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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZYNS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **03/03/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **144** (L18)

13.Total Certified Beds **144** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	144			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, HFE NE II 03/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 03/24/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/09/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245186
March 22, 2017

Ms. Carolyn Hervin, Administrator
Golden Valley Rehabilitation & Care Center
7505 Country Club Drive
Golden Valley, MN 55427

Dear Ms. Hervin:

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 the above facility is certified for or recommended for:

144 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 144 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 22, 2017

Ms. Carolyn Hervin, Administrator
Golden Valley Rehabilitation & Care Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Number S5186031

Dear Ms. Hervin:

On February 3, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2017, effective February 21, 2017 and therefore remedies outlined in our letter to you dated February 3, 2017, 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.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245186 Y1	A. Building B. Wing Y2	3/3/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0176	Correction	ID Prefix F0282	Correction
Reg. # 483.10(g)(10)(i)(11)	Completed	Reg. # 483.10(c)(7)	Completed	Reg. # 483.21(b)(3)(ii)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0285	Correction	ID Prefix F0309	Correction	ID Prefix F0311	Correction
Reg. # 483.20(e)(k)(1)-(4)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.24(a)(1)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0312	Correction	ID Prefix F0323	Correction	ID Prefix F0431	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(5)	Completed	Reg. #	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 03/22/2017	SIGNATURE OF SURVEYOR 38202	DATE 03/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2017	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245186 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	2/27/2017 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0741	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 03/22/2017	SIGNATURE OF SURVEYOR 37009	DATE 02/27/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/17/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZYNS

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

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **01/12/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **144** (L18)

13.Total Certified Beds **144** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	144			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 02/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/09/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 03/09/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 3, 2017

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

RE: Project Number S5186031

Dear Ms. Hickey:

On January 12, 2017, 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 January 12, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5186216 that was substantiated at F312. A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 12, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5186222 that was 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

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 February 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 April 12, 2017 (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 July 12, 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/9/17 to 1/12/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Golden Valley Rehab and Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. In addition, an investigation of complaint H5186216 was completed and substantiated with a deficiency cited at F312 during the survey. An investigation of complaint H5186222 was completed, and found to be unsubstantiated. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must--	F 167		2/21/17

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

Electronically Signed | 02/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	01/12/2017

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F 167	Continued From page 1 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post notice of availability of the last three years of State agency survey results. This had the potential to affect all 115 current residents, visitors, and staff who wished to review this information. Findings include: During initial tour of the facility on 1/9/17, at 1:56 p.m. a white three ring binder labeled, "MN [Minnesota] Dept [Department] of Health Current Survey Results," was observed in a clear plastic shelf mounted to the wall of the main entrance. The survey results contained inside were dated 3/3/16, from the previous full survey, however, there were no additional surveys identified in the binder, nor was there anything notifying residents, family and staff that three years of results were	F 167	1. Last 3 years of Survey/Compliant investigation were posted and made available to residents, family and legal representative of the residents. Corrective actions as it applies to others: Resident counsel updated on regulations and posting 2. Residents that reside at GVHR have the potential to be affected by this practice. Policy and procedure for Survey Results-State/Federal: Posting /Examination was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. Recurrence will be prevented by: Weekly audits by Executive Director/designee to ensure survey results/compliant investigations are	

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F 167	Continued From page 2 available upon request. During interview on 1/10/17, 11:18 a.m. the receptionist stated she was not aware of any other survey results and would ask the business office for prior years, if asked by a resident or family. During interview on 1/12/17, at 12:58 p.m. the administrator stated the facility only kept the current survey in the binder for viewing, and further stated there was nothing in the binder or around the main entrance to notify residents and families that additional survey results were available. The former administrator was unaware that three years of survey results were required to be readily available. A facility policy entitled Survey Results-State/Federal: Posting/Examination of directed to "Provide the following unaltered survey results for examination for one year, unless state regulation require more."	F 167	posted x 90 days. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion by: February 21, 2017	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self administration of medications was safe for 1 of 1 resident (R156) observed to have medications left on his bedside table to self administer.	F 176	1. R156 Self-Administration of Medication Assessment was reviewed and remains current that resident does not want to self administer medications. 2. Residents that reside at GVHR have the potential to be affected by this	2/21/17

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F 176	Continued From page 3 Findings include: R156's admission record identified R156 included diagnoses of endocarditis (inflammation of the heart), end stage renal disease, and major depressive disorder. R156's admission Minimum Data Set (MDS) dated 1/5/17, included R156 was independent with making decisions regarding tasks of daily living and had no problems with short and long term memory. In addition, the MDS identified R156 required extensive assistance with bed mobility and dressing, and required supervision for transferring, toileting, and personal hygiene. During an observation on 1/12/17, at 8:53 a.m. R156's room was dark and the blankets were covering his head. R156's covered breakfast tray was on his bedside table, and a clear plastic medication cup containing three white and blue capsules was beside the breakfast tray. During an observation and interview on 1/12/17, at 8:58 a.m. unit manager (UM)-A entered R156's room. R156 had taken the medications that were on his bedside table and threw the plastic cup into the garbage can beside the bed. R156 told UM-A the nurse had come into the room, and because he was sleeping, the nurse left the medications on the table. UM-A asked R156 if he had asked the nurse to leave the medications. R156 stated, "No, I was actually sleeping and heard the nurse, but I covered my head and went back to sleep." During an interview on 1/12/17, at 9:01 a.m. registered nurse (RN)-E stated he brought R156's medication, Phoslo (a medication used to reduce	F 176	practice. Policy and Procedure for both Medication administration and Self administration of medication policy was reviewed. An audit was completed for residents who receive medication and care plans and assessments were updated as appropriate. 3. LN & TMA staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee audit the medication pass 3 times per week for 4 weeks, then 3x per month for 3 months. 5. Audit results will be reviewed and discussed at QA committee to determine the need of on-going monitoring. 6. Date of completion by: February 21, 2017	

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F 176	Continued From page 4 phosphate levels) into his room and stated, that R156 sat up so he thought he was going to take them, and then he left. RN-E stated he should have stayed in the room until the resident swallowed the medications. During an interview on 1/12/17, at 1:42 p.m. the director of nursing (DON) stated nurses should stay with residents until they swallow their medications unless they have been assessed to safely administer their own medications. Review of R156's clinical record included a physician's order, dated 12/29/16, for "calcium acetate [Phoslo] 667mg [milligrams] 3 caps (2001 mg) by mouth/per tube three times daily with meals." The clinical record also included a Self-Medication Data Collection and Assessment, dated 12/26/16, which identified R156, "prefers for facility to administer." During a follow up interview on 1/12/17, at 3:48 p.m. the DON stated when R156 was assessed for self administration that the resident had determined that he wanted the facility staff to administer his medications. The DON added that RN-E should not have left them for R156 to take. Review of the facility's policy, Medication Administration, revised 3/16, included, "Remain with the resident until all medication is taken."	F 176		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 282		2/21/17

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F 282	Continued From page 5 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care by failing to provide oral cares for 1 of 1 residents (R33) reviewed for activities of daily living (ADLs) who was dependent upon staff for assistance. Findings include: R33's diagnosis as identified on the face sheet dated 11/23/16, included Alzheimer's dementia. R33's care plan revised 1/17, identified an ADLs problem area and directed staff to provide oral care daily and PRN (as needed), and that R33 required the physical assistance of staff. During observation on 1/11/17, at 7:29 a.m. nursing assistant (NA)-D and NA-E entered the resident's room to assist R33 with morning cares. After washing R33's face, hands and perineal area, NA-D and NA-E dressed R33, then straightened her clothing, and combed R33's hair. A small basket on the dresser near the R33's bathroom door was observed to contain several unopened packaged of toothettes (mouth swabs). NA-E briefly left R33's room and returned with a mechanical lift to transfer R33 from her bed into the wheel chair. Seated in the wheel chair at 7:42 a.m., NA-E pushed R33 out of the room, down the hall and to the dining room. At no time during the observation of cares was R33 provided or offered oral care.	F 282	1. R33 care plan communication tool was reviewed and updated to match the Care Plan policy and procedure regarding oral care. 2. Residents that are dependent on staff for oral cares have the potential to by this practice. Care Plans and NAR communication tool were reviewed on residents that are dependent on staff for oral care. Care Plans and tools were updated as appropriate. 3. Staff will be educated on providing cares per care plans and per communication tool by: February 21, 2017 4. DON/designee will complete weekly audits on each unit to ensure Care plans communication tool are begin followed. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion by: February 21, 2017	

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F 282	Continued From page 6 During interview on 1/11/17, at 9:10 a.m. nursing assistant (NA)-D stated R33 required staff to help her clean her teeth, and used a toothette (a mouth swab) to clean her mouth. NA-D stated she did not complete oral care for R33 this morning, and also acknowledged R33 was not offered oral care. NA-D stated mouth cares could also be done before lunch after she R33 gets up from her nap. During a later observation on 1/11/17, at 11:12 a.m. R33 was awake in her bed following a morning nap, and NA-G and NA-F entered the room to provide R33 with perineal care. Following the provision of care, NA-F left R33's room and quickly returned with a mechanical lift. NA-F and NA-G positioned a sling under R33, then transferred her from the bed into R33's wheel chair. NA-G placed a stocking cap on R33's head, then exited the room, pushing R33's wheel chair out of the room. During this provision of care, R33 was neither provided nor offered oral cares. During interview on 1/11/17, at 11:34 a.m. NA-G stated she did not provide R33 with any oral cares when she and NA-F got R33 up for the noon meal. NA-G stated she thought R33 had her mouth cleaned when she got up in the morning. In an interview on 1/11/17, at 1:08 p.m. licensed practical nurse (LPN)-C stated she would expect the aides to complete basic grooming, like teeth brushing, combing of hair, and washing of the face for residents who need assistance. LPN-C stated at a very minimum, those task were to be completed at least in the morning and evening.	F 282		

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F 282	Continued From page 7 In an interview on 1/12/17, at 2:55 p.m. LPN-B stated R33 was dependent upon staff for completion of basic cares, and expected a resident's care plan be followed. LPN-B stated she would expect basic cares be done, or at least, the care be offered. A facility policy, Care Plans, revised January 2017, indicated as it purpose as a "communication tool" which "...describes the services to be provided to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being."	F 282		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 285		2/21/17

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F 285	Continued From page 8 (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 285		

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for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a

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F 285	Continued From page 10 significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Level II preadmission screening and resident review (PASSR) was completed for 1 of 1 residents (R150) reviewed for preadmission screening. Findings include: R150's diagnoses as identified on a face sheet dated 12/23/16, included unspecified intellectual disabilities, bipolar disorder and brief psychotic disorder. The face sheet indicated R150's original admission date to the facility was 7/1/16. R150's annual Minimum Data Set (MDS) did not trigger a psychosocial well-being Care Area Assessment. During observation on 1/11/17, at 11:50 a.m. R150 was seated in her wheel chair at a table with three other residents, and was eating independently during the noon meal in the dining room. During an interview on 1/12/17, at 11:31 a.m. social worker (SW)-A stated R150 did not have a current, level-two, preadmission screening in her chart and questioned how R150 "was even admitted." SW-A stated the facility typically gets the pre-screen prior to admission. SW-A reviewed the document in R150's chart, and stated this screen, dated January 2011, only indicated R150	F 285	1. R150 PASRR level 2 was obtained per policy and procedure. 2. Corrective actions as it applies to others: residents audited in facility to ensure if PASRR Level 2 were completed or is needed for all newly evident or possible serious mental disorder, intellectual disability or a related condition for level 2 review upon a significant change in status assessment. Policy and procedure for PASRR was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete weekly audits for all new admits to ensure PASRR were completed before admission. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion by: February 21, 2017	

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was suitable for a nursing home stay, a convalescent stay. SW-A stated R150 had a history of mental illness, and further "we needed to get the level II screen completed" to determine if R150 required any special services or programming.

