### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZYNS

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	F	acility ID: 00112
1. MEDICARE/MEDICAID PROVIDER (L1) 245186 2.STATE VENDOR OR MEDICAID NO (L2) 254908000		3. NAME AND AD (L3) GOLDEN VA (L4) 7505 COUNT (L5) GOLDEN VA	ALLEY REHABII FRY CLUB DRIV	LITATION		CENTER 6) 55427	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9) <b>07/01/2015</b>	WNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (I 13 PTIP	L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other mplaint
6. DATE OF SURVEY 03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	03/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	144 (L18) 144 (L17)	B. Not in Com	nce With quirements		2. To 3. 24 4. 7-	roved Waivers Of The echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code A*	Following Requirements:  6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room  (L12)	or
14. LTC CERTIFIED BED BREAKDOV  18 SNF 18/19 SN  144  (L37) (L38)		ICF	IID (L43)		15. FACILITY 1861 (e) (1)	Y MEETS or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	JRVEY AGENCY API	PROVAL	Date:
Kathleen Luc	as, HFE NE I	<u> </u>	03/03/2017	(L19)	Kate Jo	ohnsTon, Pro	ogram Specialis	03/22/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OF	R SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILE  _X	Participate		IPLIANCE WITH C	IVIL	2		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
	(121)			ı				
22. ORIGINAL DATE  OF PARTICIPATION  08/31/1973  (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTARY 01-Merger, Clo			ARY set Health/Safety et Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI		(L44)			oluntary Termination on for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
(L21)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARK	S		
	(L28)	06301		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION (	OF APPROVAL DAT		Posted 0	03/24/2017 Co.		
	(L32)	03/09/2017		(L33)	DETERMIN	NATION APPRO	VAL	



#### 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



#### 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

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245186 <sub>Y1</sub>	B. Wing	Y2	3/3/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN VALLEY REHABILITATION	ON AND CARE CENTER	7505 COUNTRY CLUB DRIVE		
		GOLDEN VALLEY, MN 55427		
This report is completed by a quali-	fied State surveyor for the Medicare Medicaid a	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).

ITEI Y4			<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix Reg. # LSC	F0167 483.10(g)(10)(i)(1	1)	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	F0176 483.10(	c)(7)	Correction  Completed  02/21/2017	ID Prefix Reg. # LSC	F0282 483.21(b)(3)(ii)		Correction Completed 02/21/2017
ID Prefix Reg. # LSC	F0285 483.20(e)(k)(1)-(4	ł)	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	F0309 483.24,	483.25(k)(l)	Correction  Completed  02/21/2017	ID Prefix Reg. # LSC	F0311 483.24(a)(1)		Correction Completed 02/21/2017
ID Prefix Reg. # LSC	F0312 483.24(a)(2)		Correction Completed 02/21/2017	ID Prefix Reg. # LSC	F0323 483.25(	d)(1)(2)(n)(1)-(3)	Correction  Completed  02/21/2017	ID Prefix Reg. # LSC	F0431 483.45(b)(2)(3)(g)(l	n)	Correction Completed 02/21/2017
ID Prefix Reg. # LSC	F0441 483.80(a)(1)(2)(4	)(e)(f)	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	F0465 483.90(i	i)(5)	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
REVIEWE STATE AG REVIEWE CMS RO	SENCY	REVIEWE (INITIALS REVIEWE (INITIALS	ED BY	DATE 03/22/2 DATE		SIGNATURE OF S  TITLE  ANY UNCORRECTION	3	8202 S. WAS A SUN	IMARY OF	03/0 date	3/2017
1/12/201						ED DEFICIENCIES				☐ YES	s 🗌 NO

### **POST-CERTIFICATION REVISIT REPORT**

	R / SUPPLIER		MULTIPLE CONSTA. Building 01 -	TRUCTION MAIN BUILDING 0	11				DATE OF RE	VISIT
245186		Y1	B. Wing	WAIN BOILDING 0				Y2	2/27/2017	Y3
NAME OF GOLDEN		HABILITATIO	ON AND CARE C	ENTER		STREET ADDRESS, CIT 7505 COUNTRY CLUB I GOLDEN VALLEY, MN 5	PRIVE	DDE		
program, corrected provision	to show those and the date	e deficiencie such correct the identifica	es previously repo ctive action was a	rted on the CMS-25 ccomplished. Each	567, Staten deficiency	and/or Clinical Laborato nent of Deficiencies and should be fully identified 2567 (prefix codes show	I Plan of Correct dusing either th	ion, that have ne regulation o	r LSC	
ITE	M		DATE	ITEM		DATE	ITEM		D	ATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Co	rrection
Reg.#	NFPA 101		Completed	Reg. #		Completed	Reg. #		Co	mpleted
LSC	K0741		02/21/2017 	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Co	rrection
Reg.#			Completed	Reg. #		Completed	Reg.#		Co	mpleted
LSC				LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Co	rrection
Reg. #			Completed	Reg. #		Completed	Reg. #		Co	mpleted
LSC			_ 	LSC			LSC _			
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Reg.#			Completed	Reg. #		Completed	Reg. #		Co	mpleted
LSC			_	LSC			LSC _			
REVIEWE		REVIEW (INITIAL		DATE 03/22/2017	SIGNATUR	RE OF SURVEYOR	7009		DATE 02/27/2	2017
REVIEWE	D ВҮ	REVIEW (INITIAL		DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/17/2017					RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES [	□ NO	

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZYNS

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

	PA	RT I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGI	ENCY	F	acility ID: 00112
MEDICARE/MEDICAID PROVII     (L1)		(L3) GOLDEN VA (L4) 7505 COUNT	3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN VALLEY REHABILITATION A (L4) 7505 COUNTRY CLUB DRIVE (L5) GOLDEN VALLEY, MN			TER 55427	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) <b>07/01/2015</b>	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other
6. DATE OF SURVEY  8. ACCREDITATION STATUS:  0 Unaccredited 1 T. 2 AOA 3 O		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKD 18 SNF 18/19:	144 (L18) 144 (L17) OWN SNF 19 SN	X A. In Complia  Program Re Compliance  X 1. A  B. Not in Com Requirements	equirements		2. Techr 3. 24 Ho 4. 7-Day 5. Life \$	our RN v RN (Rural SNF) Safety Code A1*	Following Requirements:	cor
(L37) (L38	(L39)		(L43)					
	· ·		,					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY APP	PROVAL	Date:
LoAnn DeGagne	, HFE NE II		02/14/2017	(L19)	Kate John	nsTon, Pro	ogram Specialis	03/09/2017 (L20)
	PART II - T	O BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR S	INGLE STATI	E AGENCY	
DETERMINATION OF ELIGIB     1. Facility is Eligible     2. Facility is not Eligible	to Participate	RIGI	MPLIANCE WITH C	IVIL	2. O		al Solvency (HCFA-2572)  tterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE  OF PARTICIPATION  08/31/1973  (L24)	23. LTC AGRE BEGINNII (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINATI  VOLUNTARY  01-Merger, Closur  02-Dissatisfaction			eet Health/Safety
25. LTC EXTENSION DATE: (L27	A. Suspens	TIVE SANCTIONS ion of Admissions: Suspension Date:	(L44) (L45)		03-Risk of Involum 04-Other Reason fo		OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:		29. INTERMEDIARY/C			30. REMARKS			
		06301						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539		32. DETERMINATION	OF APPROVAL DAT	TE	Posted 03	3/09/2017 C	0.	
	(L32)			(L33)	DETERMINA	TION APPROV	/AL	



#### 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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	` '	E SURVEY MPLETED
		245186	B. WING _		01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	completed by surved Department of Head Rehab and Care Compliance with the 483, subpart B, required Facilities.  The facility is enroll signature is not requipage of the CMS-2 submission of the Fiverification of compliance in addition, an investigation of conductive deficiency cited a investigation of conductive in the facility is enrolled to the facility in the facility is enrolled to the fa	17, a recertification survey was eyors from the Minnesota lth (MDH). Golden Valley enter was found to not be in e regulations at 42 CFR Part uirements for Long Term Care ed in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as pliance.  Stigation of complaint inpleted and substantiated with t F312 during the survey. An inplaint H5186222 was	F 00			
F 167 SS=C	Upon receipt of an revisit of your facilit validate that substate regulations has been your verification. 483.10(g)(10)(i)(11) RESULTS - READICATE (g)(10) The resident (i) Examine the rest of the facility conductive yors and any respect to the facility (g)(11) The facility in the rest of the facility in the facility in the facility in the rest of the facility in t	sults of the most recent survey octed by Federal or State plan of correction in effect with ty; and	F 16	57 TITLE		2/21/17

