	RECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE	
K 000	Continued From pa	age 1		K 000				
		e time of the survey.						
		4.40 OED Outstand 40	22 70(-) :-					
	The requirement at MET.	t 42 CFR, Subpart 48	53.70(a) IS					
					8			
	-							



## PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted July 29, 2016

Ms. Tracy Hendrickx, Administrator Golden LivingCenter - Walker 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5323025, H5323015, H532306

Dear Ms. Hendrickx:

The above facility was surveyed on July 11, 2016 through July 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5323016 and H5323016 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Golden LivingCenter - Walker July 29, 2016 Page 2

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 08/18/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00995 07/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 **GOLDEN LIVINGCENTER - WALKER** WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

**INITIAL COMMENTS:** 

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 08/04/16

STATE FORM ZI3W11 If continuation sheet 1 of 63

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00995	B. WING		07/1	5/2016
	PROVIDER OR SUPPLIER	ALKER 209 BIRC		STATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically, is necessary for Starenter the word "correct. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm.  On July 11th, 12th, surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed.  An investigation of H5323016 were consubstantiated.  Minnesota Department the State Licensing federal software. Taxesigned to Minnesonal Nursing Homes. The assigned tag in column entitled "ID statute/rule out of completed in the statement of the statement, evidence by." Followare the Suggested Time period for Correction Correction Correction Correction Correction for Correction Correctio	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the tent of Health.  13th, 14th and 15th, 2016, epartment's staff visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted.  complaints H5323015 and mpleted and found not to be ment of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and	2 000			

6899

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	,	
GOLDEN	I LIVINGCENTER - WA	AIKER	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL THERE IS NO REC PLAN OF CORRECT	I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.	2 000			
2 302	or related disorder to ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.  (a) If a nursing facility Alzheimer's disease or related or segregated or generate staff and their supervisor care.  (b) Areas of require (1) an explanation or related disorders;	EASE OR RELATED ING: 6503 ity serves persons with disorders, whether in a ral unit, the facility's direct rs must be trained in dementia	2 302			8/22/16
	(3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	with challenging behaviors;				

Minnesota Department of Health

STATE FORM 2I3W11 If continuation sheet 3 of 63

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	by: Based on interview facility failed to prov training for 2 of 4 no NA-G) and for 1 of	and document review, the vide the required Alzheimer's cursing assistants (NA-F, 1 dining service manager to potential to affect all 26 led in the facility.		Corrected.		
	Findings include:					
		1/30/15, and the employee ence of having received the s training.				
		3/6/15, and the employee ence of having received the s training.				
		5/5/15, and the employee ence of having received the s training.				
	the facility lacked do and DSM had comp training. The admir	a.m. administrator confirmed ocumentation that NA-F, NA-G bleted their Alzheimer's histrator confirmed all three of hould have completed the				
		p.m. administrator confirmed SM are current employees of				
	No policy related to provided.	Alzheimer's training was				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - WA	DIKER	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 4	2 302			
	The director of nurs implement policies Alzheimer's training quality assessment	THOD FOR CORRECTION: sing (DON) could develop and and procedures related to the program requirements. The and assurance committee om audits to ensure				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
2 435	MN Rule 4658.0210 Assignments	O Subp. 2 A.B. Room	2 435			8/22/16
	must develop and in procedures for addinctuding complaint and roommates. A procedures must in A. a mechanism resolution of room complaints; and	complaints. A nursing home mplement written policies and dressing resident complaints, s regarding room assignments t a minimum, the policies and clude the following: n for informal dispute assignment and roommate for documenting the complaint				
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide 1 of 2 residents (R12) with ification of a roommate		Corrected.		
	Findings include:					

PRINTED: 08/18/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 435	Continued From pa	ige 5	2 435			
	moved into his room	a.m. R12 stated R18 had m about a month ago (R18 on 6/22/16). R12 stated he ed of the roommate change g in.				
	confirmed when a which had a reside room, two forms we confirmed one form resident requesting room change and to completed and give notification that the roommate. SW stathe move, then the However, if one of the move, then the period before the nR12 (resident who had not been proving A Roomma been on vacation we room and SW was through on the noting room changes in the confirmed any time regarding a room/reconversation should residents' medical medical record lack notification of R12 verified R12 had to been made aware roommate prior to	on a.m. social worker (SW) resident moved into a room and already occupying that ere to be competed. SW in was completed by the for being asked to make the he second form was en to the resident as y would be receiving a new atted if both residents agreed to move could occur right away, the residents hadn't agreed to move occurred. SW verified received a new roommate) ded or signed the Notice te form. SW stated she had when R18 moved into R12's unsure of who followed fication of roommate and/or the SW's absence. SW there was a conversation commate change that did be documented in the record. SW confirmed R12's ked documentation regarding getting a roommate. SW ld her that he (R12) had not that he would be getting a R18 moving in. SW confirmed in notice of the room change	t			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING	<del></del>	07/1	15/2016
	PROVIDER OR SUPPLIER	ALKER 209 BIRCH		ETATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 435	on 6/15/16. R18 has so the seven day as with R18 moving in	ge 6 d refused to sign the notice, djustment period was provided to R12's room on 6/22/16. 9 a.m. the administrator	2 435			
	confirmed prior to a roommate change to should be provided potential roommate consideration prior she expected all co room/roommate change administrator confirmade sure the appropriate made sure the appropriate and signed and signed and roommate and signed and roommate and signed and roommate change and room and signed and roommate change and room a	resident room change and/or the appropriate notification. The administrator stated compatibility was taken into to a roommate change and nversations regarding anges to be documented in				
	through 7/13/16, lac appropriate notifica	ress notes (PN) from 6/15/16, cked documentation of tion of a roommate change or nent of the roommate change.				
	indicated the social involved with any re resident's social, er would be assessed relocation of the reservice social service service social service social service social service service social service service social service service service social service servic	location policy dated 2/26/15, service staff would be esident room relocations. The notional and cognitive needs and considered prior to sident. The impact of room sident's psychosocial status by the social service staff. Staff would work with the m to consider roommate we at the most appropriate ent. In addition, a plan would be social service staff to assure seems related to the residents'				

Minnesota Department of Health

STATE FORM 2I3W11 If continuation sheet 7 of 63

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/	15/2016	
	PROVIDER OR SUPPLIER	ALKER 209 BIRC	DDRESS, CITY, S CHWOOD AVE I, MN 56484	TATE, ZIP CODE NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 435	ability to cope and a be addressed by:  - A verbal noticed w resident or family the this would be docured and the room options work and the roommate.  - The resident and the roommate.  - The identified soon need related to the addressed.  - A follow up visit w social service staff move.  - Social service staff	adjust to the relocation would would be provided to the nat was being relocated and mented in the medical record. Uld be given when possible. It introduced to their new or their family would be were receiving a new ial, emotional, and cognitive room relocation would be ould made as needed by the to aid in the adjustment to the fit would document the eto the move in the medical	2 435				
	within the Facility p the residents or the notified in advance affected by the tran change of room or provided. In additio	for Transfer of Resident olicy dated 5/3/16, indicated oir responsible parties would be of the transfer. All roommates sfer would be notified. A roommate notice would be n, how well the resident should be documented.					
	director of nursing with the social work and procedures for of room/roommate educate staff. The	THOD OF CORRECTION: The (DON) or designee could work ker/designee to update policies when to notify the resident(s) changes, and then could DON or designee could also esident records to determine if					