A review of R150's medical record included a document from the Illinois Department of Public Aid, Interagency Certification of Screening Results, dated 1/4/11. A second document, OBRA-I Initial Screen (Omnibus Budget Reconciliation Act level one), that was also dated 1/4/11. R150's medical record lacked a level II PASSR, or other indication a screen was completed prior to admission to this facility. R150's Interagency Certification Of Screening Results (Level 1 screening tool), indicated yes to a diagnosis of mental retardation in part II of the screening tool. This screening tool further directs the screener that if any areas in part II or part III are marked as a yes, the screener needs to complete part IV, however, no further sceening information was present in the client record.

R150's care plan dated 10/1/16, included mood and behavior and activities as problem/strength areas, however, the care plan did not identify or direct any special therapeutic or programming needs for R150.

R150's physician's orders dated 12/27/16, were reviewed and did not identify any prescription for special therapy or programming needs.

When interviewed on 1/12/17, at 1:29 p.m. the administrator stated upon admission, the facility accepted the OBRA-I Initial Screen as R150's

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F 285	Continued From page 12 PASSR, and did not get a new one. The former administrator stated R150 was admitted from a group home in another state that had closed. The administrator stated they would look at the rules to figure out how to get a screening for R150, and further would review the procedure for any new, similar admission. A policy regarding PASSR was requested from the facility, but none was provided.	F 285		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		2/21/17

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	245186	A. BUILDING _____ B. WING _____	01/12/2017

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F 309	Continued From page 13 the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care of a wound dressing following dialysis was provided appropriately and services were coordinated for 2 of 2 residents (R156, R127) reviewed who were receiving dialysis. Findings include: R156's admission record dated 12/23/16, identified diagnoses including end stage renal disease. R156's admission Minimum Data Set (MDS) dated 1/5/17, indicated R156 was independent with making decisions regarding tasks of daily living and had no problems with short and long term memory. R156's physician's orders dated 12/29/16, included having dialysis on Monday, Wednesday, and Friday. During an observation and interview on 1/10/17, at 10:18 a.m. R156 stated he had dialysis three times each week. R156 stated he carried paperwork with him to dialysis and he was to bring it back to the facility with him. R156 stated,	F 309	1. R127 and R156 care plan, orders, and treatment records were updated to match the Dialysis Management (Hemodialysis) policy and procedure. 2. Corrective actions as it applies to others: audit completed on all resident with hemodialysis to ensure dressing is completed and removed post dialysis as recommended by MD and dialysis. Policy and procedure for Dialysis Management (Hemodialysis) was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete weekly audits on each unit to ensure care/treatment is completed to hemodialysis site post dialysis. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion by: February 21, 2017	

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"Sometimes when I come back, I'm tired, and they don't ask me about the paperwork, so it stays in my bag until the next dialysis. Sometimes when I come back, they don't even take my vitals...They never ask to see my fistula." R156 displayed a dressing on his right upper arm and stated he returned last evening (1/9/17) from dialysis. R156 stated, "I will ask the nurse to remove the dressing today." R156 indicated he had gone to dialysis recently, wearing the same dressing placed by the dialysis staff two days prior, and the dialysis staff reminded him that the dressing needed to be removed when he returned to the facility.

When interviewed on 1/11/17, at 1:01 p.m. licensed practical nurse (LPN)-F indicated she did not know when R156's dressing was supposed to be removed after returning to the facility from dialysis. LPN-F stated, "I don't know the answer to that question. I took it off today [1/11/17, dialysis was on 1/9/17] because he asked me to."

Review of R156's hemodialysis (a process of filtering the blood) care plan dated 12/26/16, directed to complete vital signs upon return from dialysis, monitor for complications at vascular access site, monitor post-dialysis weight, and monitor functioning access site by checking the fistula by palpating thrill (blood flow) and listening for bruit (buzz) daily. The hemodialysis care plan also included, "dressing information," with a box checked directing staff to, "keep external catheter covered with dressing as directed by Dialysis Center," however, R156 had a fistula, not an external catheter.

Review of R156's hemodialysis fistula treatment administration record dated 12/16 and 1/17,

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included monitoring for thrill and bruit daily and post-dialysis, and documentation of post-dialysis weight, but lacked documentation regarding the removal of the dressing following dialysis.

During an interview on 1/11/17, at 1:08 p.m. the unit manager (UM)-A stated she had completed R156's hemodialysis care plan when he was admitted and had checked the intervention regarding the dressing because it noted the dialysis center would direct the facility staff when the dressing should be removed. UM-A verified R156 had a fistula, not an external catheter as noted on the care plan, and stated she didn't know when the dressing should be removed and had never contacted the dialysis center for directions as to when to remove the dressing.

During an interview on 1/11/17, at 1:26 p.m. UM-A stated she spoke to the staff at the dialysis center and was told the dressing to R156's fistula should be removed when he returned to the facility from dialysis.

During a telephone interview on 1/12/17, at 2:32 p.m. registered nurse (RN)-FDC from Fresenius dialysis center stated the dressing should be removed within a couple of hours of returning to the facility because it could cause complications with the fistula, and this should be monitored by the nursing staff. RN-FDC indicated the facility staff should have called the dialysis center if they had questions.

R127's admission record dated 1/7/16, identified R127 had diagnoses including end stage renal disease with dependence on renal dialysis.

R127's MDS, dated 10/19/16, identified R127 had

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F 309	Continued From page 16 moderate cognitive impairment. Review of R127's hemodialysis care plan dated 1/8/16, included R127 received hemodialysis Tuesday, Thursday, and Saturday, and under interventions, included, "Dressing Information," with three boxes: Catheter dressing to be changed at Dialysis Center, Keep external catheter covered with dressing as directed by Dialysis Center, or, Remove band-aid from access site the evening of dialysis. All three boxes were checked. Review of R127's hemodialysis fistula treatment record, dated 12/16 and 1/17, lacked direction regarding the removal of the fistula dressing following dialysis. During an interview on 1/11/17, at 2:20 p.m. licensed practical nurse (LPN)-B stated she was the unit manager but did not know if R127 had a fistula or an external catheter and when shown R127's hemodialysis care plan, did not know when R127's dressing was to be removed following his dialysis. During an observation and interview on 1/11/17, at 2:28 p.m. R127 stated he had dialysis on the previous day and had a dressing on his right upper arm. R127 indicated the facility staff did not remove the dressing, and stated, "I'm supposed to do it. I take it off before I go to dialysis again or they [dialysis staff] tell me it should come off because I could get an infection." R127 stated he was a "bleeder" and didn't want to remove the dressing too soon or he would bleed. R127 stated he planned to remove the dressing that evening. During a follow up interview on 1/12/17, at 10:38	F 309		

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F 309	Continued From page 17 a.m. LPN-B stated she called R127's dialysis center and they recommended the dressing be removed the next morning following his dialysis, however, she discussed this with R127 and he insisted he needed to keep the dressing on until the evening of the day following his dialysis. LPN-B stated she called the dialysis center again and discussed R127's concerns, and the dialysis center said he could leave the dressing on until the following evening. During a telephone interview on 1/12/17, at 2:53 p.m. registered nurse (RN)-DDC from Davita dialysis center stated the dressing should be removed before R127 goes to bed, on the day he receives dialysis, to prevent infection. RN-DDC stated R127 needed to be reassured that he would not bleed if the dressing was removed and education should be provided about the consequences of leaving the dressing on. Review of the facility's policy Dialysis Management (hemodialysis), dated 7/15, included the contractual agreement would include development and implementation of resident's hemodialysis care plan and interchange of information necessary for the care of the resident.	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 311	1. R87 care plan, care delivery guide,	2/21/17

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F 311	Continued From page 18 review, the facility failed to ensure a restorative walking program was consistently implemented for 1 of 1 residents (R87) reviewed for activities of daily living (ADLs). Findings include: R87's significant change Minimum Data Set (MDS) dated 8/6/16, indicated a severe cognitive impairment and identified R87 was independent with walking in his room and in the corridor. R87's significant change MDS dated 11/3/16, identified R87 did not walk in his room nor in the corridor during the observation period. R87's Care Area Assessment dated 11/9/16, indicated he was "not ambulatory at this time, using wheelchair for locomotion." R87's current physician orders dated 1/17, indicated his rehab potential was "good," and he could perform activity "as tolerated." R87's Therapy Recommendations for Restorative Program, dated 8/31/16, directed upon discharge from physical therapy (PT), R87 was placed on a supervised walking program which included ambulating twice a day to meals or to smoking with supervision and a four wheeled walker. R87's Comprehensive Care Plan Review Summary, signed 8/26/16, was completed due to the significant change MDS, dated 8/6/16. The summary contained various care planned areas including Restorative Nursing. The summary indicated R87 was not on a Restorative Nursing Program.	F 311	and Care Tracker (electronic system) were reviewed and updated to ensure staff have the ability and communication to appropriately document ambulation program for identified resident. 2. Residents currently assigned to restorative program have the potential to be affected by the current practice. Audit of residents currently on an ambulation program will be completed to ensure program is communicated. 3. Staff will be educated on the restorative program expectations and completion of program for identified residents. 4. DON/designee will complete weekly audits on each unit to ensure restorative program is being completed. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion by: February 21, 2017	

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F 311	Continued From page 19	F 311		

R87's ADL/Mobility Plan of Care, dated 1/17, identified R87 needing assistance of one staff and a walker for ambulation. There was no indication in R87's care plan regarding a supervised walking program.

During observation on 1/11/17, at 7:32 a.m. nursing assistant (NA)-A was observed assisting R87 to transfer into his wheelchair. R87 was already dressed and, once in wheelchair, began to slowly self propel to the door way. While NA-A was stripping the bed linens, NA-C came into the room and offered to assist NA-A. NA-C assisted R87 to breakfast by pushing him in his wheelchair. R87 was not observed ambulating to breakfast.

During observation on 1/11/17, at 12:51 p.m. R87 was observed self propelling in his wheelchair back to his room after lunch. R87 was not observed ambulating from lunch.

During observation on 1/12/17, at 6:53 a.m. R87 was observed self propelling in his wheel chair from his room down the hall way. A registered nurse (RN)-B offered to assist R87, and pushed him down to the dining room for breakfast. R87 was not observed ambulating to breakfast.

During observation on 1/12/17, at 10:12 a.m. R87 was observed asking RN-B for a ride to the dining room. RN-B proceeded to push R87 into the dining room. R87 was not observed ambulating before lunch.

During interview on 1/12/17, at 7:30 a.m. NA-B stated R87 could stand and would walk in his room; however, further stated that R87 was not always stable when walking and the staff would

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F 311	Continued From page 20 try to walk him "sometimes." During interview on 1/12/17, at 8:06 a.m. RN-B stated R87 used to walk with a walker, but was now wheelchair dependent. During interview on 1/12/17, at 9:10 a.m. RN-C stated R87 had a significant change MDS in August due to an improvement in his mobility and then had a significant change in November due to a decline in his mobility. She reported R87 had not ambulated during the November assessment period because he had been unsafe to ambulate and his walker had been put away after falling. During interview on 1/12/17, at 10:41 a.m. PT-A stated R87 was seen by therapy from 8/9/16 to 8/31/16, during which time he worked on gait training. PT-A stated R87 had been trialed with different walkers but was ultimately assessed as unsafe with independent ambulation. PT-A reported placing R87 on a supervised walking program on 8/31/16, which was suppose to be completed by the nursing assistants and was still expected to be implemented currently. However, PT-A stated the facility did not have specific restorative assistants and was not aware if R87's program was being completed consistently. During observation on 1/12/17, at 10:54 a.m. PT-A assisted R87 to walk down the hallway with a transfer belt and four wheeled walker. R87 appeared eager to ambulate and was able to ambulate approximately 125 feet. PT-A reported R87 had no decline in his ability to ambulate. During interview on 1/12/17, at 1:48 p.m. NA-C stated restorative programs were communicated to the nursing assistants by the nurse manager.	F 311		