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

(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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/12/	2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5) DMPLETION DATE
F 167	and family member residents, the result the facility.  (ii) Have reports we certifications, and respecting the facility sears, and any play respect to the facility are upon requirements. It is accessible to the processible	readily accessible to residents, are and legal representatives of alts of the most recent survey of alts of the most recent survey of the respect to any surveys, complaint investigations made lity during the 3 preceding of correction in effect with ity, available for any individual quest; and the availability of such reports in a that are prominent and bublic.  All not make available identifying complainants or residents.  ENT is not met as evidenced ation, interview, and document failed to post notice of ast three years of State agency is had the potential to affect all ints, visitors, and staff who	F 167	1. Last 3 years of Survey/Complia investigation were posted and made available to residents, family and leg representative of the residents. Con actions as it applies to others: Residual counsel updated on regulations and posting  2. Residents that reside at GVHR the potential to be affected by this practice. Policy and procedure for S Results-State/Federal: Posting	e gal rective dent I have	
	Survey Results," w shelf mounted to the The survey results 3/3/16, from the prothere were no add binder, nor was the	Department] of Health Current vas observed in a clear plastic the wall of the main entrance. contained inside were dated revious full survey, however, itional surveys identified in the tere anything notifying residents, at three years of results were		/Examination was reviewed and rencurrent. 3. Staff will be educated on the poand procedures by: February 21, 204. Recurrence will be prevented by Weekly audits by Executive Director/designee to ensure survey results/compliant investigations are	licy 117	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		O1/1	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	receptionist stated so ther survey results office for prior years family.  During interview on administrator stated current survey in th further stated there around the main en families that additio available. The form	<del>-</del>	F 167	posted x 90 days.  5. Audits will be completed for a posted of 90 days and audit results will be reviewed by QA committee to deter the need of on going monitoring.  6. Date of completion by: Februar 2017	mine	
F 176 SS=D	Results-State/Fede directed to "Provide survey results for examples state regular 483.10(c)(7) RESID DRUGS IF DEEME (c)(7) The right to sthe interdisciplinary §483.21(b)(2)(ii), hapractice is clinically This REQUIREMENT by:	acility policy entitled Survey sults-State/Federal: Posting/Examination of sected to "Provide the following unaltered evey results for examination for one year, less state regulation require more." 3.10(c)(7) RESIDENT SELF-ADMINISTER RUGS IF DEEMED SAFE  (7) The right to self-administer medications if interdisciplinary team, as defined by 83.21(b)(2)(ii), has determined that this actice is clinically appropriate. is REQUIREMENT is not met as evidenced				2/21/17
	Based on observate review, the facility facility facility from practice of self admissafe for 1 of 1 residuals.	ion, interview, and document ailed to determine if the ninistration of medications was lent (R156) observed to have his bedside table to self		<ol> <li>R156 Self-Administration of Medication Assessment was review and remains current that resident d not want to self administer medicat</li> <li>Residents that reside at GVHR the potential to be affected by this</li> </ol>	loes ions.	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/	12/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 COUNTRY	S, CITY, STATE, ZIP CODE CLUB DRIVE LEY, MN 55427	, , ,		
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F 176	diagnoses of endo heart), end stage redepressive disorder R156's admission dated 1/5/17, inclusivith making decisiliving and had no peterm memory. In an R156 required extermobility and dressifor transferring, toil During an observation R156's room was of covering his head, was on his bedside medication cup concapsules was beside to the parbage can be the nurse had combe was sleeping, the nurse to leave "No, I was actually but I covered my had not registered nurse (F	record identified R156 included carditis (inflammation of the enal disease, and major	F 1	practice. Po Medication administrati reviewed. A residents w care plans a updated as 3. LN & T the policy a 21, 2017 4. DON/do pass 3 time 3x per mon 5. Audit re discussed a the need of	olicy and Procedure for administration and Selftion of medication policy An audit was completed who receive medication and assessments were appropriate.  TMA staff will be educated and procedures by: Februal esignee audit the medices per week for 4 weeks of the for 3 months. The esults will be reviewed at at QA committee to determine to the estimate of the completion by: Februal estimates and procedures by: Februal	was I for and ed on cuary cation s, then		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		01/	12/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 176	phosphate levels) in R156 sat up so he in them, and then he li have stayed in the in swallowed the med	nto his room and stated, that thought he was going to take eft. RN-E stated he should room until the resident	F 17	6			
	stay with residents medications unless safely administer the Review of R156's c physician's order, d acetate [Phoslo] 66 mg) by mouth/per to meals." The clinical Self-Medication Dar	until they swallow their they have been assessed to eir own medications.  linical record included a ated 12/29/16, for "calcium 7mg [milligrams] 3 caps (2001 ube three times daily with record also included a ta Collection and Assessment, ich identified R156, "prefers					
	p.m. the DON state for self administration determined that he administer his medi RN-E should not hat Review of the facilit Administration, revi	nterview on 1/12/17, at 3:48 d when R156 was assessed on that the resident had wanted the facility staff to ications. The DON added that ave left them for R156 to take.  by's policy, Medication sed 3/16, included, "Remain and when R156 to take."					
F 282 SS=D	483.21(b)(3)(ii) SER PERSONS/PER CA (b)(3) Comprehens The services provide		F 28	2		2/21/17	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
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	PROVIDER OR SUPPLIER  I VALLEY REHABILIT	ATION AND CARE CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 282	Continued From pa	nge 5	F 282			
	accordance with eacare. This REQUIREMED by: Based on observareview, the facility for care by failing to prove the facility of care daily and care daily and PRN required the physic days of the facility of the f	qualified persons in ach resident's written plan of NT is not met as evidenced tion, interview and document ailed to implement the plan of ovide oral cares for 1 of 1 riewed for activities of daily was dependent upon staff for identified on the face sheet luded Alzheimer's dementia.  It is a needed in the provide oral in the plan of ovide oral in the plan of ovide oral in the plan of other in the plan of other in the plan of other in the plan of		1. R33 care plan communication was reviewed and updated to mate Care Plan policy and procedure regoral care.  2. Residents that are dependent for oral cares have the potential to practice. Care Plans and NAR communication tool were reviewed residents that are dependent on storal care. Care Plans and tools we updated as appropriate.  3. Staff will be educated on provide cares per care plans and per communication tool by: February 24. DON/designee will complete we audits on each unit to ensure Care communication tool are begin follows. Audits will be completed for a possible 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: Februar 2017	ch the garding on staff by this on aff for re ding 1, 2017 eekly plans wed. period rmine	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		01/	/12/2017		
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, Z 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 282	During interview on assistant (NA)-D sther clean her teeth, mouth swab) to cleshe did not complemorning, and also a offered oral care. Nalso be done before from her nap.  During a later obsea.m. R33 was awakmorning nap, and Nroom to provide R3 Following the provisor nom and quickly rendered her wheel chair. NA-G pothen transferred hewheel chair out of the wheel chair out of the of care, R33 was not cares.  During interview on stated she did not provide and not provide R3 was not cares when she and noon meal. NA-G smouth cleaned wheel chair out of the care when she and noon meal. NA-G smouth cleaned wheel chair out of the care when she and noon meal. NA-G smouth cleaned wheel chair out of the care when she and noon meal. NA-G smouth cleaned wheel chair out of the care when she and noon meal. NA-G smouth cleaned wheel chair out of the care when she and noon meal of the care when she are	1/11/17, at 9:10 a.m. nursing ated R33 required staff to help and used a toothette (a an her mouth. NA-D stated te oral care for R33 this acknowledged R33 was not A-D stated mouth cares could to lunch after she R33 gets up a lunch after she l	F 2	82				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/	12/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 282 F 285 SS=D	stated R33 was dep completion of basic resident's care plan she would expect b least, the care be o A facility policy, Car 2017, indicated as i "communication too services to be provi residents' highest p and psychosocial w 483.20(e)(k)(1)-(4) FOR MI & MR	/12/17, at 2:55 p.m. LPN-B pendent upon staff for a cares, and expected a be followed. LPN-B stated asic cares be done, or at ffered.  The Plans, revised January it purpose as a poll which "describes the ided to attain or maintain the practicable physical, mental rell-being."  PASRR REQUIREMENTS	F 2			2/21/17	
	pre-admission scre (PASARR) program of this part to the m avoid duplicative te includes:  (1) Incorporating the PASARR level II de evaluation report in care planning, and  (2) Referring all leve with newly evident of disorder, intellectual condition for level II significant change i  (k) Preadmission S	dinate assessments with the ening and resident review a under Medicaid in subpart C aximum extent practicable to sting and effort. Coordination be recommendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.  The commendations from the etermination and the PASARR to a resident's assessment, transitions of care.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	
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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:		F 2	285			
	(i) of this section, un authority has determindependent physic performed by a person	as defined in paragraph (k)(3) nless the State mental health mined, based on an eal and mental evaluation son or entity other than the a authority, prior to admission,					
	condition of the indi	of the physical and mental ividual, the individual requires s provided by a nursing facility;					
		requires such level of ne individual requires s; or					
	(k)(3)(ii) of this sect intellectual disability	pility, as defined in paragraph tion, unless the State y or developmental disability mined prior to admission-					
	condition of the indi	of the physical and mental ividual, the individual requires a provided by a nursing facility;					
	services, whether the	requires such level of ne individual requires s for intellectual disability.					
	(2) Exceptions. For	purposes of this section-					
		n screening program under this section need not provide					