Minnesota Department of Health

STATE FORM 2I3W11 If continuation sheet 8 of 63

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		07/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - WA	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 435	Continued From pa	ge 8	2 435			
	the resident(s) had	been notified as appropriate.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			8/22/16
	Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.					
	by: Based on interview facility failed to revis plan to include inter	and document review, the se the comprehensive care rventions for pressure ulcer of 1 resident (R19) who had e ulcer.		Completed.		
	Findings include:					
	6/6/16, indicated Randal Alzheimer's disease	imum Data Set (MDS) dated 19 was diagnosed with e, had severely impaired ly dependent on staff for all				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			E SURVEY PLETED	
		00995	B. WING		07/	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AI KFR	CHWOOD AVE R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 570	•	ing, and was at risk for I had developed an	2 570			
	R19 had developed heel. R19 was seen for left heel pressur	eview, dated 6/4/16, indicated and area of eschar to her left by the physician's on 6/6/19 e ulcer, with referral to the ushion device to help relieve				
	R19's wound clinic visit, 6/9/16, indicated orders for a Mepilex border heel dressing, staff to change dressing every other day and to wear a pressure relieving boot.					
	dressing change: A to left heel, ok to sh	ler dated, 7/6/16, indicated Apply wet to dry dressing daily lower, wound should be and water with each dressing				
	revision to include F	nt date 7/14/16, lacked R19's pressure ulcer and d to R19's unstageable left				
	(DON) stated, R19's	p.m. the director of nursing s care plan should have been ne needed interventions when developed.				
		Care Protocol, undated, isciplinary plan of care would				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	GOLDEN LIVINGCENTER - WALKER WALKER			NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From page 10		2 570			
	address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified.					
	dated 2/4/16, identi guidelines, directing appropriate problen dressing change as goals, list responsit	ire guide, Dressing Change, fied care plan documentation g staff to identify the n under which to list the s an approach, list measurable ble discipline, with instruction monitoring and observations asures.				
	The director of nursidevelop and implementated to care plandesignee, could prostaff related to the trevisions. The quality	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			8/22/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00995		B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	of bed as much as written order from the	possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observatireview the facility fa	ent is not met as evidenced on, interview and document alled to ensure physician ed for 1 of 1 resident (R19) ure ulcer wound care.		Corrected.		
	Findings include:					
	R19 did not receive directed by the phys	pressure ulcer wound care as sician orders.				
	6/6/16, indicated R1 Alzheimer's disease cognition, was totall activities of daily livi assist with positioni	imum Data Set (MDS) dated 19 was diagnosed with e, had severely impaired ly dependent on staff for all ing (ADLs), required extensive ng, was at risk for pressure eloped an unstageable				
	indicated: Apply we heel, ok to shower,	der report print date 7/14/16, t to dry dressing daily to left wound should be washed with n each dressing change (order				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/	15/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	On 7/14/16, at 3:06 (LPN)-C was obser pressure ulcer dres and removed R19's slipper sock from he removed from the vleft heel pressure ulcer dressing pactage, applied saline 4 and washed the vlambda A small amount of cremoved from the vleft gloves and regloved gauze 4 X 4 and ap wound and applied wet 4 X 4 followed kerlix gauze to secure moved her gloves sock and pressure washed her hands.  At 3:19 p.m. LPN-C dressing change, and indicated to wash the LPN-C verified she order, and should he soap and water price.  On 7/14/16 at 3:23 (DON) stated, it was follows the physician orders the physician orders.	p.m. licensed practical nurse ved during R19's left heel sing change. LPN-C gloved pressure relief boot and er left foot. A gauze 4 X 4 was wound. LPN-C measured the loer and stated the wound meters (cm) by 1.9 cm. r gloves and opened two 4 X 4 kages, obtained two pieces of wound wash to the gauze 4 X wound using a circular motion. debris was observed to be wound. LPN-C removed her d. LPN-C applied saline to a applied it to R19's pressure ulcer a dry gauze 4 X 4 over the by wrapping the left heel with ure the dressing. LPN-C and applied R19's slipper relief boot, LPN-C then relief boot, LPN-C then are wound with soap and water. did not follow the physician order ne wound with soap and water. did not follow the physician's ave washed the wound with or to applying the dressing.  p.m. the director of nursing sher expectation the nurse ns order as directed. The resould have been completed as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AI KER	MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	physicians orders w	as not provided.				
	R5's physician orde urinary incontinence	rs were not followed regarding e needs.				
	was diagnosed with disorders of the black	•				
	R5's Urinary Incontinence Care Area Assessment (CAA) dated 7/13/16, indicated R5 had urinary urgency, required assistance in toileting, had functional incontinence and the overall objective was to minimize risks.					
	(treats overactive blue was to try Vesicare	on 3/25/16, indicated Ditropan ladder) was ineffective, so R5 10 milligrams (mg) (treats . Could consider Botox sical.				
	recommended phys (urine test) which w home facility when results to physician infection, R5 would infection (UTI) until Botox treatment the	n 5/27/16, indicated a sician's order to get a UA ould be easier done at the R5 was in bed, then fax and if the UA was positive for be treated for a urinary tract clear and then arrange for ereafter. The report indicated with that approach would like ther management.				