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F 311	Continued From page 21 NA-C was not aware R87 had a supervised walking program, further reporting she had observed R87 walk in his room, but never in the halls. During interview on 1/12/17, at 1:54 p.m. licensed practical nurse (LPN)-A stated restorative programs were communicated on the white "communication board," and was not aware R87 had a restorative program. LPN-A further stated R87 used to be on a restorative program; however, after his falls, he didn't have a walking program. LPN-A stated "he can't walk." During interview on 1/12/17, at 3:35 p.m. director of nursing (DON) stated there was no restorative nursing program, but was working on getting one in place, and had sent staff to restorative training. She stated the nursing assistants were responsible for completing the restorative program and the nurses were to ensure it was getting done. Restorative ambulation documentation was requested. A facility document entitled ADL Detail Report, from 12/13/16 to 1/11/16, was provided and indicated R87 ambulated in the hallways eight times, well below the 60 times it should have occured, with the rest of the entries identifying "ADL activity did not occur." No further ADL documentation was provided. A Restorative Nursing Policy was requested but not provided.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out	F 312		2/21/17

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F 312	Continued From page 22 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grooming needs (shaving) or oral cares were provided for 2 of 3 residents (R120, R33) reviewed, who were dependent upon staff assistance with activities of daily living (ADLs). Findings include: R120's quarterly Minimum Data Set (MDS) dated 11/7/16, identified R120 had altered level of consciousness, severely impaired ability to make decisions, and required extensive assistance for dressing, and personal hygiene, and was totally dependent for bathing. The MDS further identified R120 did not exhibit behaviors of rejection of care. R120's ADL/Mobility Care Plan, last updated 1/17, included, "will be neat, clean and well groomed daily." R120's nursing assistant care sheet included R120 was to receive a bath on Wednesday mornings and was dependent on staff for dressing, grooming, and bathing. During an observation on 1/10/17, at 10:06 a.m. R120 was lying in bed with the head of the bed elevated. R120 had several one-half inch to one-inch curly grey and black facial hairs under her chin. During an observation on 1/11/17, at 7:16 a.m. R120 was lying in bed and the facial hairs under her chin remained. During interview on 1/11/17, at 9:11 a.m. nursing assistant (NA)-L stated residents were shaved, if needed, once a week on their bath day. NA-L	F 312	1. R120 and R33 will have plan of care reviewed and updated to ensure personal care needs are included. 2. Residents that are dependent on staff for personal care needs have the potential to be affected by this practice. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete weekly audits on each unit monitoring personal care needs are being provided per plan of care. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion: February 21,2017	

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F 312	Continued From page 23 stated she had given R120 a bed bath early that morning, but did not shave R120's facial hair because her supervisor had not told her to do so. During interview on 1/11/17, at 9:15 a.m. licensed practical nurse (LPN)-F stated R120's family attended to her facial hair because R120 did not like when staff did it. During observation on 1/12/17, at 9:24 a.m. the facial hair under R120's chin, remained. During interview on 1/12/17, at 10:09 a.m. NA-O stated she performed personal cares for R120 that morning, but did not shave her facial hair. During interview on 1/12/17, at 10:48 a.m. LPN-G stated R120's facial hair should have been removed, but, "They [NAs] just don't have time. They do the most important things, but things like facial hair don't get done. " On 1/12/17, at 3:01 p.m. R120's family member (F)-A stated it would bother R120 if she was aware that she had facial hair because she "always kept them clean." FM-A added, "I have never shaved them [R120's facial hairs]. I've always wondered about them, but never made a big deal about it." During interview on 1/12/17, at 4:40 p.m. unit manager (UM)-A stated she expected NAs to always shave residents when needed. R33's diagnosis as identified on the face sheet dated 11/23/16, included Alzheimer's dementia. The Care Area Assessment (CAA) for psychotropic drug use, dated 8/3/16, indicated R33 required assistance with dressing, grooming and bathing. The CAA further indicated R33 had difficulty communicating needs and staff anticipated R33's needs.	F 312		

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R33's care plan, revised 1/17, identified an ADLs problem area and directed staff to provide oral care daily and PRN (as needed), and that R33 required the physical assistance of staff.

During observation on 1/11/17, at 7:29 a.m. nursing assistant (NA)-D and NA-E entered the resident's room to assist R33 with morning ADLs. After washing R33's face, hands and perineal area, NA-D and NA-E dressed R33, then straightened her clothing, and combed R33's hair. A small basket on the dresser near the R33's bathroom door was observed to contain several unopened packaged of toothettes (mouth swabs). NA-E briefly left R33's room and returned with a mechanical lift to transfer R33 from her bed into the wheel chair. Seated in the wheel chair at 7:42 a.m., NA-E pushed R33 out of the room, down the hall and to the dining room. At no time during the observation of cares was R33 provided or offered oral care.

During interviewed on 1/11/17, at 9:10 a.m., nursing assistant (NA)-D stated R33 required staff to help her clean her teeth, and used a "toothette" (a mouth swab) to clean her mouth. NA-D stated she did not complete oral care for R33 this morning, and also acknowledged R33 was not offered oral care. NA-D stated mouth cares could also be done before lunch after R33 gets up from her nap.

During a later observation on 1/11/17, at 11:12 a.m. R33 was awake in her bed following a morning nap, and NA-G and NA-F entered the room to provide R33 with perineal care. Following the provision of care, NA-F left R33's room and quickly returned with a mechanical lift. NA-F and NA-G positioned a sling under R33, then

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transferred her from the bed into R33's wheel chair. NA-G placed a stocking cap on R33's head, then exited the room, pushing R33's wheel chair out of the room. During this provision of care, R33 was neither provided nor offered oral cares.

During interview on 1/11/17, at 11:34 a.m. NA-G stated she did not provide R33 with any oral cares when she and NA-F got R33 up for the noon meal. NA-G stated she thought R33 had her mouth cleaned when she got up in the morning.

In an interview on 1/11/17, at 1:08 p.m. licensed practical nurse (LPN)-C stated she would expect the aides to complete basic grooming, like teeth brushing, combing of hair, and washing of the face, for residents who need assistance. LPN-C stated at a very minimum, those task were to be completed at least in the morning and evening.

When interviewed on 1/12/17. at 2:55 p.m. LPN-B stated R33 was dependent upon staff for completion of basic cares, and expected a resident's care plan be followed. LPN-B stated she would expect basic cares be done, or at least, the care be offered.

Review of the facility's policy, Personal Needs, revised 10/16, included, "The center strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents. The center also provides the needed support when the resident performs their activities of daily living (ADLs)...Personal care and support includes but is not limited to ...Mouth Care...Shave." Also included, "Observe compliance with individualized interventions

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F 312	Continued From page 26 during daily rounds and monitor resident outcomes."	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls and behaviors possibly related to intoxication for 1 of 4 residents (R38) reviewed for accidents.	F 323	1. R38 was discharged from facility on 1/10/2017 2. Residents who have a history or current use of drugs and alcohol have the potential to be affected. Unauthorized use of Drugs, Alcohol and apparent	2/21/17

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F 323	Continued From page 27 Findings include: R38's quarterly MDS dated 10/15/16, indicated a history of manic depression and paraplegia. R38's admission diagnoses list dated 5/12/16, contained no history of alcoholism. R38 was discharged from the facility on 1/10/17. R38's current physician orders, dated 1/17, contained no indications for alcohol consumption. During interview on 1/11/16, at 12:13 a.m. nursing assistant (NA)-K stated she had observed R38 intoxicated, further stating when R38 was drunk "he would sleep a lot." NA-K stated when R38 was drunk, he wouldn't want to get out of bed when staff offered to help, even to shower. A couple minutes later R38 would want to get up right away even though we had already asked him, and then he would be crabby about it. NA-K stated when R38's significant other would visit, they would go downstairs, and R38 would come back smelling like liquor. During interview on 1/11/17, at 1:40 p.m. the health unit coordinator (HUC)-A reported observing R38 intoxicated and further reported R38 would "yell and call the providers names," he wouldn't be calmed down, and wouldn't want to lie down either during those times. HUC-A stated she thought R38's significant other would bring in alcohol when she visited about every two days, stating the staff didn't check her belongings. During an interview on 1/11/17, at 2:05 p.m. NA-H stated sometimes R38 would be a little more aggressive verbally, "just wasn't his normal self," would be more demanding, and further stated she just thought it was the medications.	F 323	Impairment on Premises policy will be enforced to ensure safety of themselves and others. Plan of care will be updated to include interventions if residents are under the influence of drugs or alcohol. 3. Staff will be educated on the policy and procedure by: February 21,2017. 4. DON/designee will complete weekly audits on each unit to monitor for the unauthorized use of drugs and alcohol. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion: February 21,2017	

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During interview on 1/12/17, at 10:25 a.m. licensed practical nurse (LPN)-A stated she had observed R38 and his wife drinking, "both being drunk," and found alcohol in his room. LPN-A indicated R38 had a large coffee cup that his wife would pour alcohol into. LPN-A reported the incident to her supervisor, who spoke to R38 and his wife, and stated the facility management had meetings about his drinking. LPN-A stated R38 had behaviors, he was impatient, impulsive, would yell and scream at staff, would try to transfer himself if he had to wait for staff, and had two or three falls because of it.

During interview on 1/12/17, at 12:31 p.m. social worker (SW)-B stated there were several complaints about R38 smelling of alcohol, for which the staff performed random room checks, would hold narcotics, and would place R38 on 15 minute checks. SW-B acknowledged these interventions were rarely charted in R38's medical record. SW-B stated the facility had suspicions that R38's significant other would bring in alcohol but couldn't prove it. SW-B further stated R38 was not restricted and would leave the facility to get groceries, but had never heard or observed R38 bring alcohol into the facility. SW-B also indicated R38 had verbal agitation and behaviors caused by his drinking, which were not addressed in his care plan.

During interview on 1/12/17, at 1:10 p.m. the director of nursing (DON) stated R38 would become intoxicated when his significant other was visiting. The DON reported the nurse manager spoke with R38's significant other about bringing alcohol in, which the DON stated she denied, but the facility did not have a record of the

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conversation. The DON stated R38 would go on outings with his significant other, but had never heard of him coming back intoxicated. The DON further reported staff performed room checks and would call the physician when R38 appeared intoxicated. She stated R38 would fall out of his chair and could exhibit unsafe behavior which could have been related to alcohol use, however, the DON acknowledged that had not been assessed.

Review of R38's Progress Notes indicated the following:
- On 7/18/16, R38 appeared "drunk" and sleepy, but denied drinking any alcohol.
- On 9/4/16, R38 was observed by staff drinking alcohol with his wife. The note further identified R38 was "intoxicated," and the physician was notified.
- On 9/6/16 and 9/7/16, notes indicated R38 was alert and staff did not see any alcohol in his room.
- On 9/23/16, R38 had "speech slurred," and a "large cup filled with whiskey" was found in his room. R38 requested oxycodone (narcotic pain medication), and became angry when he was not given any due to alcohol consumption.
- On 10/4/16, an IDT (interdisciplinary team) note identified "staff have smelled alcohol on his person" then went on to note a hospitalization related to low blood sugar. The note made no other mention of alcohol use nor any assessment by IDT.
- On 10/20/16, R38 was observed drinking beer and whiskey. The physician was notified and gave an order to hold medications "that will interact with whiskey or beer."