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		245186	B. WING		<del></del>	01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, 7505 COUNTRY C		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTI ORRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 285	for determinations it to a nursing facility being admitted to the transferred for care (ii) The State may oppreadmission screed paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after received hospital, (B) Who requires not condition for which the hospital, and (C) Whose attending before admission to is likely to require lefacility services.  (3) Definition. For positive facility services.  (i) An individual is conditional disorder defined in (ii) An individual is controllectual disability or is a person with a described in 435.10 (k)(4) A nursing facility and the alth authority and the services in the left in the	of the case of the readmission of an individual who, after the nursing facility, was in a hospital.  Shoose not to apply the ening program under this section to the admission of an individual-  If to the facility directly from a ring acute inpatient care at the ursing facility services for the the individual received care in the facility that the individual ess than 30 days of nursing the property of the section-  onsidered to have a mental dual has a serious mental dual has a serious mental at the individual has an or if the individual has an or as defined in §483.102(b)(3) a related condition as	F 2	85			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/-	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 285	condition of a reside intellectual disability. This REQUIREMENDY: Based on observation review, the facility for preadmission screet (PASSR) was computed (PASSR) was computed for the face of the face	ge 10 In the mental or physical Interview with the mental review. In it is not met as evidenced It is not met as even as eve	F 28	1. R150 PASRR level 2 was obta per policy and procedure. 2. Corrective actions as it applies others: residents audited in facility ensure if PASRR Level 2 were coor is needed for all newly evident of possible serious mental disorder, intellectual disability or a related of for level 2 review upon a significant change in status assessment. Poprocedure for PASRR was reviewer remains current. 3. Staff will be educated on the pand procedures by: February 21, 24. DON/designee will complete waudits for all new admits to ensure PASRR were completed before admission. 5. Audits will be completed for a of 90 days and audit results will be reviewed by QA committee to detet the need of on going monitoring. 6. Date of completion by: Februare 2017	s to y to mpleted or ondition nt licy and ed and oolicy 2017 veekly e period e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		<del></del>	01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7505 C	T ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427	,	
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F 285	convalescent stay. history of mental illit to get the level II so if R150 required an programming.  A review of R150's document from the Aid, Interagency Ce Results, dated 1/4/OBRA-I Initial Scre Reconciliation Act In 1/4/11. R150's men PASSR, or other incompleted prior to a R150's Interagency Results (Level 1 sc a diagnosis of men screening tool. This the screener that if are marked as a yecomplete part IV, hinformation was present the screener that if are marked as a yecomplete part IV, hinformation was present and behavior and a areas, however, the direct any special the needs for R150.  R150's physician's reviewed and did needs for R150.	ge 11 pursing home stay, a SW-A stated R150 had a ness, and further "we needed reen completed" to determine by special services or  medical record included a Illinois Department of Public crification of Screening 11. A second document, en (Omnibus Budget evel one), that was also dated dical record lacked a level II dication a screen was admission to this facility. Certification Of Screening reening tool), indicated yes to tal retardation in part II of the screening tool further directs any areas in part II or part III s, the screener needs to owever, no further sceening esent in the client record.  ated 10/1/16, included mood ctivities as problem/strength e care plan did not identify or nerapeutic or programming  orders dated 12/27/16, were or identify any prescription for orogramming needs.	F 2	85			
	administrator stated	on 1/12/17, at 1:29 p.m. the d upon admission, the facility A-I Initial Screen as R150's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY MPLETED
		245186	B. WING		01/	/12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 285	administrator stated group home in anot administrator stated to figure out how to	ge 12 t get a new one. The former d R150 was admitted from a ther state that had closed. The d they would look at the rules get a screening for R150, and w the procedure for any new,	F 2	85		
F 309 SS=D	, , , , ,		F 3	09		2/21/17
	applies to all care a residents. Each re- facility must provide services to attain or practicable physica well-being, consiste	ie undamental principle that and services provided to facility sident must receive and the ethe necessary care and maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.				
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pre practice, the compr	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including				
	provided to residen	ent. sure that pain management is ts who require such services, essional standards of practice,				

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F 309	and the residents'  (I) Dialysis. The faresidents who requestrates, consister of practice, the concare plan, and the preferences. This REQUIREME by:  Based on observative review, the facility wound dressing for appropriately and sof 2 residents (R15 receiving dialysis.)  Findings include:  R156's admission identified diagnose disease.  R156's admission identified diagnose disease.  R156's admission identified diagnose disease.  R156's physician's included having diagnose disease.  R156's physician's included having diagnose disease.  During an observation observation of the paperwork with him paperwork with him	age 13 e person-centered care plan, goals and preferences.  cility must ensure that uire dialysis receive such at with professional standards aprehensive person-centered residents' goals and  NT is not met as evidenced ation, interview, and document failed to ensure the care of a llowing dialysis was provided services were coordinated for 2 56, R127) reviewed who were  record dated 12/23/16, es including end stage renal  Minimum Data Set (MDS) ated R156 was independent ons regarding tasks of daily problems with short and long  orders dated 12/29/16, alysis on Monday, Wednesday, tion and interview on 1/10/17, 6 stated he had dialysis three R156 stated he carried in to dialysis and he was to facility with him. R156 stated,	F 309	1. R127 and R156 care plan, order and treatment records were updated match the Dialysis Management (Hemodialysis) policy and procedure 2. Corrective actions as it applies to others: audit completed on all reside with hemodialysis to ensure dressing completed and removed post dialysis recommended by MD and dialysis. I and procedure for Dialysis Managem (Hemodialysis) was reviewed and recurrent.  3. Staff will be educated on the policand procedures by: February 21, 20.4. DON/designee will complete were audits on each unit to ensure care/treatment is completed to hemodialysis site post dialysis.  5. Audits will be completed for a per of 90 days and audit results will be reviewed by QA committee to determ the need of on going monitoring.  6. Date of completion by: February 2017	to  copent g is s as Policy nent mains  ccy 17 ekly  eriod nine