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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	
		00995	B. WING	<del></del>	07/	15/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AI K F R	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From page 14		2 830			
	completed and resu	lacked indication the UA was ults faxed to the physician, or p related to R5's urology visit.				
	stated R5 needed to sometimes 15-30 ti	p.m. nursing assistant (NA)-A o go to the bathroom a lot, mes in an 8 hour shift. NA-A isted R5 to the commode 12 o far.				
	On 7/14/16, at 8:59 a.m. R5 stated the girls came and helped her but sometimes she cannot wait until they get here and my urine just comes out. R5 stated she was going to see a specialist to see what they can do for her urinary frequency as different medicine had been attempted which R5 thought is had helped. R5 also stated the physician was going to do something else, but she didn't know when.					
	stated she did not k following up on phy	a.m. registered nurse (RN)-A know who was responsible for sician orders and did not know t done about R5's urology				
	director consultant a medical record and documentation which an attempt to sched	8 a.m. the facilities clinical stated she had reviewed R5's confirmed there was no ch indicated labs, follow up, or dule the Botox appointment directed by R5's physician's ology visit.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AI KFR	CHWOOD AVI R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	(DON) verified R5's have been address	p.m. the director of nursing sphysician's orders should ed and followed up on. The her expectation that all orders				
	A facility policy for for physician's orders w	ollowing/implementing was not provided.				
	The director of nurs develop and implementated to following services as written. provide training for implementation of passessment and as	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures physician orders and follow up. The DON or designee, could all nursing staff on ohysician orders. The quality surance committee could edits to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21290	MN Rule 4658.0710 & Physician Evalua	O Subp. 3 A AdmissionOrders tions	21290			8/22/16
	A. A resident m physician at least of 90 days after admis medically necessar	y of physician evaluations. nust be evaluated by a nce every 30 days for the first ssion, and then whenever y. A physician visit is it occurs within ten days after as required.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING	<del></del>	07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI KFR	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21290	Continued From pa	ge 16	21290			
	by: Based on interview facility failed to ensi was reviewed for tir	ent is not met as evidenced and document review, the ure 1 of 1 resident (R18) who mely physician visits had n visit every 30 days for the		Corrected.		
	Findings include:					
	5/12/16, indicated F facility on 5/12/16, v anemia, coronary a hypertension, gastro	inimum Data Set (MDS) dated R18 had been admitted to the with diagnoses which included rtery disease, heart failure, oesophageal reflux, end stage etes, and depression.				
	evaluated by a phys 5/18/16, went to a for surgeon on 6/28/16	d indicated R18 had been sician's assistant (PA)-A on ollow up appointment with a s, and was evaluated by R18's ctor (MD)-A on 7/14/16.				
		trol Log for 2016, indicated I to be seen by MD-A on nd 7/14/16.				
		e dated 6/30/16, indicated 18 when MD-A rounded at the				
	On 7/15/16, at 10:2	1 a.m. licensed practical nurse				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
			7. BOILDING.			
		00995	B. WING		07/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21290	Continued From pa	age 17	21290			
	missed evaluating I she had contacted	e was unsure why MD-A R18 in June. LPN-A confirmed R18's primary clinic and the nad not been seen by MD-A, eduled.				
	(DON) and assistar confirmed R18 sho physician once a m following admissior 60, and 90 day eva physician could eva	o p.m. director of nursing nt director of nursing (ADON) and have been seen by a nonth for the first three months in to the facility. After the 30, aluations by a physician, then a aluate R18 every other month. ON confirmed R18's 60 day visited by 6/21/16.				
	A facility policy on prot provided.	ohysician visit schedules was				
	The director of nurs develop and impler related to frequency quality assessment	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures y of physician visits. The t and assurance committee lom audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21325	MN Rule 4658.0729 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			8/22/16
	Subpart 1. Routine	e dental services. A nursing				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING	<del></del>	07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	home must provideresource, routine de needs of each resici include dental exan fillings and crowns, oral surgery, bridge orthodontic proceduthat are provided for community at large reimbursement political training includes.  This MN Requirement by: Based on observative review, the facility for services for 1 of 3 or dental services.  Findings include: R14's undated Face diagnosed with multidepression and multiple for all dental status at assistance for oral or non-ambulatory.  R14's Activities of Each assessment dated required extensive to limited range of regeneralized weakned poor memory.  R14's care plan data	e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, s and removable dentures, ures, and adjunctive services or similar dental patients in the as limited by third party cies.  ent is not met as evidenced on, interview and document ailed to provide dental esidents (R14) reviewed for esidents (R14) reviewed for scle weakness.  imum Data Set (MDS) dated R14 had not issues with and R14 required extensive cares and was  Daily Living Care Area 12/8/15, indicated R14 assist with dressing secondary motion, poor balance, and ess as related to MS and a seed 5/13/16, directed staff to e two times a day and refer to	21325	Corrected.		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
	PROVIDER OR SUPPLIER	ALKER 209 BIRC		STATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21325	have multiple missing R14 stated she was the staff would not because she had M and added "I am not R14's faxed order is R14 had been compappointment had be addition, the faxed and asked if R14 re Tylenol and Tramac and R14's family was antibiotic for oral paragraph 2/23/16. The physic directed staff to "how if worse." No other issue was noted in dental appointment. The 2/19/2016, Quare Resident Review for "broken, loose, or conditional R14's nurse progresindicated R14 had a staff to "how in the miles of the	a.m. R14 was observed to ng, broken, and loose teeth. Is losing her teeth. R14 stated nelp her with dental visits IS, was on UCARE insurance, of on welfare."  Theet dated 2/17/16, indicated plaining of pain and a dental een made for 2/23/16. In order sheet queried the doctor equired antibiotics, R14 was on the lost of the lost o	21325	DEFICIENCY)		
	that she has tried to and has been reject insurance she has.' Assessment: Upper have splintered. R1 sensitivities at that the exposed root visible	r right pre-molar appeared to 4 denied any pain or hot/cold time. No swelling, bleeding, or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(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) COMPLETE DATE
21325	5 Continued From page 20		21325			
	care for resident.					
	No additional inform	nation on R14's dental issue edical record.				
	(LPN)-B stated R14 2/23/16, and was re Bemidji who could Northern Dental ref in Fargo. LPN-B sta \$1000.00 in which At the time of the a UCARE insurance. record lacked docu 2/23/16, Northern I recommendation for surgeon in Fargo of	45 p.m. licensed practical nurse was seen by a dentist eferred to Northern Dental in not pull the teeth. At that time, ferred R14 to an oral surgeon ated that facility wanted R14's daughter was notified. ppointment, R14 utilized However, R14's medical mentation regarding the Dental visit, the or follow up care with an oral or that R14's daughter had 114's dental service needs/cost				
	interview, R14's da appointment had be Fargo and stated sher mother could nourrent physical/metoo far for her mothshe was told by the place that would ac R14 went to Fargowas in Feb or Marcwith her mother's tedaughter stated heher mouth because extractions and it we nobody would take	go a.m. during a telephone ughters confirmed an een made for R14 to go to he had advised the facility that ot make the trip due to R14's edical status because it was per to travel. R14 also stated a facility that there was no local except R14's insurance unless and nothing had happened eeth since then. R14's remother had an infection in expect of the needed teeth was absolutely uncalled for that care of her mother's teeth.				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	15/2016	
	PROVIDER OR SUPPLIER	AI KFR 209 BIRC		STATE, ZIP CODE ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21325	discomfort when sh stated she had one had to periodically mouth. R14 stated UCARE insurance is someone should be dental needs.  On 7/15/16, at 8:35 (DON) and assistar were interviewed re Review of the medi indicated on 2/18/1 milligrams (mg) for The DON verified the regarding starting of to R14's complaints ADON verified staff medical record regarding appointments. The needs were not me working on getting appointment to see issues. The DON a trained on documer each residents' medical records in the second residents' medical residents' medi	the chewed her food. R14 tooth in her mouth that she bush down so it stayed in her again that she was under which was not welfare, and felt able to take care of her  a.m. the director of nursing (ADON) and the decoration of the parameters of the state of the parameters of the param	21325				
	The director of nurs develop and implen provide staff training care for residents re quality assessment	THOD OF CORRECTION: sing (DON) or designee, could nent policies/procedures and g related to assessment and egarding dental services. The and assurance committee om audits to ensure					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 22	21325			
	compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			8/22/16
	control program muprocedures which pare A. surveillance collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and content and content and content and content and immunization progration of resident here. The development of the prevention and formulation and formulation progratices, including defined in part 4658.  G. a system for products which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ect infection control, such as eptics, gloves, and				
	This MN Requirements	ent is not met as evidenced				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - WA	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	Continued From pa	ge 23	21390				
	review, the facility f hygiene was impler (R19) observed for facility failed to ens properly covered fo	on, interview and document ailed to ensure proper hand mented for 1 of 1 resident wound care. In addition, the ure wheelchair cushions were r 2 of 2 residents (R2, R28) to and sanitary surfaces were		Corrected.			
	Findings Include:						
	R19's wound care was observed and the facility failed to implement proper hand hygiene during the provision of the wound care.						
	6/6/16, indicated R Alzheimer's disease cognition, was total activities of daily liv assist with positioni	imum Data Set (MDS) dated 19 was diagnosed with e, had severely impaired ly dependent on staff for all ing (ADLs), required extensive ng, was at risk for pressure eloped an unstageable					
	indicated: Apply we heel, ok to shower,	ler report print date 7/14/16, t to dry dressing daily to left wound should be washed with n each dressing change (order					
	(LPN)-C was obser pressure ulcer dres and removed R19's	p.m. licensed practical nurse ved performing R19's left heel sing change. LPN-C gloved pressure relief boot and er left foot. A gauze 4 X 4 was					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	removed from the veleft heel pressure used 1.5 centil LPN-C removed here gauze dressing pactape, applied salined 4 and washed the velocity A small amount of commoved from the velocity gauze 4 X 4 and applied wet 4 X 4 followed kerlix gauze to sect removed her gloves sock and pressure washed her hands.  At 3:19 p.m. LPN-her hands after removed the provision of work treatment and should had training on glove process.  On 7/14/16 at 3:23 (DON) stated, it was to wash her hands prior to donning cle change. The DON sure training was power dressing changes the power and policy was followed.  The facility policy, he dated 2/4/16, indicated 1/4/16, indicated 1/	wound. LPN-C measured the lcer and stated the wound meters (cm) by 1.9 cm. or gloves and opened two 4 X 4 ckages, obtained two pieces of a wound wash to the gauze 4 X wound using a circular motion. It would be wound. LPN-C removed her downd. LPN-C applied saline to a splied it to R19's pressure ulcer a dry gauze 4 X 4 over the by wrapping the left heel with the dressing. LPN-C and applied R19's slipper relief boot, LPN-C then  C verified she did not wash noving her gloves throughout and dressing change and the dressing change  p.m. the director of nursing sher expectation for the nurse after removing gloves and an gloves during a dressing stated the facility would make rovided to all staff who perform o make sure the procedure	21390			

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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	
		00995	B. WING		07/	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	DIKER	CHWOOD AVE R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETE DATE
21390	Continued From pa	ge 25	21390			
	help prevent the sp	read of infections.				
		elchair positioning cushions ers to ensure sanitary and				
	diagnosis of edema	dated 7/15/16, identified a, muscle weakness we bladder and epilepsy.				
	R2's quarterly minimum data set (MDS) dated 6/2/16, indicated R2 was totally dependent on staff for transfers to wheelchair, was at risk for pressure ulcers, was frequently incontinent of bowel and bladder and utilized a pressure reducing device for bed and chairs.					
	observations throug approximately 8:00 and 7/15/16, R2's w wheelchair with an	0 p.m. and during intermittent ghout the survey from a.m. to 4:30 p.m. on 7/14/16, vas observed seated in a uncovered, yellow, foam at cushion. The foam was				
	diagnosis of indicat assist with transferr surfaces- bed-whee indicated, R28 was	S dated 4/27/16, identified ed R28 required extensive ring and position between elchair. The MDS further at risk for pressure ulcers and reducing device on his bed				
		e dated 7/9/16, indicated R28 ir for mobility which was				