R38's Nurse's Notes, from 7/25/16 to 9/11/16, were reviewed for five falls, of which three were

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F 323	Continued From page 30 noted to occur from 9/4/16 to 9/11/16 - On 9/4/16, at 6:05 a.m. R38 was found lying on the floor next to his bed. R38 stated he fell out of his wheelchair and experienced right leg pain when staff tried to assist him. He refused to go to the hospital for evaluation of the leg pain and fell asleep after being assisted into bed. It was noted R38 was working with therapy on wheelchair positioning, however, the note further indicated later that day "was noted to be drinking alcohol and MD (medical doctor) had all narcotics held 9/5/16." - On 9/7/16, at 6:17 a.m. R38 was again found lying on the floor. R38 stated he slid out of his wheelchair. The note further indicated staff did check for any s/s (signs or symptoms) alcohol use and found none. - On 9/11/16, at 5:31 a.m. R38 was found lying on the floor. R38 stated he was trying to get out of bed and slid to the floor. The note further indicated R38 continued to be impulsive, lacked safety awareness, and would attempt to transfer without waiting for staff to arrive. There was no indication R38 was assessed for signs of alcohol use. R38's Fall/Injury Assessment: Prevention and Management Plan of Care updated 1/8/17, indicated he had multiple falls, would slide out of his wheelchair, and had a mental status change due to "Sneaking alcohol to drink." There was no other mention of alcohol on the Fall/Injury Plan of Care. The care plan lacked any previous assessment or specific interventions related to R38 alcohol use and falls. R38's Mood and Behavior Symptom Assessment Care Plan dated 6/16, identified no specific behaviors, however, directed if R38 became	F 323		

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F 323	Continued From page 31 verbally or physically aggressive, he was removed from the situation. The care plan lacked any previous assessment and interventions for R38's specific behaviors while intoxicated. R38's medical record lacked a comprehensive assessment of his risk factors and possible complications related to his alcohol use, subsequent falls, and behaviors. A facility policy entitled Unauthorized Use of Drugs, Alcohol and Apparent Impairment on Premises, revised 1/17, directed if a physician order is not obtained for alcohol and is not removed, staff were to initiate the Unauthorized Substance Abuse: Treatment and Safety Care Plan.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		2/21/17

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F 431	Continued From page 32 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were labeled appropriately prior to administration for 1 of 2 residents (R27) reviewed.	F 431	1. R27 Discharged 2/3/2017. 2. Residents that have had a change in medication have the potential to be affected. Policy and procedure for Reordering, changing and discontinuing	

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F 431	Continued From page 33 Findings include: R27's admission record dated 8/12/16, indicated R27's diagnoses included diabetes, heart failure, and hypertension. R27's physician orders dated January 2017, indicated humulin R (human insulin used to improve blood sugar control) insulin pen to inject 90 units subcutaneous (Under skin) before breakfast. During observation on 1/11/17, at 7:38 a.m. with registered nurse (RN)-A revealed R27's humulin R insulin pen was labeled to inject 85 units of humulin R subq. During interview on 1/11/17, at 7:40 a.m. RN-A stated R27's humulin R insulin pen was not labeled correctly. RN-A stated the physician orders are for 90 units of humulin R to be given to R27. RN-A stated the pharmacy should have relabeled the humulin R insulin pen to have 90 units not 85 units of humulin R. RN-A stated, "I have never seen new labels come with dose changes, the pharmacy would have to relabel the insulin pen with the correct dose." A facility policy 4.5 Reordering, Changing, and Discontinuing Orders, dated 10/31/16, directed staff to attach a "Change in Directions" sticker to the existing quantity of medications.	F 431	orders was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete Weekly audits on medication pass on each unit to ensure change in direction stickers are being use. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion: February 21,2017	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		2/21/17

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F 441	Continued From page 34 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 441		

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F 441	Continued From page 35 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control measures were implemented for a shared glucometer that had the potential to affect 4 of 5 residents (R27, R98, R60, R70) who utilized the shared glucometer. In addition, the facility failed to ensure soiled laundry items were consistently contained to prevent the spread of infection. This had the potential to affect 26 residents who lived on the 1st floor of the facility. Findings include: SHARED GLUCOMETER During observation on 1/11/17, at 7:43 a.m. registered nurse (RN)-A washed RN-A's hands and donned gloves. RN-A went into R27's room with a green basket with lancets, alcohol wipes,	F 441	1. R27 discharged 2/3/2017, R98, R60 and R70 care plan, orders and treatment records were updated to match Glucose Monitoring Equipment: Disinfect/Decontaminate policy and procedure. 2. Corrective actions as it applies to others: Audits conducted with staff that complete Glucose checks to ensure that Glucose Monitoring equipment: Disinfect/Decontaminate policy and procedure is done correctly, increase frequency of checks to soiled utility room from 3x/day to 4x per day to stop overfilling of laundry cart and ensure linens are bagged properly. Policy and procedure for Glucose Monitoring Equipment: Disinfect/Decontaminate was reviewed and remains current. Policy and	

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F 441	Continued From page 36 and a glucometer (devise used to measure sugar levels in the blood). RN-A wiped R27's finger with an alcohol prep pad and poked finger with a disposable lancet. RN-A used a glucometer to measure R27's blood sugar level, hovever, RN-A did not clean or disinfect the glucometer after use on R27. RN-A then went to R98's room and checked R98's blood sugar with the same green basket and the glucometer. RN-A did not clean or disinfect glucometer after use on R98. RN-A then went to R60's room and checked R60's blood sugar with the same green basked and the same glucometer. RN-A did not clean or disinfect the glucometer after use on R60. RN-A then went to R70's room and checked R70's blood sugar with the same green basket and the same glucometer. RN-A did not clean or disinfect the glucometer after use on R70. During observation on 1/11/17, at 7:55 a.m. RN-A brought the green basket to the north medication cart and put the green basket with the used glucometer in the bottom drawer and locked the medication cart and went to assist another staff. During interview on 1/11/17, at 7:59 a.m. RN-A stated she cleaned the glucometer with an alcohol wipe between each resident. RN-A stated a Sani wipe (germicidal disposable wipe) could be used also on the glucometer when done using the glucometer. RN-A stated I would have to look up the policy on glucometers to see what to use to clean them with. RN-A then took out the Sani wipes and wiped the glucometer with the Sani wipe and placed it back in the green basket in the	F 441	procedure for Handling of Linen was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete weekly audits on each unit to ensure Glucometer are being clean after use. Weekly audits on each unit to ensure Laundry cart is not overfilled and that soiled items are bagged. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion: February 21,2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	01/12/2017

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

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F 441	Continued From page 37 bottom of the north medication cart. When interviewed on 1/12/17, at 4:40 p.m. the director of nursing (DON) stated the glucometer should be wiped with a purple top Sani cloth and then wrapped in a clean wet Sani cloth for two minutes and after two minutes put the glucometer in the cart to be stored. The DON stated the shared glucometer should be disinfected between each resident's use. The facility policy Glucose Monitoring Equipment: Disinfect/Decontaminate dated 7/2015, directed staff to disinfect the glucometer with the wipes following use on each resident. Staff were to: 1-Use the disinfectant wipe to clean all external parts of the glucometer with gloves on. 2-Remove gloves. 3-Perform hand hygiene. 4-Don clean gloves. 5-Obtain a second wipe and fresh paper towel. 6-Use the wipe to clean all external parts of the glucometer for the second cleaning. 7-Place the glucometer on the fresh paper towel. Allow the meter to remain wet for the contact time required by the manufacturer's recommendation before completing another glucose test. 8-Remove gloves. 9-Perform hand hygiene. 10-Place glucometer in appropriate storage until next blood glucose test. SOILED-UTILITY ROOM During the initial tour of the facility on 1/9/17, at 2:07 p.m. the 1st floor, soiled utility room was inspected. The locked room housed a plastic	F 441		

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F 441	Continued From page 38	F 441		

laundry cart, approximately 4' (feet) by 5' wide, and 4' high, and was positioned under the opening of a stainless steel laundry chute. The cart overflowed with bagged and unbagged laundry items. The items included bed sheets, bed spreads, various sizes of bath towels, wash cloths and bed mattress pads. Most of the laundry items were bagged, but numerous bags were ripped, their contents laying in the cart and on the floor of the soiled utility room. Visibly soiled bed pads were draped in and along the side of the cart, and one of the bed pads was dark and soiled, found among other towels on the floor.

In an interview on 1/9/17 at 2:09 p.m. the housekeeping manager (HM) stated the laundry room was full, and there was bagged and un-bagged laundry in the cart, and some other laundry and towels on the floor. The HM stated the chutes were metal, and had some edges on, and when the bags were sent down the chute, many arrived torn, and the laundry spilled out.

During a later observation on 1/9/17, at 6:45 p.m. the 1st floor soiled utility room cart was not overfilled with laundry, and contained mostly bagged laundry items. Several large bath towels were also observed in the cart, unbagged.

During observation the next morning on 1/10/17 at 10:34 a.m., a housekeeper was working in resident room across from the 1st floor soiled utility room. The laundry cart in the room was again observed overfilled, and the laundry chute was backed up with laundry. Five bags of laundry, all tied, and a visibly soiled hospital gown, were all observed on the floor in the room.

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F 441	Continued From page 39 When interviewed on 1/10/17, at 10:55 a.m. housekeeper (HK)-B stated she was swapping out the laundry carts, which was a task that was done a couple of time every day. HK-B stated she sees the soiled laundry as mostly bagged when it came down the chute, but has often seen un-bagged, soiled laundry. The HK-B stated the laundry chute went to the 4th floor, and added "all items" were to be bagged. When interview on 1/12/17 at 7:31 a.m. the HM stated carts in the soiled area were to be removed three times daily to keep laundry from overflowing. The HM stated some of the laundry bags do rip, and that bags were often not tied tightly. The HM stated that some staff do not always bag soiled laundry, and stated nursing staff were trained on proper disposal, but there were new people who may not know the rules. The HM then stated this was an "inservice opportunity" for staff to review the proper handling of soiled linen. A facility policy, Infection Control, Handling of Linen, effective July 2015, indicated its purpose was to reduce the risk of infection to residents and employees. The policy indicated standard precautions would be followed when handling soiled linens. The policy directed all soiled linen was to be bagged and collected by cart at the chutes at regular intervals, and not allow hampers to overfill.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions	F 465		2/21/17

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F 465	Continued From page 40 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary toilet in the shower room on the 1st floor unit which had potential to affect 26 residents who utilized the shower and restroom. Findings include: During observation on 1/9/17, at 7:24 p.m. the resident shower/bathroom on the 1st floor of the facility was inspected. A large door from the main hallway led into the shower room, and upon entrance, a full privacy curtain hung from the ceiling to the floor. Three large bath towels and wash cloths were observed scattered on the floor, and there was a toilet in the corner of the room. The floor area and wall directly to the left of and behind the toilet was heavily soiled. The soiling was an unidentified, brown-colored and substance which covered and adhered to the walls behind and along side the toilet. The tile floor between the wall and toilet, an area approximately 8" (inches) x 20", was also covered with this same, unknown substance. Although the soiled areas did not smell, the substance was dried to the wall and floor surfaces. During an interview on 1/9/17, at 7:27 p.m.	F 465	1. Shower room and Toilet was clean and sanitized 2. Residents who use the shower room have the potential to be affected by the deficient practice. Policy and procedure for Health Service Group, Bloodborne Pathogens employee handbook was reviewed and remains current. 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee weekly audits on each unit to ensure shower room and toilets are clean and sanitized. 5. Audits will be completed for a period of 90 days and audit results will be reviewed by QA committee to determine the need of on going monitoring. 6. Date of completion: February 21,2017	

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F 465	Continued From page 41	F 465		

nursing assistant (NA)-I acknowledged the presence of the soiled wall and floors in the corner of the shower room near the toilet, as well as the towels on the floor in the shower room. NA-I stated she wondered if someone got sick, and also staed that it needed to be cleaned.

The following day at 1/10/17, at 10:52 a.m. a resident exited from the shower/bathroom, and as she ambulated past the surveyor, the resident pointed to the room stated it was "the third day" the mess was in the bathroom and pointed to the shower room. Upon a subsequent review of the 1st floor bathroom/ shower after the resident left the area, the walls and floor area surrounding the toilet remained as it was found the previous day, heavily soiled and unclean.

During interview on 1/10/17, at 11:01 a.m. when asked about the soiled resident shower room/bathroom, licensed practical nurse (LPN)-E stated she saw a resident use the bathroom earlier, and indicated the resident may have got the bathroom dirty. When LPN-E looked at the bathroom she stated, "Oh, my God!" and added she would get someone to clean it up right away. LPN-E also stated resident bathrooms and shower rooms were cleaned on a daily basis, but was unaware of the mess in this bathroom, or how long the 1st floor bathroom had been dirty.

During interview on 1/10/17, at 1:53 p.m. housekeeper (HK)-A stated shower rooms were cleaned everyday. HK-A stated she did now know why the 1st floor shower was not clean, and also stated those resident bathrooms and showers were cleaned, mopped and disinfected daily.

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F 465	Continued From page 42	F 465		

During interview about the unclean 1st floor shower/bathroom on 1/12/17, at 7:18 a.m. LPN-B stated she thought there was some confusion as to who can clean what. LPN-B stated housekeeping cannot clean bodily fluids, and nursing would have to initially clean up any BM (bowel movement), then notify housekeeping to disinfect an area. LPN-B stated with all the new staff, that shower room got missed. LPN-B stated whoever found the mess should have communicated right away, and one of the nurses should have taken action, cleaned it themselves, and then let housekeeping know.