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	they don't ask me a stays in my bag unt when I come back, vitalsThey never a displayed a dressin stated he returned dialysis. R156 state remove the dressin had gone to dialysis dressing placed by prior, and the dialysis dressing needed to returned to the facil.  When interviewed a licensed practical in not know when R15 be removed after redialysis. LPN-F state to that question. I to dialysis was on 1/9/1. Review of R156's he filtering the blood) of directed to complet dialysis, monitor for access site, monitor functioning fistula by palpating for bruit (buzz) daily also included, "dresched directing secovered with dressi Center," however, fexternal catheter.	come back, I'm tired, and about the paperwork, so it till the next dialysis. Sometimes they don't even take my ask to see my fistula." R156 g on his right upper arm and last evening (1/9/17) from ed, "I will ask the nurse to g today." R156 indicated he is recently, wearing the same the dialysis staff two days is staff reminded him that the be removed when he	F3	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245186	B. WING			01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	post-dialysis, and diveight, but lacked or removal of the dress.  During an interview unit manager (UM)-R156's hemodialysis admitted and had or regarding the dress dialysis center woulthe dressing should R156 had a fistula, noted on the care pknow when the dreshad never contacted directions as to whe During an interview stated she spoke to and was told the dreshed be removed when his dialysis.  During a telephone p.m. registered nurse.	ge 15 If for thrill and bruit daily and ocumentation of post-dialysis documentation regarding the sing following dialysis.  on 1/11/17, at 1:08 p.m. the A stated she had completed is care plan when he was hecked the intervention ing because it noted the Id direct the facility staff when I be removed. UM-A verified not an external catheter as lan, and stated she didn't ssing should be removed and d the dialysis center for en to remove the dressing.  on 1/11/17, at 1:26 p.m. UM-A of the staff at the dialysis center essing to R156's fistula should he returned to the facility from interview on 1/12/17, at 2:32 se (RN)-FDC from Fresenius ed the dressing should be	F3	09			
	removed within a co the facility because with the fistula, and the nursing staff. R	ouple of hours of returning to it could cause complications this should be monitored by N-FDC indicated the facility alled the dialysis center if they					
	R127 had diagnose	ecord dated 1/7/16, identified es including end stage renal dence on renal dialysis.					
	R127's MDS, dated	10/19/16, identified R127 had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245186	B. WING			01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 309	1/8/16, included R1 Tuesday, Thursday interventions, includ with three boxes: C changed at Dialysis catheter covered wi Dialysis Center, or, access site the eve boxes were checke Review of R127's h record, dated 12/16 regarding the remo- following dialysis.  During an interview licensed practical n the unit manager bu fistula or an externa R127's hemodialysi when R127's dress following his dialysis  During an observati at 2:28 p.m. R127 s previous day and ha upper arm. R127 in remove the dressin to do it. I take it off I they [dialysis staff] t because I could get was a "bleeder" and dressing too soon of he planned to remo-	impairment.  emodialysis care plan dated 27 received hemodialysis, and Saturday, and under ded, "Dressing Information," atheter dressing to be Center, Keep external th dressing as directed by Remove band-aid from ning of dialysis. All three d.  emodialysis fistula treatment and 1/17, lacked direction val of the fistula dressing  on 1/11/17, at 2:20 p.m. urse (LPN)-B stated she was at did not know if R127 had a all catheter and when shown is care plan, did not know ing was to be removed		809			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/12/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
F 309	center and they recremoved the next in however, she discuinsisted he needed the evening of the cLPN-B stated she cand discussed R12 center said he coult the following evening. During a telephone p.m. registered nur dialysis center state removed before R1 receives dialysis, to stated R127 neede would not bleed if the education should be	she called R127's dialysis commended the dressing be norning following his dialysis, assed this with R127 and he to keep the dressing on until day following his dialysis. called the dialysis center again 17's concerns, and the dialysis d leave the dressing on until	F 309			
F 311 SS=D	included the contra development and ir hemodialysis care pinformation necess 483.24(a)(1) TREA IMPROVE/MAINTA  (a)(1) A resident is treatment and servior her ability to carr living, including the of this section.  This REQUIREMED by:	odialysis), dated 7/15, ctual agreement would include	F 311	1 P97 care plan, care delivery d	2/21/17	
	Based on observat	tion, interview, and document		R87 care plan, care delivery g	uide,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING		<del></del>	01/-	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	review, the facility for walking program was for 1 of 1 residents daily living (ADLs).  Findings include:  R87's significant che (MDS) dated 8/6/16 impairment and ide with walking in his research to the control of th	ailed to ensure a restorative as consistently implemented (R87) reviewed for activities of ange Minimum Data Set 5, indicated a severe cognitive ntified R87 was independent from and in the corridor.  ange MDS dated 11/3/16, ot walk in his room nor in the observation period.  seessment dated 11/9/16, ot ambulatory at this time, r locomotion."  cian orders dated 1/17, potential was "good," and he	F3	311	and Care Tracker (electronic syste were reviewed and updated to ens staff have the ability and communic to appropriately document ambulat program for identified resident.  2. Residents currently assigned to restorative program have the poter be affected by the current practice of residents currently on an ambulat program will be completed to ensure program is communicated.  3. Staff will be educated on the restorative program expectations a completion of program for identified residents.  4. DON/designee will complete we audits on each unit to ensure restorative program is being completed.  5. Audits will be completed for a possible of 90 days and audit results will be reviewed by QA committee to dete the need of on going monitoring.  6. Date of completion by: Februal 2017	eekly rative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		01	/12/2017	
	IAME OF PROVIDER OR SUPPLIER  GOLDEN VALLEY REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 311	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 31			COMPLETION	
	stated R87 could s room; however, fur	n 1/12/17, at 7:30 a.m. NA-B tand and would walk in his ther stated that R87 was not n walking and the staff would					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/	12/2017
NAME OF PROVIDER OR SUPPLIER  GOLDEN VALLEY REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			01/12/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPLETION	
	stated R87 used to now wheelchair dep During interview on stated R87 had a si August due to an in then had a significa a decline in his monot ambulated durin period because he and his walker had During interview on stated R87 was see 8/31/16, during which training. PT-A stated different walkers but unsafe with indeper reported placing R8 program on 8/31/16 completed by the nexpected to be implemented by the nexpected to be implemented assistant program was being During observation PT-A assisted R87 a transfer belt and from a transfer belt a	netimes." 1/12/17, at 8:06 a.m. RN-B walk with a walker, but was	F3	311			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING _	· · · · · · · · · · · · · · · · · · ·	01/	12/2017	
	OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 311	1 Continued From page 21		F 3	11			
	NA-C was not awar walking program, fu	re R87 had a supervised urther reporting she had in his room, but never in the					
	practical nurse (LPI programs were com "communication bohad a restorative pr R87 used to be on a however, after his fa	1/12/17, at 1:54 p.m. licensed N)-A stated restorative nmunicated on the white ard," and was not aware R87 rogram. LPN-A further stated a restorative program; alls, he didn't have a walking ated "he can't walk."					
	of nursing (DON) st nursing program, be in place, and had se training. She stated responsible for com	1/12/17, at 3:35 p.m. director tated there was no restorative ut was working on getting one ent staff to restorative the nursing assistants were apleting the restorative urses were to ensure it was					
	requested. A facility Report, from 12/13/ and indicated R87 a eight times, well be have occured, with	tion documentation was document entitled ADL Detail (16 to 1/11/16, was provided ambulated in the hallways low the 60 times it should the rest of the entries ivity did not occur." No further in was provided.					
F 312 SS=D	not provided.	ng Policy was requested but ARE PROVIDED FOR IDENTS	F 3 <sup>-</sup>	12		2/21/17	
	(a)(2) A resident wh	no is unable to carry out					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245186	B. WING		01/1	2/2017	
PROVIDER OR SUPPLIER  I VALLEY REHABILIT	TATION AND CARE CENTER	7	7505 COUNTRY CLUB DRIVE			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
activities of daily living services to maintain personal and oral harmonic personal and personal perso	ring receives the necessary in good nutrition, grooming, and hygiene.  NT is not met as evidenced ition, interview and document railed to ensure grooming oral cares were provided for 2 to, R33) reviewed, who were aff assistance with activities of inimum Data Set (MDS) dated R120 had altered level of werely impaired ability to make uired extensive assistance for onal hygiene, and was totally ing. The MDS further identified it behaviors of rejection of the y Care Plan, last updated 1/17, eat, clean and well groomed isstant care sheet included we a bath on Wednesday dependent on staff for g, and bathing. Sition on 1/10/17, at 10:06 a.m. and with the head of the bed diseveral one-half inch to a and black facial hairs under the facial hairs under a 1/11/17, at 9:11 a.m. nursing	F 312	<ol> <li>R120 and R33 will have plan or reviewed and updated to ensure percare needs are included.</li> <li>Residents that are dependent for personal care needs have the percent to be affected by this practice.</li> <li>Staff will be educated on the percent percent</li></ol>	on staff obtential olicy 017 reekly sonal plan of operiod		
	PROVIDER OR SUPPLIER  I VALLEY REHABILIT  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  Continued From pa activities of daily liv services to maintai personal and oral h This REQUIREME by: Based on observa review, the facility f needs (shaving) or of 3 residents (R12 dependent upon st daily living (ADLs).  Findings include: R120's quarterly M 11/7/16, identified f consciousness, set decisions, and requ dressing, and perso dependent for bath R120 did not exhib care. R120's ADL/Mobilit included, "will be no daily." R120's nursing ass R120 was to receiv mornings and was dressing, grooming During an observat R120 was lying in te elevated. R120 had one-inch curly grey her chin. During an observat R120 was lying in te her chin remained. During interview or assistant (NA)-L sta	PROVIDER OR SUPPLIER  I VALLEY REHABILITATION AND CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  During interview on 1/11/17, at 9:11 a.m. nursing assistant (NA)-L stated residents were shaved, if	PROVIDER OR SUPPLIER  245186  245186  245186  245186  245186  245186  245186  25TREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY) SITE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 squarterly 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 unursing 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 curty 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	TOOMED TO SUPPLIER  245186  2461866  2461866  2461866  2461866  2461866  2461866  2461866  2461866  2461866  2461866  2461866	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/12/2017			
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	REET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	morning, but did not because her super During interview or practical nurse (LP attended to her face like when staff did in During observation facial hair under Red During interview or stated she perform that morning, but do During interview or stated R120's facial removed, but, "The They do the most in facial hair don't get On 1/12/17, at 3:01 (F)-A stated it would aware that she had "always kept them never shaved them always wondered a big deal about it." During interview or manager (UM)-A stalways shave resident R33's diagnosis as dated 11/23/16, inc.	en R120 a bed bath early that of shave R120's facial hair visor had not told her to do so. in 1/11/17, at 9:15 a.m. licensed N)-F stated R120's family ital hair because R120 did not told to told to told hair because R120 did not told told told told told told told to	F3	112				