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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	
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	DIKER	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	propelled by staff.  On 7/12/16, at 1:21 seated in the wheel wheelchair cushion  On 7/13/16, at 12:3 the dining room, se of a gray, uncovere  On 7/14/16, at 11:0 the hallway, seated gray, uncovered for the hallway, seated gray, uncovered for maintenance direct cushion which a who for the yellow for the cushion should cushion cover on it. wheelchair cushion cushion should also housekeeping clear cushions became dicleaned. The MD stopen replaced right verified the lack of confection control conwere not cleanable	p.m. R28 was observed chair in own room. The was an uncovered, gray foam 1 p.m. R28 was observed in ated in the wheelchair on top d, foam cushion.  O a.m. R28 was observed in in the wheelchair on top of a am cushion.  4 a.m. R28 was observed in in the wheelchair on top of a am cushion.  I 5/16, at 9:59 a.m. the or (MD) observed R2's interpretation bath towel was placed on am cushion. The MD verified have a non-permeable and verified the grey foam obe covered. The MD stated ned the wheelchairs and if the lirty, they were removed to be tated the covers should have away prior to use. The MD cushion covers was an incern as the foam cushions surfaces. The MD stated he facility had a policy regarding	21390			
		p.m. the DON verified the e relieving cushions should				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
		00995	B. WING		07/1	5/2016	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - WA	AI KFR	HWOOD AVE MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	have covers on the confirmed with the luncovered cushions issue.  SUGGESTED MET The director of nurs could develop and i and staff training re practices. The qua assurance committ audits to ensure co	m at all times. The DON also ack of cleanability, the swould be an infection control THOD OF CORRECTION: sing (DON) or their designee, mplement policies/procedures lated to infection control lity assessment and ee could perform random	21390			8/22/16	
21420	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.	21420			8/22/10	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	0,2010
GOLDENTIVINGCENTER - WALKER			HWOOD AVI MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 28	21426			
	by: Based on interview facility failed to ens assistant (NA)-G, re symptom screening with residents, as re failed to ensure 4 o	ent is not met as evidenced and document review, the ure 1 of 5 employees nursing eceived a tuberculosis g prior to having direct contact equired. In addition, the facility f 5 residents (R35, R38, R44, losis screen completed and a erculin test.		Corrected.		
	Findings include:					
	The facility's Tuberculosis Exposure Control Plan policy and procedure reviewed 12/21/15, directed the staff to ensure all new admissions, new associates, and volunteers received a two-step tuberculin skin test (TST)/or chest x-ray and a TB symptom screen upon admission or upon hire with the second step TST adminsitered 7-10 after the first step TST.					
		NA)-G was hired on 3/6/15. ecord lacked a tuberculosis en.				
	to the facility on 12/	rd indicated R5 was admitted 30/15. R35's medical record TB administration and a pmology screening.				
	B38's medical reco	rd indicated R38 was admitted				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			R WING			
		00995	B. WING		07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE ENUE WEST PO BOX 700		
GOLDEN	I LIVINGCENTER - W	DIKER	, MN 56484	INOL WEST TO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 29	21426			
		1/16. R38's medical record TB administration and a emology screening.				
	R44's medical record indicated R44 was admitted to the facility on 5/20/16. R44's medical record lacked the 2nd step TB administration and a baseline TB symptomology screening.					
	to the facility on 4/1	rd indicated R22 was admitted 1/16. R22's medical record TB administration and a omology screening.				
	On 7/15/16, at 10:15 a.m. the director of nursing (DON) verified the above findings and stated education would be completed with the licensed staff.					
	SUGGESTED MET	HOD OF CORRECTION:				
	review and revise the auditing system to employees received and tuberculin skin assurance and asset	sing (DON) or designee could ne TB policy and develop an ensure all residents and d their TB symptom screening testing. The quality essment committee cold to audit tuberculosis testing to				
	TIME PERIOD FOR Twenty-one (21) da					