During interview on 1/12/17, at 7:35 a.m. the housekeeping manager (HM) stated that housekeeping staff did not clean bodily fluids, that was for nursing. The HM explained the facility blood borne policy, but stated there must have been some mis-communication between the aides and staff. The HM stated they need to do some kind of staff inservice, and it was something staff need to be educated on, and also stated it was good to have this brought to staff's attention.

A facility document, from Health Service Group, bloodborne Pathogens Employee Handbook, undated, indicated "Any equipment or furniture that is contaminated with visibly large quantities of blood or other bodily fluids will be referred to nursing personnel of the client facility for decontamination. The document further indicated their employees "are only to clean previously decontaminated areas..."

A facility document, Healthcare Services Group, Inc, Housekeeping Inservice, dated 1/1/2000, provided direction for "7-Step Daily Washroom Cleaning." Included in the inservice was direction

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F 465	Continued From page 43 to "clean and sanitize commode" and "damp mop floor."	F 465		

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	245186	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/17/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 17, 2017. At the time of this survey, Golden Valley Rehab and Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/13/2017

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.

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Valley Rehab and Care Center is a 3-story building that was constructed in 1972 and was determined to be of Type II (222) construction. It has partial basement and is fully protected by an automatic fire sprinkler system. The facility has fire alarm detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 164 beds and had a census of 111 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall	K 741		2/21/17

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K 741	Continued From page 2 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not adhere to their written smoking policy in accordance with the 2012 LSC NFPA 101. 19.7.4. This deficient practice could effect any residents or staff in the smoking area. Findings include: On a facility tour between the hours of 1000 and 1500 on January 17, 2017, observation revealed that that several residents were smoking at the front entrance where no smoking signs were present. I was also observed that a staff member	K 741	The facility failed to appropriatly redirect residents away from the facility enterance to the designated smoking area. All facility staff will be educated by 2/21/2017 regarding facility smoking policy and designated smoking area. Reoccurance will be prevented by weekly audits to ensure the facility smoking policy is being adheared to. Corrections will be monitored by maintenance/designee.	

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K 741	Continued From page 3 was placing wheel chair bound residents in this location to smoke. This deficient practice was verified by the director of maintenance at the time of inspection.	K 741		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
February 3, 2017

Ms. Lynn Hickey, Administrator
Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, MN 55427

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5186031 and Complaint Numbers H5186216 and H5186222

Dear Ms. Hickey:

The above facility was surveyed on January 17, 2017 through January 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5186216 that was substantiated and complaint number H5186222 that was 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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/infobul.htm . 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.

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00112	A. BUILDING: _____ B. WING _____	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 1/9/17 to 1/12/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigations were also completed at the time of the licensing survey. Investigation of complaints H5186216 and H5186222 were completed. The complaint was substantiated related to H5186216. Correction order issued at State Licensing 0920. The complaint/s related to H5186222 was not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as	2 000		

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2 000	Continued From page 2 evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees	2 302		2/21/17

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2 302	Continued From page 3 trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that residents and/or interested family were provided information regarding the Alzheimer's training staff received including who received training, how often, and a description of the training provided. This had the potential to affect 115 of 115 current residents of the facility and their families. Findings include: A review of staff participant list for the "CARES: An Approach to Managing Dementia Behaviors" course, print date of 1/9/17, included 224 staff on the roster. The roster indicated all 224 employees of the facility had completed the Alzheimer's training between January 1, 2016 and December 31st, 2016, however, there was a lack of evidence that the facility had a system in place to educate residents/families and guardians on how and when facility staff were educated on Alzheimer's and dementia care. During interview on 01/12/17, at 3:22 p.m. the director of nursing (DON) stated she was unaware of consumers/residents/families being provided information of facility training of staff on Alzheimer's and dementia care. The DON stated that she would check with social services, to see if it was covered in the admission process. At 3:55 p.m., the DON returned and stated that this	2 302	corrected	

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2 302	Continued From page 4 information was not included in the admission process, and when she had contacted outside resources, it was discovered that they do not provide information on training to families and consumers. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care by failing to provide oral cares for 1 of 1 residents (R33) reviewed for activities of daily living (ADLs) who was dependent upon staff for assistance. Findings include: R33's diagnosis as identified on the face sheet	2 565	corrected	2/21/17

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2 565	Continued From page 5 dated 11/23/16, included Alzheimer's dementia. R33's care plan revised 1/17, identified an ADLs problem area and directed staff to provide oral care daily and PRN (as needed), and that R33 required the physical assistance of staff. During observation on 1/11/17, at 7:29 a.m. nursing assistant (NA)-D and NA-E entered the resident's room to assist R33 with morning cares. After washing R33's face, hands and perineal area, NA-D and NA-E dressed R33, then straightened her clothing, and combed R33's hair. A small basket on the dresser near the R33's bathroom door was observed to contain several unopened packaged of toothettes (mouth swabs). NA-E briefly left R33's room and returned with a mechanical lift to transfer R33 from her bed into the wheel chair. Seated in the wheel chair at 7:42 a.m., NA-E pushed R33 out of the room, down the hall and to the dining room. At no time during the observation of cares was R33 provided or offered oral care. During interview on 1/11/17, at 9:10 a.m. nursing assistant (NA)-D stated R33 required staff to help her clean her teeth, and used a toothette (a mouth swab) to clean her mouth. NA-D stated she did not complete oral care for R33 this morning, and also acknowledged R33 was not offered oral care. NA-D stated mouth cares could also be done before lunch after she R33 gets up from her nap. During a later observation on 1/11/17, at 11:12 a.m. R33 was awake in her bed following a morning nap, and NA-G and NA-F entered the room to provide R33 with perineal care. Following the provision of care, NA-F left R33's room and quickly returned with a mechanical lift.	2 565		

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2 565	Continued From page 6 NA-F and NA-G positioned a sling under R33, then transferred her from the bed into R33's wheel chair. NA-G placed a stocking cap on R33's head, then exited the room, pushing R33's wheel chair out of the room. During this provision of care, R33 was neither provided nor offered oral cares. During interview on 1/11/17, at 11:34 a.m. NA-G stated she did not provide R33 with any oral cares when she and NA-F got R33 up for the noon meal. NA-G stated she thought R33 had her mouth cleaned when she got up in the morning. In an interview on 1/11/17, at 1:08 p.m. licensed practical nurse (LPN)-C stated she would expect the aides to complete basic grooming, like teeth brushing, combing of hair, and washing of the face for residents who need assistance. LPN-C stated at a very minimum, those task were to be completed at least in the morning and evening. In an interview on 1/12/17, at 2:55 p.m. LPN-B stated R33 was dependent upon staff for completion of basic cares, and expected a resident's care plan be followed. LPN-B stated she would expect basic cares be done, or at least, the care be offered. A facility policy, Care Plans, revised January 2017, indicated as it purpose as a "communication tool" which "...describes the services to be provided to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 565		

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2 565	Continued From page 7 review and revise policies and procedures related to ensuring the care plan for each resident is followed. To ensure ongoing compliance, the DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing are as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care of a wound dressing following dialysis was provided appropriately and services were coordinated for 2 of 2 residents (R156, R127) reviewed who were receiving dialysis.	2 830	corrected	2/21/17

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2 830	Continued From page 8 Findings include: R156's admission record dated 12/23/16, identified diagnoses including end stage renal disease. R156's admission Minimum Data Set (MDS) dated 1/5/17, indicated R156 was independent with making decisions regarding tasks of daily living and had no problems with short and long term memory. R156's physician's orders dated 12/29/16, included having dialysis on Monday, Wednesday, and Friday. During an observation and interview on 1/10/17, at 10:18 a.m. R156 stated he had dialysis three times each week. R156 stated he carried paperwork with him to dialysis and he was to bring it back to the facility with him. R156 stated, "Sometimes when I come back, I'm tired, and they don't ask me about the paperwork, so it stays in my bag until the next dialysis. Sometimes when I come back, they don't even take my vitals...They never ask to see my fistula." R156 displayed a dressing on his right upper arm and stated he returned last evening (1/9/17) from dialysis. R156 stated, "I will ask the nurse to remove the dressing today." R156 indicated he had gone to dialysis recently, wearing the same dressing placed by the dialysis staff two days prior, and the dialysis staff reminded him that the dressing needed to be removed when he returned to the facility. When interviewed on 1/11/17, at 1:01 p.m. licensed practical nurse (LPN)-F indicated she did not know when R156's dressing was supposed to be removed after returning to the facility from	2 830		

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2 830	Continued From page 9 dialysis. LPN-F stated, "I don't know the answer to that question. I took it off today [1/11/17, dialysis was on 1/9/17] because he asked me to." Review of R156's hemodialysis (a process of filtering the blood) care plan dated 12/26/16, directed to complete vital signs upon return from dialysis, monitor for complications at vascular access site, monitor post-dialysis weight, and monitor functioning access site by checking the fistula by palpating thrill (blood flow) and listening for bruit (buzz) daily. The hemodialysis care plan also included, "dressing information," with a box checked directing staff to, "keep external catheter covered with dressing as directed by Dialysis Center," however, R156 had a fistula, not an external catheter. Review of R156's hemodialysis fistula treatment administration record dated 12/16 and 1/17, included monitoring for thrill and bruit daily and post-dialysis, and documentation of post-dialysis weight, but lacked documentation regarding the removal of the dressing following dialysis. During an interview on 1/11/17, at 1:08 p.m. the unit manager (UM)-A stated she had completed R156's hemodialysis care plan when he was admitted and had checked the intervention regarding the dressing because it noted the dialysis center would direct the facility staff when the dressing should be removed. UM-A verified R156 had a fistula, not an external catheter as noted on the care plan, and stated she didn't know when the dressing should be removed and had never contacted the dialysis center for directions as to when to remove the dressing. During an interview on 1/11/17, at 1:26 p.m. UM-A stated she spoke to the staff at the dialysis center	2 830		

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2 830	Continued From page 10 and was told the dressing to R156's fistula should be removed when he returned to the facility from dialysis. During a telephone interview on 1/12/17, at 2:32 p.m. registered nurse (RN)-FDC from Fresenius dialysis center stated the dressing should be removed within a couple of hours of returning to the facility because it could cause complications with the fistula, and this should be monitored by the nursing staff. RN-FDC indicated the facility staff should have called the dialysis center if they had questions. R127's admission record dated 1/7/16, identified R127 had diagnoses including end stage renal disease with dependence on renal dialysis. R127's MDS, dated 10/19/16, identified R127 had moderate cognitive impairment. Review of R127's hemodialysis care plan dated 1/8/16, included R127 received hemodialysis Tuesday, Thursday, and Saturday, and under interventions, included, "Dressing Information," with three boxes: Catheter dressing to be changed at Dialysis Center, Keep external catheter covered with dressing as directed by Dialysis Center, or, Remove band-aid from access site the evening of dialysis. All three boxes were checked. Review of R127's hemodialysis fistula treatment record, dated 12/16 and 1/17, lacked direction regarding the removal of the fistula dressing following dialysis. During an interview on 1/11/17, at 2:20 p.m. licensed practical nurse (LPN)-B stated she was the unit manager but did not know if R127 had a	2 830		

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2 830	Continued From page 11 fistula or an external catheter and when shown R127's hemodialysis care plan, did not know when R127's dressing was to be removed following his dialysis. During an observation and interview on 1/11/17, at 2:28 p.m. R127 stated he had dialysis on the previous day and had a dressing on his right upper arm. R127 indicated the facility staff did not remove the dressing, and stated, "I'm supposed to do it. I take it off before I go to dialysis again or they [dialysis staff] tell me it should come off because I could get an infection." R127 stated he was a "bleeder" and didn't want to remove the dressing too soon or he would bleed. R127 stated he planned to remove the dressing that evening. During a follow up interview on 1/12/17, at 10:38 a.m. LPN-B stated she called R127's dialysis center and they recommended the dressing be removed the next morning following his dialysis, however, she discussed this with R127 and he insisted he needed to keep the dressing on until the evening of the day following his dialysis. LPN-B stated she called the dialysis center again and discussed R127's concerns, and the dialysis center said he could leave the dressing on until the following evening. During a telephone interview on 1/12/17, at 2:53 p.m. registered nurse (RN)-DDC from Davita dialysis center stated the dressing should be removed before R127 goes to bed, on the day he receives dialysis, to prevent infection. RN-DDC stated R127 needed to be reassured that he would not bleed if the dressing was removed and education should be provided about the consequences of leaving the dressing on. Review of the facility's policy Dialysis	2 830		