	R33 required assistand bathing. The 0	use, dated 8/3/16, indicated stance with dressing, grooming CAA further indicated R33 had eating needs and staff						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		01/	12/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	problem area and care daily and PRN required the physic During observation nursing assistant (I resident's room to After washing R33' area, NA-D and NA straightened her cla A small basket on the bathroom door was unopened package NA-E briefly left R3 mechanical lift to the wheel chair. So a.m., NA-E pushed the observation of offered oral care.  During interviewed nursing assistant (I staff to help her cle "toothette" (a mout NA-D stated she di R33 this morning, a was not offered oral cares could also be gets up from her na During a later observation of a later observation of a later observation of a morning, a later observation of a la	vised 1/17, identified an ADLs directed staff to provide oral I/ (as needed), and that R33 ral assistance of staff.  I on 1/11/17, at 7:29 a.m.  NA)-D and NA-E entered the assist R33 with morning ADLs. Is face, hands and perineal A-E dressed R33, then othing, and combed R33's hair. The dresser near the R33's sobserved to contain several red of toothettes (mouth swabs). The armsfer R33 from her bed into reated in the wheel chair at 7:42 I R33 out of the room, down dining room. At no time during cares was R33 provided or  on 1/11/17, at 9:10 a.m., NA)-D stated R33 required rean her teeth, and used a h swab) to clean her mouth. In a complete oral care for and also acknowledged R33 al care. NA-D stated mouth red done before lunch after R33	F 312			
	morning nap, and room to provide R3 the provision of car quickly returned wi	NA-G and NA-F entered the 33 with perineal care. Following re, NA-F left R33's room and th a mechanical lift. NA-F and sling under R33, then				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/	12/2017	
	PROVIDER OR SUPPLIER  I VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, 7505 COUNTRY CI GOLDEN VALLE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOUL FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 312	transferred her from chair. NA-G placed head, then exited the chair out of the root care, R33 was neith cares.  During interview on stated she did not perfect the care when she and noon meal. NA-G sher mouth cleaned morning.  In an interview on 1 practical nurse (LP) the aides to complete at least.  When interviewed of stated R33 was deprompleted at least.  When interviewed of stated R33 was deprompleted at least.  When interviewed of stated R33 was deprompleted at least. The complete the care be of the facility revised 10/16, inclupromote a healthy end infection by meeting the residents. The confeder support what it is a support included careShave." Also careShaveSh	the bed into R33's wheel d a stocking cap on R33's he room, pushing R33's wheel m. During this provision of her provided nor offered oral  1/11/17, at 11:34 a.m. NA-Gorovide R33 with any oral d NA-F got R33 up for the stated she thought R33 had when she got up in the  1/11/17, at 1:08 p.m. licensed N)-C stated she would expect be basic grooming, like teeth of hair, and washing of the who need assistance. LPN-C nimum, those task were to be in the morning and evening.  1/12/17. at 2:55 p.m. LPN-B bendent upon staff for a cares, and expected a be followed. LPN-B stated asic cares be done, or at	F3	12				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/	12/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	outcomes." 483.25(d)(1)(2)(n)(	and monitor resident  1)-(3) FREE OF ACCIDENT	F 31 F 32			2/21/17	
SS=D	from accident haza  (2) Each resident re and assistance dev  (n) - Bed Rails. Th appropriate alternated rail. If a bed on must ensure correct maintenance of bed to the following eler  (1) Assess the residerom bed rails prior  (2) Review the risks the resident or resident or resident or resident or resident formed consent p  (3) Ensure that the appropriate for the This REQUIREMED by: Based on observative review the facility facesess falls and be	vironment remains as free rds as is possible; and eceives adequate supervision rices to prevent accidents.  e facility must attempt to use tives prior to installing a side or riside rail is used, the facility et installation, use, and drails, including but not limited ments.  dent for risk of entrapment to installation.  and benefits of bed rails with dent representative and obtain rior to installation.  bed's dimensions are resident's size and weight.  NT is not met as evidenced tion, interview, and document ailed to comprehensively haviors possibly related to		1. R38 was discharged from facili 1/10/2017 2. Residents who have a history of the control of t	or		
	Based on observation review the facility factors assess falls and be	ailed to comprehensively		1/10/2017	or ave the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/1	2/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	history of manic de R38's admission di contained no histori discharged from the R38's current physicontained no indicated. During interview or assistant (NA)-K stintoxicated, further "he would sleep a live was drunk, he would when staff offered couple minutes lateright away even the him, and then he wistated when R38's they would go dow back smelling like. During interview or health unit coordinates observing R38 into R38 would "yell and wouldn't be calmed down either during she thought R38's alcohol when she wistated sometimes aggressive verbally would be more der	OS dated 10/15/16, indicated a appression and paraplegia. iagnoses list dated 5/12/16, ry of alcoholism. R38 was e facility on 1/10/17. ician orders, dated 1/17, ations for alcohol consumption. In 1/11/16, at 12:13 a.m. nursing rated she had observed R38 stating when R38 was drunk ot." NA-K stated when R38 Idn't want to get out of bed to help, even to shower. A per R38 would want to get up ough we had already asked rould be crabby about it. NA-K significant other would visit, instairs, and R38 would come	F 323	Impairment on Premises policy will enforced to ensure safety of themse and others. Plan of care will be upon to include interventions if residents ander the influence of drugs or alcomal staff will be educated on the ponent procedure by: February 21,20114. DON/designee will complete we audits on each unit to monitor for the unauthorized use of drugs and alcomal staff will be completed for a ponent 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.	elves dated are hol. licy 7. eekly e hol. eriod	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 323	licensed practical robserved R38 and drunk," and found indicated R38 had would pour alcohol incident to her suphis wife, and stated meetings about his had behaviors, he would yell and scretransfer himself if htwo or three falls be During interview or worker (SW)-B state complaints about F which the staff performed would hold narcotic minute checks. SW interventions were record. SW-B state that R38's significated but couldn't prove is was not restricted aget groceries, but he R38 bring alcohol indicated R38 had caused by his drink in his care plan.  During interview or director of nursing become intoxicated was visiting. The D manager spoke with bringing alcohol in,	n 1/12/17, at 10:25 a.m. nurse (LPN)-A stated she had his wife drinking, "both being alcohol in his room. LPN-A a large coffee cup that his wife into. LPN-A reported the ervisor, who spoke to R38 and the facility management had a drinking. LPN-A stated R38 was impatient, impulsive, eam at staff, would try to he had to wait for staff, and had	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, S 7505 COUNTRY CLUB D GOLDEN VALLEY, MN	STATE, ZIP CODE RIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 323	outings with his sigheard of him comin further reported star would call the physintoxicated. She star chair and could exhould have been rethe DON acknowled assessed.  Review of R38's Problem of	DON stated R38 would go on nificant other, but had never go back intoxicated. The DON off performed room checks and ician when R38 appeared ated R38 would fall out of his nibit unsafe behavior which lated to alcohol use, however, dged that had not been ogress Notes indicated the appeared "drunk" and sleepy, any alcohol. as observed by staff drinking e. The note further identified ed," and the physician was of see any alcohol in his room. The note indicated R38 was not see any alcohol in his room. The oxycodone (narcotic pain ecame angry when he was not ecohol consumption. The indicated R38 was not esemiled alcohol on his onto note a hospitalization of sugar. The note made note cohol use nor any assessment was observed drinking beer only sician was notified and old medications "that will"	F3	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		01/	12/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	- On 9/4/16, at 6:0 the floor next to his his wheelchair and when staff tried to the hospital for eva asleep after being R38 was working a positioning, howevel later that day "was and MD (medical of 9/5/16."  - On 9/7/16, at 6:1 lying on the floor. If wheelchair. The not check for any s/s (use and found nor - On 9/11/16, at 5:3 the floor. R38 states bed and slid to the indicated R38 comsafety awareness, without waiting for indication R38 was use.  R38's Fall/Injury AM Management Plantindicated he had not reason to have to his wheelchair.	in 9/4/16 to 9/11/16 5 a.m. R38 was found lying on a bed. R38 stated he fell out of a bed. R38 stated he fell out of a experienced right leg pain assist him. He refused to go to aluation of the leg pain and fell assisted into bed. It was noted with therapy on wheelchair er, the note further indicated noted to be drinking alcohol doctor) had all narcotics held as stated he slid out of his ote further indicated staff did signs or symptoms) alcohol lie. 31 a.m. R38 was found lying on ed he was trying to get out of a floor. The note further tinued to be impulsive, lacked and would attempt to transfer staff to arrive. There was no a sassessed for signs of alcohol assessment: Prevention and of Care updated 1/8/17, nultiple falls, would slide out of	F 32	3		
	due to "Sneaking a other mention of a Care. The care pla assessment or spe R38 alcohol use a R38's Mood and B Care Plan dated 6	d had a mental status change alcohol to drink." There was no loohol on the Fall/Injury Plan of an lacked any previous ecific interventions related to and falls.  ehavior Symptom Assessment (16, identified no specific er, directed if R38 became				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/	12/2017	
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F 323	removed from the any previous asse R38's specific beh R38's specific beh R38's medical rec assessment of his complications rela subsequent falls, a A facility policy ent Drugs, Alcohol and Premises, revised order is not obtain removed, staff we Substance Abuse: Plan.  483.45(b)(2)(3)(g) LABEL/STORE DITTHE facility must p drugs and biologic them under an agi §483.70(g) of this unlicensed person law permits, but or supervision of a lice (a) Procedures. A pharmaceutical set that assure the act dispensing, and act biologicals) to meet (b) Service Consultations assure the act dispensing, and act biologicals) to meet the same statement of the same statement	ally aggressive, he was situation. The care plan lacked ssment and interventions for aviors while intoxicated.  Ord lacked a comprehensive risk factors and possible ted to his alcohol use, and behaviors.  Itled Unauthorized Use of dapparent Impairment on 1/17, directed if a physician ed for alcohol and is not re to initiate the Unauthorized Treatment and Safety Care  (h) DRUG RECORDS, RUGS & BIOLOGICALS  rovide routine and emergency rals to its residents, or obtain reement described in part. The facility may permit nel to administer drugs if State only under the general	F 3:			2/21/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	(X3) DATE SURVE COMPLETED		
		245186	B. WING _		01/12/201	7	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•		
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F 431	disposition of all codetail to enable and (3) Determines that that an account of maintained and per (g) Labeling of Drugs and biological labeled in accordatorofessional principal propriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance the facility must stolocked compartment controls, and perminate access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except whe package drug distributed in the readily detected this REQUIREMENT by:  Based on observative review, the facility	ystem of records of receipt and ontrolled drugs in sufficient accurate reconciliation; and all controlled drugs is riodically reconciled.  gs and Biologicals.  als used in the facility must be nece with currently accepted ples, and include the sory and cautionary ne expiration date when  gs and Biologicals.  with State and Federal laws, ore all drugs and biologicals in ints under proper temperature it only authorized personnel to exeys.  st provide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to en the facility uses single unit inbution systems in which the ininimal and a missing dose cand.  NT is not met as evidenced ation, interview, and document failed to ensure medications opriately prior to administration	F 43	<ol> <li>R27 Discharged 2/3/2017.</li> <li>Residents that have had a medication have the potential to affected. Policy and procedure Reordering, changing and disconsistent in the potential to a feet the potential the potential to a feet t</li></ol>	be for		