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDENTIVINGCENTER - WALKER			HWOOD AVI MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21495	Continued From pa	ge 30	21495				
21495	MN Rule 4658.1009 Providing Social Se	5 Subp. 5 Social Services; rrvices	21495			8/22/16	
	services must be plidentified social ser according to the co assessment and co	y social services. Social rovided on the basis of vice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services to promote the psychosocial well-being for 2 of 2 residents (R12, R18) who had unresolved roommate conflicts. R12 experienced psychosocial harm due to persistent sleep disturbance and decline in mood.			Corrected.			
	Findings include:						
	identified R12's dia attack, heart failure sleep apnea (a disc repeatedly stops ar the throat muscles	ogress note dated 6/14/16, gnoses as history of a heart , hypertension, obstructive order where breathing and starts which occurs when relax), cerebral vascular ith left-sided weakness.					
	5/17/16, indicated F no signs and sympt behavior exhibited the assessment pe	imum Data Set (MDS) dated R12's cognition was intact, had coms of a mood disorder, no towards self or others during riod. R12 required extensive polity, transferring, toileting and					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	15/2016
	PROVIDER OR SUPPLIER	ALKER 209 BIRC		ETATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21495	personal hygiene. locomotion off the ucontinent of bladde	R12 was independent with unit. R12 was always r.	21495			
	of focus regarding I abuse due to R12's Interventions includ who disturbed him a removed from any p situations. In addition					
	indicated R12 recei	dministration Record (MAR) ved Lasix (a diuretic) 20 ly. In addition, melatonin 10 iia.				
	R18's diagnoses as	eport dated 7/14/16, identified sobstructive sleep apnea, ende, dependent on renal dialysis, on.				
	R18 had intact cogneceived a daily ant symptoms of a mod	DS dated 5/12/16, indicated nition, was on dialysis, idepressant, had no signs and od disorder, and no behavior elf or others during the initial.				
		a.m. during the initial resident R12 (R18's roommate),				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		0, = 0
GOLDEN	I LIVINGCENTER - W	AI K F R	CHWOOD AVE R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21495	knocked on the resif he could come in bathroom. R18 lou seated in his motor the open door, "tell always has to use twas granted and Rway to his side of the exited the room. Oasked if she could that would be okay the family room.  On 7/12/16, at 9:29 resumed. R18 statp.m. and wanted to stated he [R18] nor 10:00 p.m. and did breakfast at 8:00 a	age 32 sident's room door. R12 asked as he (R12) had to go to the adly responded, with R12 rized wheelchair right outside him to stay out he [R12] the bathroom." R12's request 12 entered the room, made his ne room, used the urinal and on R12's way out, the surveyor talk to him later. R12 stated and that he (R12) would be in each at 12 went to bed at 7:30 of get up at 5:00 a.m. R18 rmally went to bed around n't get up until right before .m. R18 stated R12 didn't the television but "he [R18]				
	watches it anyway." was an "ass." R18 time out of the roor stated, "It has been moved in." R18 sta the roommate situa offered a room cha words had been ex R12. R18 stated he if he [R12] tried to t  On 7/12/16, at 9:50 into his [R12] room stated R18 always stated R18 "tells m stated R18 was not	" R18 stated his roommate stated R12 spent most of his mand down by the desk. R18 in this way since he [R18] had ated the staff were aware of ation, but the facility hadn't inge. R18 confirmed that changed between himself and e did not feel threatened by "would beat the hell out of him				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/	15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVE , MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21495	on all night long and that he [R12] could all night. R12 state times to "get off my like it because he [I bathroom frequent! the television, so R time out of the room in the facility family said anything to any assistants were aw R12 stated when R "sneaks back in the stated he was not a had not been notified prior to R18 moving -On 7/12/16, at 1:14 motorized wheelcha	d that R18 didn't understand n't sleep with the television on d he had told R18 a couple of back." R12 stated R18 didn't R12] had to go to the y. R12 stated R18 dominated 12 stated he spent most of his n and watched television down room. R12 stated he hadn't yone, however, the nursing are of his roommate situation. 18 went to dialysis, he [R12] a room as much as I can." R12 fraid of R18. R12 stated he ed of the roommate change into the room.					
	seated in his motor room. R18 was lay sleeping with the te-At 7:50 a.m. R12 eroom and used the exited their room af the urinal on R12's proceeded to go ba-At 7:56 a.m. R12 wheelchair in the fadangled down onto positioned on the fotogether and legs bin bed sleeping in the At 8:08 a.m. R12 motorized wheelchair	entered their (R12 and R18's) urinal. R12 immediately ter using the urinal, leaving bed side table. R12 ck into the family room. was seated in his motorized mily room. R12's left arm R12's lap and both feet oot rest with R12's heels owed outward. R18 remained					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, S	TATE ZIP CODE	<del></del>	
		209 BIRC		NUE WEST PO BOX 700		
GOLDEN	N LIVINGCENTER - W	ALKER WALKER	, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21495	Continued From pa	ge 34	21495			
21495	the nape of R12's nand his chin was do-At 8:19 a.m. R12 nseated in his motor room, while R18 has erved breakfast in -At 8:27 a.m. R12 nmotorized wheelchastated he would ratithan in the family rotake a nap. R12 stated a nap. R12 stated has gone to dialysis room. R12 stated hnot comfortable to stoo small for him (Finew wheelchair and was on order)At 9:05 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:21 a.m. R12 whis motorized whee slightly moved off to-At 9:25 a.m. R12 whis motorized whee slightly moved off to-At 9:26 a.m. R12 whis motorized whee slightly moved off to-At 9:27 a.m. R12 whis motorized whee slightly moved off to-At 9:28 a.m. R12 whis motorized whee slightly moved off to-At 9:28 a.m. R12 whis motorized whee slightly moved off to-At 9:28 a.m. R12 whis motorized wheelength a.m. R12 whis motori	leck. R12's eyes were closed own towards his chest. emained sleeping while ized wheelchair in the family d woken up and had been their room. emained seated in his air in the family room. R12 her spend time in his room oom, so he could lay down and ated R18 went to dialysis three in [R12] wasn't aware of R18's R12 stated when he knew R18 is motorized wheelchair was sleep in as the wheelchair was at 2 had been measured for a d a new motorized wheelchair was sleeping while seated in lichair. R12's neck pillow had				
		6 p.m. nursing assistant and R18 got along like "oil and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVE MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21495	water" and were "por R12 was in the roor R18 had moved in. sleep at night and F NA-E stated R12's match up. NA-E stated R12's match up. NA-E stated R12 didn't want to be she was aware of ti "F-off" and R12 had business. NA-E co occurred between F physical. NA-E stated demeanor had char R12's roommate. No become more hosti stated she had info couple of weeks agtreating R12 and the been the worst dechad changed though the administrator's nursing assistants with input with potential NA-E state it was how had been so higrump all the time.  On 7/13/16, at 1:08 and R18 did not gestated R18 liked to to go to bed earlier at R12 when R12 h NA-A stated R12 when R12 since R12 and NA-A stated R12 when R12 when R12 when R12 used to get up in the results of th	olar opposites." NA-E stated in first and about a month ago NA-E stated R12 liked to R18 was more of a night owl. and R18's sleep hours did not ated R12 spent more time in ce R18 moved in because of around R18. NA-E stated imes when R18 told R12 to did told R18 to mind his own infirmed verbal exchanges had R12 and R18, but nothing ted R12's mood and inged since R18 had become NA-E stated R12's mood had ille towards the staff. NA-E immed the administrator a go about how R18 had been at putting them together had ision. NA-E stated nothing in since she had brought it to attention. NA-E stated the were not asked to provide room or roommate changes. and to see someone (R12) appy to now go to being a total of p.m. NA-A stated R18 had sworn and to use the urinal so much. In all to use	21495				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21495	thought R12 still wo now just lied awake he (R12) felt it was his roommate (R18 and R18 became rodown a lot more an room or would just and watch television now R12 spent moand in the family rowhen R18 was at droom and laid down hollered at R12, R1 doesn't respond to trying to ignore R18 to provide input regroommate changes been asked in a lor stated it wasn't a got together. NA-A stated finitely impacted negative way.  On 7/13/16, at 2:07 R18 argued about stated R12 used to and now R12 does p.m. (staying up ab past preference/root to go into his room nap, but now R12 of R12 noticed that stated she thought	rige 36 7:00 a.m. NA-A stated she oke up around 5:00 a.m., but a until 6:30 - 7:00 a.m. when okay to get up and not disturb b). NA-A stated before R12 commates, R12 would lay dusually took a nap in his kick back in his wheelchair in his room. NA-A stated st of his time out of his room om. NA-A stated sometimes ialysis, R12 would go into his in. NA-A stated when R18 it's like he [R12] was just in it's like he like in it's like in it's like he like in it's like he like in it's like in it's like he like in it's like in it'	21495			
	watched television with the television of	ted R18 stayed up late and and that R18 liked to sleep on. NA-F stated she thought television was left on during				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A PUBLICATION	(X3) DATE SURVEY COMPLETED	
A. BUILDING:		
00995 B. WING	07/15/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER  209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX TAG  CROSS-REFERENCED TO THE APPROF	D BE COMPLETE	
the night because that was how R18 liked it. NA-F stated R12 appeared more moody since R18 had become R12's roommate.  On 7/14/16, at 8:37 a.m. R12 was observed seated in his motorized wheelchair in the activity room watching television.  On 7/14/16, at 8:53 a.m. NA-C stated R12 and R18 should never have become roommates. NA-C stated R18 had told R12 that he [R12] did not need to get up at 5:00 a.m. When R18 told R12 this, NA-C stated she had written on a piece of paper that R12 could get up whenever he (R12) wanted to and showed the note to R12. NA-C stated R12 "shook his head yes." However, NA-C stated now R12 stayed in bed until around 7:00 a.m. (two hours later than R12's past preference/routine). NA-C stated R18 had told R12 "if you didn't have to drink so much you wouldn't have to use that urinal so much," NA-C stated R12 had told her that he was ready to pop R18 one. NA-C stated R18 liked to have the television on all the time and NA-C had thought the facility was going to get another television in the room. However, NA-C stated she didn't think that would resolve the roommate problem. NA-C confirmed R12 spent more time out his room since R18 became R12's roommate. NA-C stated R12 used to take a nap in R12's room, but now R12 spent the majority of the time in the family room. NA-C stated she had expressed on two different occasions to the nurse in charge regarding R12 and R18's roommate situation. NA-C stated the first time she brought it up was around 6/23/16. NA-C stated she had seen a change in R12 since R18 became R12's		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING	<del></del>	07/1	15/2016
	PROVIDER OR SUPPLIER	AI KFR 209 BIRCI		STATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21495	and smile and now doesn't talk much. occurrence on how	R12 was more withdrawn and NA-C confirmed it was a daily	21495			
	verbal interactions to pretty much daily - in would be a "good daily - in would be a "good daily - in would be a "good daily - in word -	from R18 to R12 happened if it didn't happen then that ay".				
	verbal interactions to daily. NA-A stated to was in the bathroom NA-A, and R12 told being smart. NA-A	a.m. NA-A confirmed the from R18 to R12 happened for example this morning R12 n being assisted with cares by NA-A that he [R12] was just stated R18 hollered "you are ." NA-A stated it was stuff like daily.				
	seated in his wheel he didn't sleep as w became his roomm	a.m. R12 was observed chair on the patio. R12 stated rell as he used to since R18 ate and he was always tired didn't want to talk about R18				
	by another surveyor member of the residence of the reside	0 a.m. R12 was interviewed r as R12 was an active dent council. R12 confided to be facility was currently R18 away from R12. R12 yelled at him. R12 stated R18 emote, so when R18 had the just rolled over. R12 stated sion on and R12 felt the ashes of light which kept him he was just going to keep his				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21495	•	ge 39 [R12] could be moved.	21495				
	7/12/16, indicated upon comment section the following: - having R18 in R12 - R18 thought he wellow and the televolutions.	ence Summary note dated under the family/resident nat R12 had expressed the 2's room was disturbing as the boss ision on at night and R18 tously about R12 making noise ving to use the urinal.					
	through 7/13/16, lac	ress note (PN) from 6/15/16, cked documentation regarding commate conflict with R12.					
	documentation regard conflict with R18. I record lacked docu	5/16, through 7/13/16, lacked arding R12's unresolved n addition, R12's medical mentation of appropriate mmate change or a follow up roommate change.					
	confirmed the facili which was 40 and t residents. SW stat a room change a for a resident moved in resident already oc forms were to be consumed to make the condition of the co	0 a.m. social worker (SW) ty was not at full capacity he current census was 26 ed when a resident requested orm was completed and when not a room which had a cupying that room, then two competed. SW stated one form the resident requesting or see the room change and the completed and given to the tion that they would be formate. SW stated if both					