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2 830	Continued From page 12 Management (hemodialysis), dated 7/15, included the contractual agreement would include development and implementation of resident's hemodialysis care plan and interchange of information necessary for the care of the resident. Based on observation, interview, and document review the facility failed to comprehensively assess falls and behaviors possibly related to intoxication for 1 of 4 residents (R38) reviewed for accidents. Findings include: R38's quarterly MDS dated 10/15/16, indicated a history of manic depression and paraplegia. R38's admission diagnoses list dated 5/12/16, contained no history of alcoholism. R38 was discharged from the facility on 1/10/17. R38's current physician orders, dated 1/17, contained no indications for alcohol consumption. During interview on 1/11/16, at 12:13 a.m. nursing assistant (NA)-K stated she had observed R38 intoxicated, further stating when R38 was drunk "he would sleep a lot." NA-K stated when R38 was drunk, he wouldn't want to get out of bed when staff offered to help, even to shower. A couple minutes later R38 would want to get up right away even though we had already asked him, and then he would be crabby about it. NA-K stated when R38's significant other would visit, they would go downstairs, and R38 would come back smelling like liquor. During interview on 1/11/17, at 1:40 p.m. the health unit coordinator (HUC)-A reported observing R38 intoxicated and further reported	2 830		

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2 830	Continued From page 13 R38 would "yell and call the providers names," he wouldn't be calmed down, and wouldn't want to lie down either during those times. HUC-A stated she thought R38's significant other would bring in alcohol when she visited about every two days, stating the staff didn't check her belongings. During an interview on 1/11/17, at 2:05 p.m. NA-H stated sometimes R38 would be a little more aggressive verbally, "just wasn't his normal self," would be more demanding, and further stated she just thought it was the medications. During interview on 1/12/17, at 10:25 a.m. licensed practical nurse (LPN)-A stated she had observed R38 and his wife drinking, "both being drunk," and found alcohol in his room. LPN-A indicated R38 had a large coffee cup that his wife would pour alcohol into. LPN-A reported the incident to her supervisor, who spoke to R38 and his wife, and stated the facility management had meetings about his drinking. LPN-A stated R38 had behaviors, he was impatient, impulsive, would yell and scream at staff, would try to transfer himself if he had to wait for staff, and had two or three falls because of it. During interview on 1/12/17, at 12:31 p.m. social worker (SW)-B stated there were several complaints about R38 smelling of alcohol, for which the staff performed random room checks, would hold narcotics, and would place R38 on 15 minute checks. SW-B acknowledged these interventions were rarely charted in R38's medical record. SW-B stated the facility had suspicions that R38's significant other would bring in alcohol but couldn't prove it. SW-B further stated R38 was not restricted and would leave the facility to get groceries, but had never heard or observed R38 bring alcohol into the facility. SW-B also	2 830		

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2 830	Continued From page 14 indicated R38 had verbal agitation and behaviors caused by his drinking, which were not addressed in his care plan. During interview on 1/12/17, at 1:10 p.m. the director of nursing (DON) stated R38 would become intoxicated when his significant other was visiting. The DON reported the nurse manager spoke with R38's significant other about bringing alcohol in, which the DON stated she denied, but the facility did not have a record of the conversation. The DON stated R38 would go on outings with his significant other, but had never heard of him coming back intoxicated. The DON further reported staff performed room checks and would call the physician when R38 appeared intoxicated. She stated R38 would fall out of his chair and could exhibit unsafe behavior which could have been related to alcohol use, however, the DON acknowledged that had not been assessed. Review of R38's Progress Notes indicated the following: - On 7/18/16, R38 appeared "drunk" and sleepy, but denied drinking any alcohol. - On 9/4/16, R38 was observed by staff drinking alcohol with his wife. The note further identified R38 was "intoxicated," and the physician was notified. - On 9/6/16 and 9/7/16, notes indicated R38 was alert and staff did not see any alcohol in his room. - On 9/23/16, R38 had "speech slurred," and a "large cup filled with whiskey" was found in his room. R38 requested oxycodone (narcotic pain medication), and became angry when he was not given any due to alcohol consumption. - On 10/4/16, an IDT (interdisciplinary team) note identified "staff have smelled alcohol on his person" then went on to note a hospitalization	2 830		

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2 830	Continued From page 15	2 830		

related to low blood sugar. The note made no other mention of alcohol use nor any assessment by IDT.
- On 10/20/16, R38 was observed drinking beer and whiskey. The physician was notified and gave an order to hold medications "that will interact with whiskey or beer."

R38's Nurse's Notes, from 7/25/16 to 9/11/16, were reviewed for five falls, of which three were noted to occur from 9/4/16 to 9/11/16
- On 9/4/16, at 6:05 a.m. R38 was found lying on the floor next to his bed. R38 stated he fell out of his wheelchair and experienced right leg pain when staff tried to assist him. He refused to go to the hospital for evaluation of the leg pain and fell asleep after being assisted into bed. It was noted R38 was working with therapy on wheelchair positioning, however, the note further indicated later that day "was noted to be drinking alcohol and MD (medical doctor) had all narcotics held 9/5/16."
- On 9/7/16, at 6:17 a.m. R38 was again found lying on the floor. R38 stated he slid out of his wheelchair. The note further indicated staff did check for any s/s (signs or symptoms) alcohol use and found none.
- On 9/11/16, at 5:31 a.m. R38 was found lying on the floor. R38 stated he was trying to get out of bed and slid to the floor. The note further indicated R38 continued to be impulsive, lacked safety awareness, and would attempt to transfer without waiting for staff to arrive. There was no indication R38 was assessed for signs of alcohol use.

R38's Fall/Injury Assessment: Prevention and Management Plan of Care updated 1/8/17, indicated he had multiple falls, would slide out of his wheelchair, and had a mental status change

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2 830	Continued From page 16 due to "Sneaking alcohol to drink." There was no other mention of alcohol on the Fall/Injury Plan of Care. The care plan lacked any previous assessment or specific interventions related to R38 alcohol use and falls. R38's Mood and Behavior Symptom Assessment Care Plan dated 6/16, identified no specific behaviors, however, directed if R38 became verbally or physically aggressive, he was removed from the situation. The care plan lacked any previous assessment and interventions for R38's specific behaviors while intoxicated. R38's medical record lacked a comprehensive assessment of his risk factors and possible complications related to his alcohol use, subsequent falls, and behaviors. A facility policy entitled Unauthorized Use of Drugs, Alcohol and Apparent Impairment on Premises, revised 1/17, directed if a physician order is not obtained for alcohol and is not removed, staff were to initiate the Unauthorized Substance Abuse: Treatment and Safety Care Plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to dialysis fistula assessments and proper care related to the fistula. The DON or designee could review and revise policies and prodecures relaated to ensuring all residents are assessed for fall risk and interventions are implemented and care planned upon admission and reveiwed and revised as necessary. The DON or designee could conduct audits to ensure ongoing compliance. The results of the audits could be	2 830		

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2 830	Continued From page 17 reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a restorative walking program was consistently implemented for 1 of 1 residents (R87) reviewed for activities of daily living (ADLs). Findings include:	2 915	corrected	2/21/17

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2 915	Continued From page 18 R87's significant change Minimum Data Set (MDS) dated 8/6/16, indicated a severe cognitive impairment and identified R87 was independent with walking in his room and in the corridor. R87's significant change MDS dated 11/3/16, identified R87 did not walk in his room nor in the corridor during the observation period. R87's Care Area Assessment dated 11/9/16, indicated he was "not ambulatory at this time, using wheelchair for locomotion." R87's current physician orders dated 1/17, indicated his rehab potential was "good," and he could perform activity "as tolerated." R87's Therapy Recommendations for Restorative Program, dated 8/31/16, directed upon discharge from physical therapy (PT), R87 was placed on a supervised walking program which included ambulating twice a day to meals or to smoking with supervision and a four wheeled walker. R87's Comprehensive Care Plan Review Summary, signed 8/26/16, was completed due to the significant change MDS, dated 8/6/16. The summary contained various care planned areas including Restorative Nursing. The summary indicated R87 was not on a Restorative Nursing Program. R87's ADL/Mobility Plan of Care, dated 1/17, identified R87 needing assistance of one staff and a walker for ambulation. There was no indication in R87's care plan regarding a supervised walking program. During observation on 1/11/17, at 7:32 a.m. nursing assistant (NA)-A was observed assisting	2 915		

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2 915	Continued From page 19	2 915		

R87 to transfer into his wheelchair. R87 was already dressed and, once in wheelchair, began to slowly self propel to the door way. While NA-A was stripping the bed linens, NA-C came into the room and offered to assist NA-A. NA-C assisted R87 to breakfast by pushing him in his wheelchair. R87 was not observed ambulating to breakfast.

During observation on 1/11/17, at 12:51 p.m. R87 was observed self propelling in his wheelchair back to his room after lunch. R87 was not observed ambulating from lunch.

During observation on 1/12/17, at 6:53 a.m. R87 was observed self propelling in his wheel chair from his room down the hall way. A registered nurse (RN)-B offered to assist R87, and pushed him down to the dining room for breakfast. R87 was not observed ambulating to breakfast.

During observation on 1/12/17, at 10:12 a.m. R87 was observed asking RN-B for a ride to the dining room. RN-B proceeded to push R87 into the dining room. R87 was not observed ambulating before lunch.

During interview on 1/12/17, at 7:30 a.m. NA-B stated R87 could stand and would walk in his room; however, further stated that R87 was not always stable when walking and the staff would try to walk him "sometimes."

During interview on 1/12/17, at 8:06 a.m. RN-B stated R87 used to walk with a walker, but was now wheelchair dependent.

During interview on 1/12/17, at 9:10 a.m. RN-C stated R87 had a significant change MDS in August due to an improvement in his mobility and

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2 915	Continued From page 20	2 915		

then had a significant change in November due to a decline in his mobility. She reported R87 had not ambulated during the November assessment period because he had been unsafe to ambulate and his walker had been put away after falling.

During interview on 1/12/17, at 10:41 a.m. PT-A stated R87 was seen by therapy from 8/9/16 to 8/31/16, during which time he worked on gait training. PT-A stated R87 had been trialed with different walkers but was ultimately assessed as unsafe with independent ambulation. PT-A reported placing R87 on a supervised walking program on 8/31/16, which was suppose to be completed by the nursing assistants and was still expected to be implemented currently. However, PT-A stated the facility did not have specific restorative assistants and was not aware if R87's program was being completed consistently.

During observation on 1/12/17, at 10:54 a.m. PT-A assisted R87 to walk down the hallway with a transfer belt and four wheeled walker. R87 appeared eager to ambulate and was able to ambulate approximately 125 feet. PT-A reported R87 had no decline in his ability to ambulate.

During interview on 1/12/17, at 1:48 p.m. NA-C stated restorative programs were communicated to the nursing assistants by the nurse manager. NA-C was not aware R87 had a supervised walking program, further reporting she had observed R87 walk in his room, but never in the halls.