I		(X3) DATE SURVEY COMPLETED	
<b>245186</b> B. WING	§	01/12/2017	
NAME OF PROVIDER OR SUPPLIER  GOLDEN VALLEY REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(X5) COMPLETION DATE	
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.	orders was reviewed and remains curre 3. Staff will be educated on the policy and procedures by: February 21, 2017 4. DON/designee will complete Weekl audits on medication pass on each unit 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 21,20	y to	

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		245186	B. WING			01/-	12/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505	ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427		
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F 441	investigating, and communicable disvolunteers, visitors providing services arrangement base conducted according accepted national implementation is  (2) Written standard for the program, which is the program, which is the program, which is the prossible communication before they can spracility;  (ii) When and to whe communicable distributed to the program is to be followed to provide to be followed to provide the program is the program in the program is the provided in the pro	eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment Phase 2);  and other individuals under a contractual dupon the facility assessment personal following standards (facility assessment Phase 2);  and other persons in the phase 2);  and procedures hich must include, but are not eveillance designed to identify cable diseases or infections are do other persons in the phase or infections should be expected and procedures are presented of infections;  and other individuals under a session of the individuals and individuals are not infections.	F	.41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			01/1	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	contact with resider contact will transmit (vi) The hand hygie by staff involved in  (4) A system for recunder the facility's lactions taken by the (e) Linens. Person process, and transpapered of infection.  (f) Annual review.  annual review of its program, as necess This REQUIREMED by:  Based on observareview, the facility frontrol measures will glucometer that have residents (R27, R9) shared glucometer to ensure soiled laccontained to preven had the potential to on the 1st floor of the Findings include:  SHARED GLUCON During observation registered nurse (Fand donned gloves)	skin lesions from direct hts or their food, if direct it the disease; and the procedures to be followed direct resident contact.  cording incidents identified IPCP and the corrective e facility.  Incording incidents identified IPCP and the corrective e facility.  Incording incidents identified IPCP and the corrective e facility.  Incording incidents identified IPCP and the corrective e facility.  Incording incidents identified IPCP and the corrective e facility will conduct an a IPCP and update their sary.  In and update their sary.  In is not met as evidenced the potential to affect 4 of 5 solution, interview, and document ailed to ensure infection were implemented for a shared of the potential to affect 4 of 5 solution, the facility failed undry items were consistently in the spread of infection. This affect 26 residents who lived the facility.	F 4	141	1. R27 discharged 2/3/2017, R98 and R70 care plan, orders and trea records were updated to match Glu Monitoring Equipment: Disinfect/Decontaminate policy and procedure. 2. Corrective actions as it applies others: Audits conducted with staff complete Glucose checks to ensure Glucose Monitoring equipment: Disinfect/Decontaminate policy and procedure is done correctly, increase frequency of checks to soiled utility from 3x/day to 4x per day to stop overfilling of laundry cart and ensure linens are bagged properly. Policy procedure for Glucose Monitoring Equipment: Disinfect/Decontaminate reviewed and remains current.	to that e that se room	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 441	levels in the blood an alcohol prep padisposable lancet measure R27's bl did not clean or di on R27.  RN-A then went to R98's blood sugar and the glucomet disinfect glucome  RN-A then went to R60's blood sugar and the same glucodisinfect the	lage 36 (devise used to measure sugar ). RN-A wiped R27's finger with a and poked finger with a RN-A used a glucometer to bood sugar level, hovever, RN-A sinfect the glucometer after use  O R98's room and checked with the same green basket er. RN-A did not clean or the after use on R98.  O R60's room and checked with the same green basked cometer. RN-A did not clean or the after use on R60.  O R70's room and checked with the same green basket cometer. RN-A did not clean or the after use on R70.  O R70's room and checked with the same green basket cometer. RN-A did not clean or the after use on R70.  O R70's room and checked with the same green basket cometer after use on R70.  O R70's room and checked with the same green basket of the north medication and the same that the same that the same that the same en basket with the used bottom drawer and locked the not went to assist another staff.  On 1/11/17, at 7:59 a.m. RN-A did the glucometer with an een each resident. RN-A stated dicidal disposable wipe) could be glucometer when done using the A stated I would have to look uponeters to see what to use to RN-A then took out the Sani the glucometer with the Sani the plack in the green basket in the sani the back in the green basket in the sani the back in the green basket in the sani the sani the sani the glucometer with the Sani	F 4	141	procedure for Handling of Linen wa reviewed and remains current.  3. Staff will be educated on the pound procedures by: February 21, 20, 4. DON/designee will complete we audits on each unit to ensure Glucous are being clean after use. Weekly and on each unit to ensure Laundry cardoverfilled and that soiled items are bagged.  5. Audits will be completed for a prof 90 days and audit results will be reviewed by QA committee to deter the need of on going monitoring.  6. Date of completion: February 2	olicy 017 eekly ometer audits t is not eriod	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	, 0.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	director of nursing should be wiped we then wrapped in a minutes and after in the cart to be stored shared glucometer each resident's us.  The facility policy of Disinfect/Decontar staff to disinfect the following use on each 1-Use the disinfect parts of the glucom 2-Remove gloves.  3-Perform hand hy 4-Don clean glove.  5-Obtain a second 6-Use the wipe to glucometer for the 7-Place the glucom Allow the meter to required by the mater before completing 8-Remove gloves.  9-Perform hand hy	on 1/12/17, at 4:40 p.m. the (DON) stated the glucometer ith a purple top Sani cloth and clean wet Sani cloth for two two minutes put the glucometer ored. The DON stated the reshould be disinfected between e.  Glucose Monitoring Equipment: minate dated 7/2015, directed e glucometer with the wipes ach resident. Staff were to: tant wipe to clean all external meter with gloves on.  Agiene.  S.  wipe and fresh paper towel. clean all external parts of the second cleaning. The meter on the fresh paper towel. The remain wet for the contact time anufacturer's recommendation another glucose test.	F	141			
	2:07 p.m. the 1st f	ROOM our of the facility on 1/9/17, at loor, soiled utility room was cked room housed a plastic					