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Minneso	<u>ita Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMPLETED	
		00995	B. WING	<del></del>	07/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE	·	
INAIVIL OI I	THOUBLINGING TELLIN			ENUE WEST PO BOX 700		
GOLDEN	I LIVINGCENTER - WA	AIKER	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
	CURALA DV OTA					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21495	Continued From pa	age 40	21495			
		o the move, then the move				
		way. However, if one of the				
		greed to the move, then there				ı
		djustment period before the				
		V verified R12 (resident who				ı
		ommate) had not been provided				ı
		e Getting A Roommate form,				ı
		tated she had been on				
		B moved and SW was unsure				
		ough on the notification of				
		oom changes in the SW's				
		firmed any time there was a				
		ding a room/roommate change				
		should be documented in the				ı
		record. SW confirmed R12's				
		ked documentation regarding getting a roommate. SW				
		old her that he had not been				ı
		e would be getting a roommate				
		g in. SW confirmed R18 had				ı
		of the room change on 6/15/16.				
		sign the notice, so the seven				ı
	day adjustment per	riod was provided with R18				
		room on 6/22/16. SW				
		d R18 did not get along well as				
		stated on 7/12/16, R12 held a				
		hich R12's son also attended				ı
		W stated at the care				
		xpressed his displeasure of				
		with R18. SW stated R12's sed on the television and how				ı
		the television on all night long				
		elevision was positioned				ı
		of R12's bed the flickering				ı
		ne television kept R12 awake at				
		R12 voiced concerns that R18				
		be the boss and that R18				
		of the noise that R12 made.				ı
		pressed at the care conference				ı
		d about R12 getting enough				1

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21495	not slept as well. Sight the roommate is had negatively impowell-being, especial brought up at the cishe expressed to the stand up meetings concerns regarding situation. SW states move R18, however R12 should be the had requested to most recent mood conducted 5/17/16, behavioral concernexpect if R12's mood, it would be diff R12's mood. SW siless satisfied with F	R18 had moved in, R12 had a W stated "most definitely" she situation between R12 and R18 acted R12's psychosocial are conference. SW stated he leadership team at their these last couple of days, her are R12 and R18's roommate and she thought they should be an eleadership team thought one that moved because R12 hove. SW confirmed R12's and behavior assessment identified no mood or s. SW stated she would be devaluation was completed ferent and show a decline in stated overall she felt R12 was R12's current situation.	21495			
	(DON) and adminish ad open resident confirmed prior to a roommate change was to be provided had spoken to both (7/13/16) and had a temporary room. Troommate had bee facility would again the new roommate declined the temporary to twice. R12 owas provided to his then be relocated. was being moved to the confirmation of the con	eg a.m. the director of nursing strator confirmed the facility rooms. The administrator a resident room change and/or the appropriate notification. The administrator stated she a R12 and R18 yesterday offered to move R12 to a then when R12's potential new in provided proper notice, the move R12 into that room with a The administrator stated R12 rary move as he didn't want to pted to wait until proper notice is potential new roommate and The administrator stated R12 recause R12 had made the ed. The administrator stated				

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - WA	AI K F R	HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	potential roommate consideration prior the nurse manager other staff which incresident and family the safety with the residents liked the definitely sleep rout the NAs had made that R12 and R18 hast Friday (7/8/16). NAs had made her television and that television on all the confirmed some television on all the confirmed some television on all the confirmed some television well-benegative manner si roommates. In add she was aware R12 current roommate at that R12 was frustrommate at that R12 was frustrommate at the R12 was frustrommate at the R15 medical reconsideration on the resident's social, er would be assessed relocation on the resident of the resident on the resident of the resident of the resident on the resident of th	compatibility was taken into to a roommate change and also gathered input from the cluded the NAs and the Other things considered were equipment in the room, if the television on, and most tines. The administrator stated ther aware today (7/14/16) and argued last evening, and The administrator stated the aware of the conflicts with the R18 liked to have the time. The administrator ension existed between R12 inistrator verfied R12's reing had been affected in a nece R18 and R12 became lition, the administrator stated 2 was not comfortable with the arrangement and was aware	21495			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	The social service sinterdisciplinary teal compatibility to arrivlocation for a reside be developed by the the needs and concability to cope and a be addressed by:  - A verbal noticed we resident or family the this would be docured and properties.  - The resident would be roommate.  - The resident and/informed that they we roommate.  - The identified social need related to the addressed.  - A follow up visit we social service staff move.  - Social service staff move.  - Social service staff move.  - General Guidelines within the Facility per the residents or the notified in advance affected by the transport of the social service and the social service affected by the social service affected by the transport of the social service and the social service affected by the social service affected by the social service and the social service affected by the social service and the social service affected by the social service and the social service affected by the social service and the social	staff would work with the m to consider roommate we at the most appropriate ent. In addition, a plan would be social service staff to assure cerns related to the residents' adjust to the relocation would would be provided to the nat was being relocated and mented in the medical record. In the introduced to their new or their family would be were receiving a new ial, emotional, and cognitive room relocation would be ould made as needed by the to aid in the adjustment to the enter the introduced to the medical in the move in the medical enter responsible parties would be of the transfer. All roommates sfer would be notified. In the resident tolerated the move	21495			
	SUGGESTED MET	HOD OF CORRECTION:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
	PROVIDER OR SUPPLIER	209 BIRCI		STATE, ZIP CODE ENUE WEST PO BOX 700		
GOLDEN	I LIVINGCENTER - W	AI K F R	MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	The director of nurs could review or review or review or review of the ducation for staff of the follow through on idneeds. The Quality (QAA) committee compliance.  TIME PERIOD FOR (21) days.	sing (DON) and/or designee se policies, and provide egarding assessment and entified resident psychosocial Assessment and Assurance ould do random audits to	21495			8/22/16
	A. The drug regim reviewed at least m currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incavailable through the system. It is not sure B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pure upon means the acreport and the significant of nursing services C. If the attend with the pharmacist not provide adequate.	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next poner, if indicated by the proses of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. In ing physician does not concurts recommendation, or does the justification, and the sethe resident's quality of life is				G, <u>E</u> L, T G