During interview on 1/12/17, at 1:54 p.m. licensed practical nurse (LPN)-A stated restorative programs were communicated on the white "communication board," and was not aware R87 had a restorative program. LPN-A further stated

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2 915	Continued From page 21 R87 used to be on a restorative program; however, after his falls, he didn't have a walking program. LPN-A stated "he can't walk." During interview on 1/12/17, at 3:35 p.m. director of nursing (DON) stated there was no restorative nursing program, but was working on getting one in place, and had sent staff to restorative training. She stated the nursing assistants were responsible for completing the restorative program and the nurses were to ensure it was getting done. Restorative ambulation documentation was requested. A facility document entitled ADL Detail Report, from 12/13/16 to 1/11/16, was provided and indicated R87 ambulated in the hallways eight times, well below the 60 times it should have occured, with the rest of the entries identifying "ADL activity did not occur." No further ADL documentation was provided. A Restorative Nursing Policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could revise policies and procedures for documentation and implementation of ambulation programs and educate staff related to the changes. The DON or designee could audit resident ambulation programs for ongoing compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 915		

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2 920	Continued From page 22	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grooming needs (shaving) or oral cares were provided for 2 of 3 residents (R120, R33) reviewed, who were dependent upon staff assistance with activities of daily living (ADLs). Findings include: R120's quarterly Minimum Data Set (MDS) dated 11/7/16, identified R120 had altered level of consciousness, severely impaired ability to make decisions, and required extensive assistance for dressing, and personal hygiene, and was totally dependent for bathing. The MDS further identified R120 did not exhibit behaviors of rejection of care. R120's ADL/Mobility Care Plan, last updated 1/17, included, "will be neat, clean and well groomed daily." R120's nursing assistant care sheet included R120 was to receive a bath on Wednesday mornings and was dependent on staff for dressing, grooming, and bathing. During an observation on 1/10/17, at 10:06 a.m. R120 was lying in bed with the head of the bed elevated. R120 had several one-half inch to one-inch curly grey and black facial hairs under	2 920	corrected	2/21/17

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2 920	Continued From page 23 her chin. During an observation on 1/11/17, at 7:16 a.m. R120 was lying in bed and the facial hairs under her chin remained. During interview on 1/11/17, at 9:11 a.m. nursing assistant (NA)-L stated residents were shaved, if needed, once a week on their bath day. NA-L stated she had given R120 a bed bath early that morning, but did not shave R120's facial hair because her supervisor had not told her to do so. During interview on 1/11/17, at 9:15 a.m. licensed practical nurse (LPN)-F stated R120's family attended to her facial hair because R120 did not like when staff did it. During observation on 1/12/17, at 9:24 a.m. the facial hair under R120's chin, remained. During interview on 1/12/17, at 10:09 a.m. NA-O stated she performed personal cares for R120 that morning, but did not shave her facial hair. During interview on 1/12/17, at 10:48 a.m. LPN-G stated R120's facial hair should have been removed, but, "They [NAs] just don't have time. They do the most important things, but things like facial hair don't get done. " On 1/12/17, at 3:01 p.m. R120's family member (F)-A stated it would bother R120 if she was aware that she had facial hair because she "always kept them clean." FM-A added, "I have never shaved them [R120's facial hairs]. I've always wondered about them, but never made a big deal about it." During interview on 1/12/17, at 4:40 p.m. unit manager (UM)-A stated she expected NAs to always shave residents when needed. R33's diagnosis as identified on the face sheet dated 11/23/16, included Alzheimer's dementia. The Care Area Assessment (CAA) for psychotropic drug use, dated 8/3/16, indicated	2 920		

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2 920	Continued From page 24 R33 required assistance with dressing, grooming and bathing. The CAA further indicated R33 had difficulty communicating needs and staff anticipated R33's needs. R33's care plan, revised 1/17, identified an ADLs problem area and directed staff to provide oral care daily and PRN (as needed), and that R33 required the physical assistance of staff. During observation on 1/11/17, at 7:29 a.m. nursing assistant (NA)-D and NA-E entered the resident's room to assist R33 with morning ADLs. After washing R33's face, hands and perineal area, NA-D and NA-E dressed R33, then straightened her clothing, and combed R33's hair. A small basket on the dresser near the R33's bathroom door was observed to contain several unopened packaged of toothettes (mouth swabs). NA-E briefly left R33's room and returned with a mechanical lift to transfer R33 from her bed into the wheel chair. Seated in the wheel chair at 7:42 a.m., NA-E pushed R33 out of the room, down the hall and to the dining room. At no time during the observation of cares was R33 provided or offered oral care. During interviewed on 1/11/17, at 9:10 a.m., nursing assistant (NA)-D stated R33 required staff to help her clean her teeth, and used a "toothette" (a mouth swab) to clean her mouth. NA-D stated she did not complete oral care for R33 this morning, and also acknowledged R33 was not offered oral care. NA-D stated mouth cares could also be done before lunch after R33 gets up from her nap. During a later observation on 1/11/17, at 11:12 a.m. R33 was awake in her bed following a morning nap, and NA-G and NA-F entered the	2 920		

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2 920	Continued From page 25 room to provide R33 with perineal care. Following the provision of care, NA-F left R33's room and quickly returned with a mechanical lift. NA-F and NA-G positioned a sling under R33, then transferred her from the bed into R33's wheel chair. NA-G placed a stocking cap on R33's head, then exited the room, pushing R33's wheel chair out of the room. During this provision of care, R33 was neither provided nor offered oral cares. During interview on 1/11/17, at 11:34 a.m. NA-G stated she did not provide R33 with any oral cares when she and NA-F got R33 up for the noon meal. NA-G stated she thought R33 had her mouth cleaned when she got up in the morning. In an interview on 1/11/17, at 1:08 p.m. licensed practical nurse (LPN)-C stated she would expect the aides to complete basic grooming, like teeth brushing, combing of hair, and washing of the face, for residents who need assistance. LPN-C stated at a very minimum, those task were to be completed at least in the morning and evening. When interviewed on 1/12/17. at 2:55 p.m. LPN-B stated R33 was dependent upon staff for completion of basic cares, and expected a resident's care plan be followed. LPN-B stated she would expect basic cares be done, or at least, the care be offered. Review of the facility's policy, Personal Needs, revised 10/16, included, "The center strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents. The center also provides the needed support when the resident performs their activities of daily living (ADLs)...Personal care	2 920		

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2 920	Continued From page 26 and support includes but is not limited to ...Mouth Care...Shave." Also included, "Observe compliance with individualized interventions during daily rounds and monitor resident outcomes." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for providing shaving/grooming/oral care needs as directed by the assessed needs of residents and provide education to nursing staff to follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in	21390		2/21/17

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21390	Continued From page 27 the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control measures were implemented for a shared glucometer that had the potential to affect 4 of 5 residents (R27, R98, R60, R70) who utilized the shared glucometer. Findings include: During observation on 1/11/17, at 7:43 a.m. registered nurse (RN)-A washed RN-A's hands and donned gloves. RN-A went into R27's room with a green basket with lancets, alcohol wipes, and a glucometer (devise used to measure sugar levels in the blood). RN-A wiped R27's finger with an alcohol prep pad and poked finger with a disposable lancet. RN-A used a glucometer to measure R27's blood sugar level, hovever, RN-A did not clean or disinfect the glucometer after use on R27. RN-A then went to R98's room and checked R98's blood sugar with the same green basket and the glucometer. RN-A did not clean or	21390	corrected	

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21390	Continued From page 28 disinfect glucometer after use on R98. RN-A then went to R60's room and checked R60's blood sugar with the same green basked and the same glucometer. RN-A did not clean or disinfect the glucometer after use on R60. RN-A then went to R70's room and checked R70's blood sugar with the same green basket and the same glucometer. RN-A did not clean or disinfect the glucometer after use on R70. During observation on 1/11/17, at 7:55 a.m. RN-A brought the green basket to the north medication cart and put the green basket with the used glucometer in the bottom drawer and locked the medication cart and went to assist another staff. During interview on 1/11/17, at 7:59 a.m. RN-A stated she cleaned the glucometer with an alcohol wipe between each resident. RN-A stated a Sani wipe (germicidal disposable wipe) could be used also on the glucometer when done using the glucometer. RN-A stated I would have to look up the policy on glucometers to see what to use to clean them with. RN-A then took out the Sani wipes and wiped the glucometer with the Sani wipe and placed it back in the green basket in the bottom of the north medication cart. When interviewed on 1/12/17, at 4:40 p.m. the director of nursing (DON) stated the glucometer should be wiped with a purple top Sani cloth and then wrapped in a clean wet Sani cloth for two minutes and after two minutes put the glucometer in the cart to be stored. The DON stated the shared glucometer should be disinfected between each resident's use. The facility policy Glucose Monitoring Equipment:	21390		

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21390	Continued From page 29 Disinfect/Decontaminate dated 7/2015, directed staff to disinfect the glucometer with the wipes following use on each resident. Staff were to: 1-Use the disinfectant wipe to clean all external parts of the glucometer with gloves on. 2-Remove gloves. 3-Perform hand hygiene. 4-Don clean gloves. 5-Obtain a second wipe and fresh paper towel. 6-Use the wipe to clean all external parts of the glucometer for the second cleaning. 7-Place the glucometer on the fresh paper towel. Allow the meter to remain wet for the contact time required by the manufacturer's recommendation before completing another glucose test. 8-Remove gloves. 9-Perform hand hygiene. 10-Place glucometer in appropriate storage until next blood glucose test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures and staff training related to infection control practices. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		2/21/17

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21426	Continued From page 30 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete initial Tuberculosis (TB) screen and initial Tuberculin Skin Testing (TST) for 5 of 5 employees (LPN-D, NA-A, NA-I, RN-D, NA-J) reviewed. In addition, the facility failed to complete initial TB symptom screen and obtain a chest x-ray timely, and complete initial TST on 2 of 5 (R183, R166) residents reviewed for TB testing. Findings include: EMPLOYEE SYMPTOM SCREEN AND SKIN TEST Licensed practical nurse (LPN)-D was hired 12/6/16. LPN-D's employee file contained a Baseline TB Screening Tool for Health Care Workers (HCWs), which was completed, but was undated. The screening tool indicated LPN-D had	21426	corrected	

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21426	Continued From page 31	21426		

received the first TST on 12/5/16; however, there was no indication on the screening tool that the TST had been read, nor that a second TST had been administered, as both fields to record administration and results were left blank.

Nursing assistant (NA)-A was hired 11/8/16. NA-A's employee file contained a Chest X-ray Reading, dated 4/14/15, which was negative for TB. However, NA-A's employee file did not contain a Baseline TB Screening Tool for Health Care Workers and there was no evidence a symptom screen had been performed.

NA-I was hired 10/25/16. NA-I's employee file did not contain a Baseline TB Screening Tool for Health Care Workers, nor did it contain any evidence of receiving an initial TST.

Registered nurse (RN)-D was hired 11/8/16. RN-D's employee file did not contain a Baseline TB Screening Tool for Health Care Workers, nor did it contain any evidence of receiving an initial TST.

NA-J was hired 11/22/16. NA-J's employee file did not contain a Baseline TB Screening Tool for Health Care Workers, nor did it contain any evidence of receiving an initial TST.

A facility policy entitled Tuberculosis: Evaluation and Management (Healthcare Workers), revised 10/15, directed procedures in the event of active TB exposure or positive TB testing of employees. It did not address screening and testing upon hire of new employees.

RESIDENT SYMPTOM SCREEN AND TESTING

R183 was admitted to the facility on 12/9/16.