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		245186	B. WING _	·····	01	/12/2017
	PROVIDER OR SUPPLIER  I VALLEY REHABILIT	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	and 4' high, and wa opening of a stainle cart overflowed with laundry items. The bed spreads, various cloths and bed mail laundry items were were ripped, their con the floor of the soiled bed pads we side of the cart, and dark and soiled, for floor.  In an interview on thousekeeping man room was full, and un-bagged laundry laundry and towels the chutes were meand when the bags many arrived torn,  During a later obsethe 1st floor soiled overfilled with laund bagged laundry item were also observed.  During observation at 10:34 a.m., a horesident room acroutility room. The laagain observed over was backed up with laundry, all tied, and	age 38  ximately 4' (feet) by 5' wide, as positioned under the ess steel laundry chute. The h bagged and unbagged items included bed sheets, us sizes of bath towels, wash tress pads. Most of the bagged, but numerous bags contents laying in the cart and soiled utility room. Visibly are draped in and along the done of the bed pads was und among other towels on the lager (HM) stated the laundry there was bagged and in the cart, and some other on the floor. The HM stated etal, and had some edges on, were sent down the chute, and the laundry spilled out.  Ervation on 1/9/17, at 6:45 p.m. utility room cart was not dry, and contained mostly ms. Several large bath towels do in the cart, unbagged.  The next morning on 1/10/17 usekeeper was working in se from the 1st floor soiled aundry cart in the room was erfilled, and the laundry chute in laundry. Five bags of did a visibly soiled hospital erved on the floor in the room.	F 44	.1		

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-	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 465 SS=E	housekeeper (HK)- out the laundry car- done a couple of til sees the soiled lau came down the chu un-bagged, soiled l laundry chute went items" were to be b  When interview on stated carts in the s removed three time overflowing. The H bags do rip, and th- tightly. The HM sta always bag soiled I staff were trained of were new people w The HM then state opportunity" for sta of soiled linen.  A facility policy, Infe Linen, effective July was to reduce the and employees. Th precautions would soiled linens. The p was to be bagged a chutes at regular in to overfill. 483.90(i)(5)	on 1/10/17, at 10:55 a.m.  B stated she was swapping its, which was a task that was me every day. HK-B stated she ndry as mostly bagged when it ute, but has often seen laundry. The HK-B stated the ito the 4th floor, and added "all bagged.  1/12/17 at 7:31 a.m. the HM soiled area were to be est daily to keep laundry from M stated some of the laundry at bags were often not tied ted that some staff do not aundry, and stated nursing on proper disposal, but there who may not know the rules. Ed this was an "inservice iff to review the proper handling ection Control, Handling of y 2015, indicated its purpose risk of infection to residents are policy indicated standard be followed when handling colicy directed all soiled linen and collected by cart at the intervals, and not allow hampers	F 44			2/21/17
	., Caio. Livionin	onditions				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	sanitary, and comforesidents, staff and (5) Establish policie applicable Federal, regulations, regardi and smoking safety non-smoking resided This REQUIREMEN by: Based on observation review, the facility facility for sanitary toilet in the unit which had pote utilized the shower.  During observation resident shower/bate facility was inspected hallway led into the entrance, a full privice iling to the floor. wash cloths were of and there was a toing The floor area and behind the toilet was an unidentified substance which convalls behind and all floor between the wapproximately 8" (in with this same, unked the total and the soiled areas did dried to the wall areas dried to the wal	ovide a safe, functional, ortable environment for the public.  Is, in accordance with State, and local laws and ng smoking, smoking areas, that also take into account ents.  It is not met as evidenced ion, interview and document ailed to maintain a clean and shower room on the 1st floor ntial to affect 26 residents who and restroom.  On 1/9/17, at 7:24 p.m. the throom on the 1st floor of the ed. A large door from the main shower room, and upon acy curtain hung from the Three large bath towels and bserved scattered on the floor, let in the corner of the room. In the corner of the room, wall directly to the left of and sheavily soiled. The soiling the properties of the toilet. The tile all and toilet, an area anches) x 20", was also covered nown substance. Although I not smell, the substance was	F 46	1. Shower room and Toilet wand sanitized 2. Residents who use the shave the potential to be affected deficient practice. Policy and for Health Service Group, Block Pathogens employee handbook reviewed and remains current. 3. Staff will be educated on the and procedures by: February 24. DON/designee weekly aud unit to ensure shower room and clean and sanitized. 5. Audits will be completed for 90 days and audit results with reviewed by QA committee to the need of on going monitoring 6. Date of completion: February 24.	ower room ed by the procedure odborne ok was he policy 21, 2017 dits on each nd toilets are or a period ill be determine ng.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		01	/12/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	presence of the soil corner of the shown as the towels on the NA-I stated she would also stated that. The following day a resident exited from the shower room. Upon 1st floor bathroom/ the area, the walls to to the room/ the area, the walls to to the room/ the area, the walls to to the room/ the area, the walls to to the soil to	NA)-I acknowledged the iled wall and floors in the er room near the toilet, as well e floor in the shower room. Indered if someone got sick, at it needed to be cleaned.  At 1/10/17, at 10:52 a.m. a in the shower/bathroom, and as it the surveyor, the resident in stated it was "the third day" is bathroom and pointed to the in a subsequent review of the shower after the resident left and floor area surrounding the t was found the previous day,	F 4	65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	_	(X3) DATE SURVEY COMPLETED		
		245186	B. WING			01/1	2/2017
-	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, ST 7505 COUNTRY CLUB DRI GOLDEN VALLEY, MN	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD E ED TO THE APPROPRI ICIENCY)		(X5) COMPLETION DATE
F 465	During interview a shower/bathroom stated she thought to who can clean whousekeeping can nursing would hav (bowel movement) disinfect an area. staff, that shower stated whoever for communicated rigishould have taken and then let house During interview o housekeeping man housekeeping staff was for nursing. To blood borne policy been some mis-coaides and staff. To some kind of staff staff need to be edwas good to have A facility documen bloodborne Pathoundated, indicated that is contamination. Their employees "a decontaminated a A facility documen Inc, Housekeeping provided direction	bout the unclean 1st floor on 1/12/17, at 7:18 a.m. LPN-B there was some confusion as what. LPN-B stated not clean bodily fluids, and e to initially clean up any BM then notify housekeeping to LPN-B stated with all the new room got missed. LPN-B und the mess should have he away, and one of the nurses action, cleaned it themselves, ekeeping know.  In 1/12/17, at 7:35 a.m. the hager (HM) stated that if did not clean bodily fluids, that the HM explained the facility, but stated there must have emmunication between the he HM stated they need to do inservice, and it was something ducated on, and also stated it this brought to staff's attention.  It, from Health Service Group, gens Employee Handbook, d'Any equipment or furniture ed with visibly large quantities odily fluids will be referred to of the client facility for The document further indicated are only to clean previously	F 4	.65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465		ige 43 ze commode" and "damp mop	F 4	65		