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/15/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY	STATE, ZIP CODE	07/1	3/2010
		209 BIRC	*	ENUE WEST PO BOX 700		
GOLDEN	I LIVINGCENTER - W.	WALKER	, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	being adversely aff refer the matter to tif the medical direct physician. If the methe attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter assessment and a	ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality saurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality saurance committee.  ent is not met as evidenced and document review, the upon the consulting namendations for 1 of 5 o had ongoing consulting mendations which were not	21530	Corrected.		
		linimum Data Set (MDS) dated R18 was on dialysis and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		07/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	SHOULD BE COMPLETE	
21530	Continued From page 46		21530			
	received a daily dose of insulin and an antidepressant.					
	R18's Psychotropic Drug Use Care Area Assessment (CAA) dated 5/20/16, indicated R18 had not been taking a sedative/hypnotic.					
	R18's Order Summary Report dated 7/14/16, directed staff to administer: - Pantoprazole Sodium delayed release 40 milligrams (mg) twice a day (medication usually used short term to treat GERD and excessive acid production) - temazepam 15 mg every evening as needed (medication used to treat insomnia)					
	6/13/16, and 7/11/1 the consulting phar recommended a graphe considered for p	eview notes dated 5/16/16, 6, repeatedly indicated that macist (CP) had adual dose reduction (GDR) antoprazole. In addition, ken for a GDR for temazepam				
	for May, June and a not taken the temaz	dministration records (MAR) July 2016, indicated R18 had zepam at all and had on dose of R18's scheduled				
		gress note dated 7/14/16, ement of the CP's above ttions.				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		<b>07</b> /1	15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•		
GOLDEN	I LIVINGCENTER - W	AI K F R	CHWOOD AVE R, MN 56484	ENUE WEST PO BOX 700			
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21530	On 7/15/16, at 8:37 (LPN)-B confirmed when needed at be had not been admit the month of July.  On 7/15/16, at 1:42 (DON) confirmed F had received panto 40 mg twice a day. confirmed R18 had as needed at night temazepam since to ordered (5/12/16). above noted CP re 6/13/16, and 7/11/1 considerations for 0 temazepam and paher expectation that followed up upon in assistant director of e-mail was sent ear included the CP's resident in which slee-mails into the phyphysician's review rounds the next time never reviewed the review note in the CP's monthly record confirmed she had day prior (7/14/16), physician had recefrom the pharmacis for May, June or Julian in the pharmacis for May in the pharmaci	a.m. licensed practical nurse R18 had temazepam ordered adtime for sleep, however, R18 nistered the temazepam for the property of the property					
		p.m. the CP confirmed he month in the medical record					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
	PROVIDER OR SUPPLIER	ALKER 209 BIRC		STATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	his recommendation the CP's monthly rereview. In addition, e-mail each month recommendations he pharmacy review not available in the resi CP verified he had GDR's for R18's terfor the last three month is expectation that brought to the physupon.  Consultant Pharma Requirements policity would review the month resident at least month of the readily retrievable for communicate month prescriber and the fire review.	ns for each resident based on sident medication regime the CP stated he sent an to the ADON with the same he had articulated in the ote which was already dent's medical record. The made recommendations for mazepam and pantoprazole on the same stated it would be these recommendations be ician's attention and acted cist Services Provider y dated 5/12, indicated the CP edication regimen of each on thly and this review would be resident's medical record or a format. The CP would hly to the responsible	21530			
	The director of nurs their designee, coul policies/procedures assurance that con- recommendations a quality assessment	HOD OF CORRECTION: sing (DON) and pharmacist or ld develop and implement and staff training related to sulting pharmacist are followed up upon. The and assurance committee om audits to ensure				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILBING.			
		00995	B. WING		07/15/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	AI K F R	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 49	21530			
	(21) days					
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.		21550			8/22/16
		acy services. A nursing home e provision of pharmacy				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a hypnotic medication was available as prescribed for 1 of 1 resident (R18) who had an as needed (PRN) hypnotic prescribed.			Corrected.		
	Findings include:					
	R18's diagnoses as disease (GERD-hea apnea (a sleep disc repeatedly stops ar	eport dated 7/14/16, identified is gastro-esophageal reflux art burn), obstructive sleep order when breathing and starts), end stage renal it on renal dialysis, diabetes, aajor depression.				
		inimum Data Set (MDS) dated R18 was on dialysis and se of insulin and an				
	R18's Psychotropic	Drug Use Care Area				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA	AI KFR	HWOOD AVE , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21550	Assessment (CAA)	ge 50 dated 5/20/16, indicated R18 g a sedative/hypnotic.	21550			
	directed staff to adr milligrams (mg) eve (medication used to	ary Report dated 7/14/16, minister temazepam 15 ery evening as needed o treat insomnia). R18's tially been ordered on 5/12/16.				
	6/13/16, and 7/11/1 consulting pharmac gradual dose reduc	eview notes dated 5/16/16, 6, repeatedly indicated the sist (CP) had recommended a tion (GDR) be considered for 8 had not been using the				
	for May, June and	dministration records (MAR) July 2016, indicated R18 had red the temazepam 15 mg at l.				
	(LPN)-B confirmed when needed at be had not been admir the month of July. didn't know if the fa in the medication carequested. LPN-B	a.m. licensed practical nurse R18 had temazepam ordered dtime for sleep, however, R18 histered the temazepam for LPN-B commented that she cility even had the medication art to give R18, if he had thought there may have been ere R18 would have used the				
	nursing (ADON) ve	p.m. assistant director of rified the facility did not have ble for R18. Both the director				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00995	B. WING		07/	15/2016	
NAME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOLDEN LIVINGCENTER -	WAIKER	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
expectation that to ordered medicatic confirmed the phoresidents' medical articulate a reason had been ordered unavailable to R1  On 7/15/16, at 2: (CP) stated he would be to mazepam had CP confirmed all the temazepam, made available to the temazepam which had not been filled a hard copy of the ordered prescriptic confirmed the phoresident that the facility either electronically significant temazepam 15 medically the hospit submitted their procession with obtained the hard then be faxed to serious articular to the significant temperature of the phoresident temperature of the phoresi	and ADON confirmed it was the he facility have all of R18's ons available for R18. The DON armacy in town filled the ations. The ADON was unable to on why R18's temazepam which d on 5/12/16, was still 8 today (7/15/16).  56 p.m. consulting pharmacist as unaware that R18's not been made available to R18. ordered medications, including should have been filled and o R18.  30 p.m. pharmacy technician local pharmacy) verified their ed the medications for the afirmed R18's prescription for h had been ordered on 5/12/16, d due to the pharmacy required a prescription or an electronically ion for the temazepam. PT-A armacy had not received from the hard copy prescription or the ned prescription for R18's					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COM			SURVEY LETED	
			A. BUILDING:			
		00995	B. WING	<del></del> -	07/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - WA	AI K F R	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21550	confirmed when the medications to the signed off that they however, the facility reconciliation process medications had be ADON was unable temazepam order hon 7/15/16, at 6:00 confirmed R18 had assessment complete Pharmacy 5/12, indicated regular pharmaceutical serprovide residents when the months of the director of nurse their designee, coupolicies/procedures assurance that the resident are meet in assessment and assessme	copy prescription. LPN-B e pharmacy delivered facility, the medication nurse had received the medications, y had no medication ess in place to determine if all een received as ordered. The to explain why R18's had not been followed through.  I p.m. nurse consultant (NC) not had a sleep pattern eted.  Requirements policy dated ular and reliable vices would be available to vith prescription and	21550			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21615	MN Rule 4658.1346 Preparation Area;S	0 Subp. 2 MedicineCabinet & cheduleII	21615			8/22/16
	Subp. 2. Storage	of Schedule II drugs. A				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - W	DIKER		ENUE WEST PO BOX 700		
	I	WALKER	, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21615	Continued From pa	ge 53	21615			
	nursing home must compartments, peri physical plant or me	provide separately locked manently affixed to the edication cart for storage of ted in Minnesota Statutes,				
	by: Based on observati review, the facility fa monitoring and secondication kits, one medication. This ha residents residing in	ent is not met as evidenced on, interview and document ailed to ensure the proper urity for 5 of 5 emergency e which contained narcotic at the potential to affect all 26 in the facility who could have medications/narcotics from		Corrected.		
	Findings include:					
	storage tour of the licensed practical n medication (ekit) storage grey plastic with a cappropximately 18 inches in depth. The four of the five ekits of each individual e label). Three of the narcotic medication an automated medi The other two ekits padlock on the door was unaware of the storage and monito	p.m. during the medication main medication room with urse (LPN)-A, five emergency orage boxes were observed. boxes were composed of a clear plastic lid and measured inches by 24 inches, and three ere were labels on the lids of a which identified the contents kit (one of the ekits lacked a ekits, one which contained as were found stored on top of cation dispensing machine. Were in a cabinet with a r handles. LPN-A stated she facility's policy for medication ring of the ekits which ic ekit. LPN-A verified the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		07/1	5/2016
				STATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21615	pharmacy which ini was no longer prov facility. LPN-A state the ekits on this para an order for an anticontained the antib LPN-A contacted the provided the facility verified she would be the ekit if it had been on 7/15/16, at 2:35 nursing (ADON) state about the ekits. The not know if anyone medications for expressive security of the seals logs used to docum medications in the ekits were there where about two years agonomic that the contents of the verified by the direct linjectable Emergent -Adrenalin (Epineph (mg) (used in life-the quantity (QTY) 2 -Benadryl 50 mg (allocagon Emerge levels) QTY 2 -Haldol 5 mg (antip Heparin-5000 units Lasix-10 mg (diure Lovenox 40 mg (allocagon Emerge)	tially had provided the ekits iding pharmacy services to the ed she had recently accessed at Monday, as a resident had biotic. The ekits had not idictic the resident required, so the pharmacy which currently with it's medications. LPN-A nave used the medication from an available.  In p.m. the assistant director of ated she did not know anything a ADON further stated she did routinely checked the poiration dates, checked the son the ekits, or if there were nent the usage of the ekits. The ADON stated the ten she started which was not ekits were as followed and cor of nursing (DON):  The Supply Kit -  The principal of the interpretation of the exits were as followed and correct of the exits were	21615			