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21426	Continued From page 32 Review of R183's medical record indicated a Baseline Screening Tool for Patients had been completed on 12/10/16. However, there was no indication R183 had received an initial or second TST, as all fields to record administration and results were left blank. R166 was admitted to the facility on 9/8/16. Review of R166's medical record indicated a Baseline Screening Tool for Patients had been completed on 9/22/16, two weeks after his admission. In addition, a hand written note on the tool indicated R166 was not a candidate for a TST, so a chest x-ray was obtained. Although negative, the chest x-ray was obtained on 9/28/16, almost three weeks after admission. A facility policy entitled Tuberculosis Screening-Residents, dated 7/15, directed a two-step TST was completed on all new admission, with the first step completed on day of admission, and the second step administered one to three weeks after the negative first step. Chest x-rays were to be accepted "within 90 days preceding admission or 7 days after admission." During interview on 1/12/17, at 2:46 p.m. the director of nursing (DON) stated the facility's policy was to perform a symptom screen and two step TST on new admissions and new hires. She further stated TST's should be done upon admission of residents, upon hire of new employees, and read within 48 to 72 hours. DON reported the evening shift supervisor was responsible for ensuring TB screens and testing were done on every new admission, and the nurses were responsible for administering the TST's. The DON further reported that in December the facility had identified a problem with completing TB testing and they were working	21426		

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21426	Continued From page 33 on an action plan to address TB testing throughout the whole building. During interview on 1/12/17, at 2:53 p.m. the director of human resource (DHR) stated that in December they had identified employee TB screening and testing was not being completed. The DHR stated the facility created a new process for TB testing including getting caught up on TB screenings, and working with employees to get TST's/chest x-rays completed. DHR reported he was working on a letter to employees, addressing the expectation to get their TB testing done. He further reported offering every other week TB testing clinics for employees. The DHR stated they had the initial clinic on 12/21/16 with the next one scheduled for 1/18/17, and were still in the process of administering TB screening and testing to the employees listed above. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service staff regarding current tuberculosis regulations for health care facilities and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there	21565		2/21/17

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21565	Continued From page 34 is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self administration of medications was safe for 1 of 1 resident (R156) observed to have medications left on his bedside table to self administer. Findings include: R156's admission record identified R156 included diagnoses of endocarditis (inflammation of the heart), end stage renal disease, and major depressive disorder. R156's admission Minimum Data Set (MDS) dated 1/5/17, included R156 was independent with making decisions regarding tasks of daily living and had no problems with short and long term memory. In addition, the MDS identified R156 required extensive assistance with bed mobility and dressing, and required supervision for transferring, toileting, and personal hygiene. During an observation on 1/12/17, at 8:53 a.m. R156's room was dark and the blankets were covering his head. R156's covered breakfast tray was on his bedside table, and a clear plastic medication cup containing three white and blue capsules was beside the breakfast tray. During an observation and interview on 1/12/17, at 8:58 a.m. unit manager (UM)-A entered R156's room. R156 had taken the medications that were on his bedside table and threw the plastic cup into the garbage can beside the bed. R156 told UM-A the nurse had come into the room, and because	21565	corrected	

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21565	Continued From page 35	21565		

he was sleeping, the nurse left the medications on the table. UM-A asked R156 if he had asked the nurse to leave the medications. R156 stated, "No, I was actually sleeping and heard the nurse, but I covered my head and went back to sleep."

During an interview on 1/12/17, at 9:01 a.m. registered nurse (RN)-E stated he brought R156's medication, Phoslo (a medication used to reduce phosphate levels) into his room and stated, that R156 sat up so he thought he was going to take them, and then he left. RN-E stated he should have stayed in the room until the resident swallowed the medications.

During an interview on 1/12/17, at 1:42 p.m. the director of nursing (DON) stated nurses should stay with residents until they swallow their medications unless they have been assessed to safely administer their own medications.

Review of R156's clinical record included a physician's order, dated 12/29/16, for "calcium acetate [Phoslo] 667mg [milligrams] 3 caps (2001 mg) by mouth/per tube three times daily with meals." The clinical record also included a Self-Medication Data Collection and Assessment, dated 12/26/16, which identified R156, "prefers for facility to administer."

During a follow up interview on 1/12/17, at 3:48 p.m. the DON stated when R156 was assessed for self administration that the resident had determined that he wanted the facility staff to administer his medications. The DON added that RN-E should not have left them for R156 to take.

Review of the facility's policy, Medication Administration, revised 3/16, included, "Remain with the resident until all medication is taken."

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21565	Continued From page 36 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and re-educate staff on self-administration assessments for residents. The DON or designee could audit medication passes for staff/resident compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were labeled appropriately prior to administration for 1 of 2 residents (R27) reviewed. Findings include: R27's admission record dated 8/12/16, indicated R27's diagnoses included diabetes, heart failure, and hypertension. R27's physician orders dated January 2017, indicated humulin R (human insulin used to improve blood sugar control) insulin pen to inject 90 units subcutaneous (Under skin) before breakfast. During observation on 1/11/17, at 7:38 a.m. with registered nurse (RN)-A revealed R27's humulin R insulin pen was labeled to inject 85 units of humulin R subq.	21620	corrected	2/21/17

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21620	Continued From page 37 During interview on 1/11/17, at 7:40 a.m. RN-A stated R27's humulin R insulin pen was not labeled correctly. RN-A stated the physician orders are for 90 units of humulin R to be given to R27. RN-A stated the pharmacy should have relabeled the humulin R insulin pen to have 90 units not 85 units of humulin R. RN-A stated, "I have never seen new labels come with dose changes, the pharmacy would have to relabel the insulin pen with the correct dose." A facility policy 4.5 Reordering, Changing, and Discontinuing Orders, dated 10/31/16, directed staff to attach a "Change in Directions" sticker to the existing quantity of medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written in this licensing order. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21620		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH.	21675		2/21/17

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21675	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled laundry items were consistently contained to prevent the spread of infection. This had the potential to affect 26 residents who lived on the 1st floor of the facility. Findings include During the initial tour of the facility on 1/9/17, at 2:07 p.m. the 1st floor, soiled utility room was inspected. The locked room housed a plastic laundry cart, approximately 4' (feet) by 5' wide, and 4' high, and was positioned under the opening of a stainless steel laundry chute. The cart overflowed with bagged and unbagged laundry items. The items included bed sheets, bed spreads, various sizes of bath towels, wash cloths and bed mattress pads. Most of the laundry items were bagged, but numerous bags were ripped, their contents laying in the cart and on the floor of the soiled utility room. Visibly soiled bed pads were draped in and along the side of the cart, and one of the bed pads was dark and soiled, found among other towels on the floor. In an interview on 1/9/17 at 2:09 p.m. the housekeeping manager (HM) stated the laundry room was full, and there was bagged and un-bagged laundry in the cart, and some other laundry and towels on the floor. The HM stated the chutes were metal, and had some edges on, and when the bags were sent down the chute, many arrived torn, and the laundry spilled out. During a later observation on 1/9/17, at 6:45 p.m.	21675	corrected	

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	00112	A. BUILDING: _____ B. WING _____	01/12/2017

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21675	Continued From page 39 the 1st floor soiled utility room cart was not overfilled with laundry, and contained mostly bagged laundry items. Several large bath towels were also observed in the cart, unbagged. During observation the next morning on 1/10/17 at 10:34 a.m., a housekeeper was working in resident room across from the 1st floor soiled utility room. The laundry cart in the room was again observed overfilled, and the laundry chute was backed up with laundry. Five bags of laundry, all tied, and a visibly soiled hospital gown, were all observed on the floor in the room. When interviewed on 1/10/17, at 10:55 a.m. housekeeper (HK)-B stated she was swapping out the laundry carts, which was a task that was done a couple of time every day. HK-B stated she sees the soiled laundry as mostly bagged when it came down the chute, but has often seen un-bagged, soiled laundry. The HK-B stated the laundry chute went to the 4th floor, and added "all items" were to be bagged. When interview on 1/12/17 at 7:31 a.m. the HM stated carts in the soiled area were to be removed three times daily to keep laundry from overflowing. The HM stated some of the laundry bags do rip, and that bags were often not tied tightly. The HM stated that some staff do not always bag soiled laundry, and stated nursing staff were trained on proper disposal, but there were new people who may not know the rules. The HM then stated this was an "inservice opportunity" for staff to review the proper handling of soiled linen. A facility policy, Infection Control, Handling of Linen, effective July 2015, indicated its purpose was to reduce the risk of infection to residents	21675		

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21675	Continued From page 40 and employees. The policy indicated standard precautions would be followed when handling soiled linens. The policy directed all soiled linen was to be bagged and collected by cart at the chutes at regular intervals, and not allow hampers to overfill. SUGGESTED METHOD FOR CORRECTION: The director of environmental services could review and revise the policies and procedures related to linen handling. The director of environmental services or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21675		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary toilet in the shower room on the 1st floor unit which had potential to affect 26 residents who	21695	corrected	2/21/17

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21695	Continued From page 41 utilized the shower and restroom. Findings include: During observation on 1/9/17, at 7:24 p.m. the resident shower/bathroom on the 1st floor of the facility was inspected. A large door from the main hallway led into the shower room, and upon entrance, a full privacy curtain hung from the ceiling to the floor. Three large bath towels and wash cloths were observed scattered on the floor, and there was a toilet in the corner of the room. The floor area and wall directly to the left of and behind the toilet was heavily soiled. The soiling was an unidentified, brown-colored and substance which covered and adhered to the walls behind and along side the toilet. The tile floor between the wall and toilet, an area approximately 8" (inches) x 20", was also covered with this same, unknown substance. Although the soiled areas did not smell, the substance was dried to the wall and floor surfaces. During an interview on 1/9/17, at 7:27 p.m. nursing assistant (NA)-I acknowledged the presence of the soiled wall and floors in the corner of the shower room near the toilet, as well as the towels on the floor in the shower room. NA-I stated she wondered if someone got sick, and also staed that it needed to be cleaned. The following day at 1/10/17, at 10:52 a.m. a resident exited from the shower/bathroom, and as she ambulated past the surveyor, the resident pointed to the room stated it was "the third day" the mess was in the bathroom and pointed to the shower room. Upon a subsequent review of the 1st floor bathroom/ shower after the resident left the area, the walls and floor area surrounding the toilet remained as it was found the previous day,	21695		

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21695	Continued From page 42 heavily soiled and unclean. During interview on 1/10/17, at 11:01 a.m. when asked about the soiled resident shower room/bathroom, licensed practical nurse (LPN)-E stated she saw a resident use the bathroom earlier, and indicated the resident may have got the bathroom dirty. When LPN-E looked at the bathroom she stated, "Oh, my God!" and added she would get someone to clean it up right away. LPN-E also stated resident bathrooms and shower rooms were cleaned on a daily basis, but was unaware of the mess in this bathroom, or how long the 1st floor bathroom had been dirty. During interview on 1/10/17, at 1:53 p.m. housekeeper (HK)-A stated shower rooms were cleaned everyday. HK-A stated she did now know why the 1st floor shower was not clean, and also stated those resident bathrooms and showers were cleaned, mopped and disinfected daily. During interview about the unclean 1st floor shower/bathroom on 1/12/17, at 7:18 a.m. LPN-B stated she thought there was some confusion as to who can clean what. LPN-B stated housekeeping cannot clean bodily fluids, and nursing would have to initially clean up any BM (bowel movement), then notify housekeeping to disinfect an area. LPN-B stated with all the new staff, that shower room got missed. LPN-B stated whoever found the mess should have communicated right away, and one of the nurses should have taken action, cleaned it themselves, and then let housekeeping know. During interview on 1/12/17, at 7:35 a.m. the housekeeping manager (HM) stated that housekeeping staff did not clean bodily fluids, that	21695		

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21695	Continued From page 43 was for nursing. The HM explained the facility blood borne policy, but stated there must have been some mis-communication between the aides and staff. The HM stated they need to do some kind of staff inservice, and it was something staff need to be educated on, and also stated it was good to have this brought to staff's attention. A facility document, from Health Service Group, bloodborne Pathogens Employee Handbook, undated, indicated "Any equipment or furniture that is contaminated with visibly large quantities of blood or other bodily fluids will be referred to nursing personnel of the client facility for decontamination. The document further indicated their employees "are only to clean previously decontaminated areas..." A facility document, Healthcare Services Group, Inc, Housekeeping Inservice, dated 1/1/2000, provided direction for "7-Step Daily Washroom Cleaning." Included in the inservice was direction to "clean and sanitize commode" and "damp mop floor." SUGGESTED METHOD OF CORRECTION: The director of maintenance could ensure that bathrooms were clean. The director of maintenance could develop a monitoring system to ensure ongoing compliance. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21695		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils	21942		2/21/17

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21942	Continued From page 44 Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 115 residents and their families who resided in the facility. Findings include: On 1/11/17, at 2:15 p.m. the facility's administrator stated there had been a recent change in the director of social services position and there was no evidence in the previous director's paperwork that there had been an attempt to form a family council during the past year. Review of the facility's policy, Family Council, dated 7/15, included, "Conduct continual recruitment and notify families/resident representatives and post a routine time and place for meetings: Send notification to all current families and resident representatives...Post meeting time and place in center lobby using the	21942	corrected	

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21942	Continued From page 45 Family Council Meeting Notice...Produce brochures or fliers that council members can give to other families and resident representatives they see when they visit." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		