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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	
		00995	B. WING		07/	15/2016
	PROVIDER OR SUPPLIER	AI KFR 209 BIRG		TATE, ZIP CODE NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21615	-Narcan 0.4 mg (op-Reglan 5mg (gastr-Solu-Medrol 125 mg (ant-Vitamin K 10 mg (-Zofran 2 mg (antie)  The director of nurshad seals on the thelacked identification was broken. The Dicount was accurate expired.  The Oral Emergence #368210/46011 corroll -Amoxil 250 mg (and -Augmentin 500 mg -Augmentin 875 mg -Avelox 400 mg (and -Bactrim 800 mg (and -Catapres 0.1 mg (and -Cipro 250 mg (and -Cipro 250 mg (and -Compazine supposed -Coumadin 1 mg (and -Coumadin 1 mg (and -Instaglucose 31 gr QTY 2 -Kayexalate 15 gm -Keflex 250 mg (diured -Levaquin 250 mg -Macrobid 100 mg -Nitroquick 0.4 mg -Proventil/Ventolin (QTY 6	piate antidote) QTY 2 poesophogeal reflux) QTY 4 pig (corticosteriod) QTY 2 pithistamine) QTY 2 panticoagulant) QTY 10 pantibiotic) QTY 20 pantibiotic) QTY 10	21615			

Minnesota Department of Health

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY
		00995	B. WING		07/1	15/2016
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET AL			STATE, ZIP CODE	1 31.	. 0, = 0 1 0
GOLDENTIVINGCENTER - WALKER			HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21615	QTY 2 -Zithromax 250 mg The DON verified the broken, the medical four doses of the Placcounted for and kit, and no medicate.  The Oral Emergence contained seals with Contents included:  -Amoxil 250 mg (a. 11/30/15) -Augmentin 500 mg (a. 11/30/15) -Augmentin 875 mg (a. 11/30/15) -Augmentin 875 mg (a. 11/30/15) -Bactrim 800 mg (a. 11/30/15) -Bactrim 800 mg (a. 11/30/15) -Catapres 0.1 mg (a. 11/30/14) -Cipro 250 mg (a. 11/30/14) -Cipro 250 mg (a. 11/30/14) -Compazine support (a. 11/31/15) -Instaglucose 31 gr (a. 11/31/15) -Instaglucose 31 gr (a. 11/30/14) -Casix 20 mg (diure a. 11/30/14) -Lasix 20 mg (diure a. 11/30/14)		21615			

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STATE FORM 2I3W11 If continuation sheet 57 of 63

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		07/	15/2016
-	PROVIDER OR SUPPLIER	AI KFR 209 BIRC		ETATE, ZIP CODE ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21615	9/2014) -Macrobid 100 mg 8/2014) -Nitroquick 0.4 mg 6/2015) -Proventil/Ventolin (QTY 6 -Vitamin K 5 mg (us QTY 2 (expired 10/ -Zithromax 250 mg 10/11/14)  The DON verified a exception of the Ca Instaglucose and K in addition, the med accurate. The inverekit, indicated there of the Macrobid 100 contained nine dose unaccounted for).  Medication Ekit sea not have a contents contained:  -Benadryl 50 mg (a -Decadron 4 mg (o -Adrenalin (Epineph (mg) (used in life-thi QTY 2 vials -Haldol 5 mg (antip -Heparin-5000 units -Lasix-10 mg (diure -Narcan 0.4 mg (op -Reglan 5mg (gastr vials -Solu-Medrol 125 m	(antibiotic) QTY 10 (expired (nitrate) QTY 25 (expired 0.083% (nebulizer solution) sed for blood coagulation) 11/14) (antibiotic) QTY 6 (expired III of the medication with the stapres, Compazine, ayexalate had expired dates, dication count was not ntory list taped to the top of the should have been 10 doses 0 mg and the ekit only es (one dose of Macrobid III tags #368213/368279 did Ist on the lid. The ekit III on the	21615			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00995	B. WING		07/1	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21615	(expired 5/2016) -Vitamin K 10 mg (expired 5/1/16) -Zofran 2 mg (antie-Lovenox 40 mg (and Lovenox 100 mg (	(anticoagulant) QTY 2 vials emetic) QTY 6 vials inticoagulant) QTY 2 syringes anticoagulant) QTY 4 were the medication count was an, verified the ekit contained ations, the Visteril 25 mg and and the narcute and ations and TY 2 and TY 4 and TY 6 and TY 2 and TY 6 and	21615			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN LIVINGCENTER - WALKER			HWOOD AVE , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21615	-Morphine sulfate o	ral solution 10 mg QTY 6 uppository 5 mg. QTY 4	21615			
	The DON verified the above noted medications were unaccounted for.					
	unaware that the elattempted to utilize ekits. The DON ve been routinely ensure with the required set to ensure the secur medications should expiration dates and the ekit storage syswas a concern and monitoring them da	p.m. the DON stated she was cits existed, or that staff had the medications out of the rified the nurses should have uring the ekits were secured eals, were stored appropriately ity of the medications, and the have been monitored for d reconciled. The DON stated tem and lack of monitoring she would expect staff to be ily, and the narcotic have been double locked.				
	pharmacist (CP) sta medication storage The CP stated he was recommendations of storage on his reported protection of ekits was something of ekit medications medications. The CF facility to monitor that the seals on a daily controlled (narcotic he was unaware the room contained the	extended the consulting stated he checked the facility's room on a quarterly basis. Would have included any regarding ekits monitoring and rt to the facility, but does not recommendations for the ekits. The per monitoring and storage of going he looked for, including use and expiration dates of the representation of the representation of the representations. The CP stated representation is to represent the residual process. The CP stated representation of the representation of the representation of the representations. The CP stated representation of the representat				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00995	B. WING		07/	15/2016
GOLDEN LIVINGCENTER - WALKER 209 BIRC				TATE, ZIP CODE NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21615	been something that his review of the method the facility.  Emergency Pharmatics Notice Pharmatics policy, dated 5/ supply was maintainalong with a list of sexpirations dates, the medication use from medication form an color-coded lock to replacement. The key the consultant plat least every 30 day expiration dating of	at he should have included in edication storage process at acy Service and Emergency (12, indicated the emergency ned at a designated area, supply contents and he nurse records the m the emergency kit on the d flags the kit with a indicate need for cits are monitored/inventoried harmacist/provider pharmacy bys for completeness and	21615			
	the emergency kit is perpetual inventory separate sheet or a pages for each indice Each dose given ar received from the pappropriate invento Remaining" adjuste and outgoing nurse controlled substance exchange of keys.  SUGGESTED MET The director of nurse their designee, coupolicies/procedures	s maintained as follows: a system is used with a bound book with numbered vidual medication in the kit. In all replacement doses sharmacy are entered on the ry sheet with the "Amount ad accordingly. The incoming is verified the inventory of ses at each change of shift or the sharmacist or lid develop and implement and staff training related to the control of the quality assessment and				

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00995	B. WING		07/1	15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - WA	AI KFR	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21615	•	ee could perform random	21615				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one					
21942	MN St. Statute 144 Resident and Famil	A.10 Subd. 8b Establish y Councils	21942			8/22/16	
	boarding care home advisory council and fewer than three per participating. If one function, the nursing home shall docume council or councils a year. This subdivision	council. Each nursing home or a shall establish a resident d a family council, unless rsons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of es provided by section n 27.					
	by: Based on interview facility failed to ensi	and document review, the ure attempts to form a family cted in the last calendar year,		Corrected.			
	Findings include:						
	(SW) verified there	57 a.m. the social worker was not a family council at the d been no formal attempts to					

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

_	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00995	B. WING		07/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	AI K F R	HWOOD AVI MN 56484	ENUE WEST PO BOX 700		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21942	Continued From pa	age 62	21942			
	the facility five mon had no information attempts at forming unaware that one o	cil since she began working at ths ago. The SW stated she regarding any previous g a family council and was of her responsibilities was to tion of a Family Council for the				
	On 7/15/16, at 9:14 a.m. the administrator verified the facility should have attempted to form or arrange a family council and or a meeting annually.					
	The facility policy, Family Council dated 2/4/16, indicated a family council would be developed to serve as a mechanism for promoting communication, education, and support between members and staff. The expectation was to coordinate a Family Council meeting at least quarterly.					
	The director of nurs could develop and procedures related Council. The qualit	THOD FOR CORRECTION: sing (DON) or their designee implement policies and to the formation of a Family ty assessment and assurance erform random audits to				
	TIME PERIOD FOR days	R CORRECTION: Twenty (21)				

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