F5186029

PRINTED: 02/14/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245186 B. WING 01/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARE CENTER **GOLDEN VALLEY, MN 55427** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

**Electronically Signed** 

02/13/2017

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTI NG <b>01 - MAIN BUII</b>		E SURVEY IPLETED	
		245186	B. WING			01/	17/2017
	PROVIDER OR SUPPLIER VALLEY REHABILI	TATION AND CARE CENTER		7505 COUNTRY	SS, CITY, STATE, ZIP COD CCLUB DRIVE .LEY, MN 55427	Æ	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	St. Paul, MN 5510  By email to: Marian.Whitney@ Angela.Kappenma  THE PLAN OF CO DEFICIENCY MU FOLLOWING INF  1. A description of to correct the defi  2. The actual, or p  3. The name and responsible for co prevent a reoccur  Golden Valley Re 3-story building th was determined to construction. It ha protected by an a The facility has fir rooms, corridors a that is monitored  The facility has a	estate.mn.us and an@state.mn.us  ORRECTION FOR EACH ST INCLUDE ALL OF THE FORMATION:  f what has been, or will be, done	KO	00			
K 741 SS=D	NOT MET as evice NFPA 101 Smokin Smoking Regulat	ng Regulations	K 7	41			2/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION IG <b>01 - Main Building 01</b>	COMPLETED	
		245186	B. WING _		01/17/2017	
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
K 741	(1) Smoking shall ward, or compart combustible gase and in any other I area shall be pos SMOKING or sha international sym (2) In health care prohibited and sig major entrances, that prohibits smo (3) Smoking by presponsible shall (4) The requirem where the patient (5) Ashtrays of nodesign shall be psmoking is permi (6) Metal contained devices into which be readily available permitted.  18.7.4, 19.7.4  This STANDARD Based on observing and the standard policy in accorda 101. 19.7.4. This any residents or significant shall be promited.  On a facility tour 1500 on January that that several front entrance where the patient contains the standard policy in accordance in the s	han the following provisions: I be prohibited in any room, ment where flammable liquids, es, or oxygen is used or stored hazardous location, and such ted with signs that read NO all be posted with the bol for no smoking. occupancies where smoking is gns are prominently placed at all secondary signs with language oking shall not be required. atients classified as not be prohibited. ent of 18.7.4(3) shall not apply it is under direct supervision. oncombustible material and safe rovided in all areas where tted. ers with self-closing cover h ashtrays can be emptied shall ble to all areas where smoking is of is not met as evidenced by: vation and staff interview, the here to their written smoking nce with the 2012 LSC NFPA deficient practice could effect staff in the smoking area.	K 74	The facility failed to appropriatly residents away from the facility to the designated smoking area. All facility staff will be educated I 2/21/2017 regarding facility smo policy and designated smoking a Reoccurance will be prevented I audits to ensure the facility smol is being adheared to. Corrections will be monitored by maintenance/designee.	enterance by king area. by weekly king policy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245186	B. WING			01/1	17/2017
	PROVIDER OR SUPPLIER  I VALLEY REHABILIT	ATION AND CARE CENTER		7!	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 741	was placing wheel location to smoke.  This deficient pract	chair bound residents in this ice was verified by the director	К7	741			
	of maintenance at t	the time of inspection.					



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule

Golden Valley Rehabilitation And Care Center February 3, 2017 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 03/22/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00112 01/12/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

Minnesota Department of Health

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

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with

http://www.health.state.mn.us/divs/fpc/profinfo/inf

the Minnesota Department of Health Informational Bulletin 14-01, available at

obul.htm The State licensing orders are delineated on the attached Minnesota

**INITIAL COMMENTS:** 

**Electronically Signed** 02/13/17

STATE FORM If continuation sheet 1 of 46 ZYNS11

TITLE

(X6) DATE

PRINTED: 03/22/2017 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
			A. BOILDING.				
		00112	B. WING	<del></del>	01/1	2/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	I VALLEY REHABILIT	ALION AND CARL	JNTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa		2 000				
	you electronically. is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Departm"  On 1/9/17 to 1/12/1	17, surveyors of this					
	the following correction that you	visited the above provider and ation orders are issued. Four electronic plan of have reviewed these orders, when they will be completed.					
	completed at the tir Investigation of con H5186222 were con substantiated relate order issued at Stat	int investigations were also me of the licensing survey. nplaints H5186216 and mpleted. The complaint was ed to H5186216. Correction te Licensing 0920. The to H5186222 was not					
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are it	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the nis column also includes the in violation of the state statute of, "This Rule is not met as					

Minnesota Department of Health

STATE FORM 5699 ZYNS11 If continuation sheet 2 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00112	B. WING		01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
		wing the surveyors findings Method of Correction and rection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			2/21/17
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related of segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic	of Alzheimer's disease and activities of daily living; with challenging behaviors;				

Minnesota Department of Health

PRINTED: 03/22/2017 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7. BOILBING.			
		00112	B. WING	<del></del>	01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	nge 3	2 302			
	topics covered.	ncy of training, and the basic				
	by: Based on interview facility failed to ens interested family we regarding the Alzhe including who recei description of the tr	ent is not met as evidenced and document review, the ure that residents and/or ere provided information eimer's training staff received ived training, how often, and a raining provided. This had the 15 of 115 current residents of r families.		corrected		
	Findings include:					
	An Approach to Ma course, print date of the roster. The rost of the facility had contraining between Ja 31st, 2016, however evidence that the faceducate residents/f	rticipant list for the "CARES: anaging Dementia Behaviors" of 1/9/17, included 224 staff on the result of the Alzheimer's anuary 1, 2016 and December er, there was a lack of acility had a system in place to families and guardians on how aff were educated on the acility care.				
	director of nursing unaware of consum provided information Alzheimer's and de that she would cheef if it was covered in	n 01/12/17, at 3:22 p.m. the (DON) stated she was ners/residents/families being on of facility training of staff on mentia care. The DON stated ck with social services, to see the admission process. At I returned and stated that this				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00112		B. WING	·····	01/1	2/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	ORESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 302	information was not process, and when resources, it was di provide information consumers.  SUGGESTED MET The administrator of process to ensure: others are made aw provided to staff, while frequency of training training topics.	ge 4 t included in the adm she had contacted o scovered that they do not raining to familie. THOD OF CORRECT or designee could revesidents and interevare that dementia trans received training, g, and a description of the correction of the correct	utside o not es and TION: iew its sted aining is the of the	2 302			
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident  This MN Requirement by: Based on observation review, the facility facare by failing to prove residents (R33) revolving (ADLs) who wassistance.  Findings include:	ent is not met as evi on, interview and doc ailed to implement th ovide oral cares for 1 iewed for activities of vas dependent upon	f care in the denced cument e plan of of 1 f daily staff for	2 565	corrected		2/21/17
	R33's diagnosis as	identified on the face	sheet				

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PRINTED: 03/22/2017 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00112		B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	dated 11/23/16, inc	luded Alzheimer's dementia.				
	problem area and of care daily and PRN required the physic During observation nursing assistant (Noresident's room to a After washing R33's area, NA-D and NA straightened her clock A small basket on the bathroom door was unopened package NA-E briefly left R3 mechanical lift to the wheel chair. See a.m., NA-E pushed the hall and to the control of the control of the care and the second of the physical straight and to the control of the care and the physical straight and to the control of the physical straight and the physical problem.	rised 1/17, identified an ADLs directed staff to provide oral (as needed), and that R33 al assistance of staff.  on 1/11/17, at 7:29 a.m.  NA)-D and NA-E entered the assist R33 with morning cares. If a face, hands and perineal area or the R33's hair. The dresser near the R33's observed to contain several d of toothettes (mouth swabs). It is room and returned with a ansfer R33 from her bed into eated in the wheel chair at 7:42 R33 out of the room, down dining room. At no time during cares was R33 provided or				
	assistant (NA)-D st her clean her teeth mouth swab) to cle she did not comple morning, and also a offered oral care. N also be done before from her nap. During a later obse a.m. R33 was awak	1/11/17, at 9:10 a.m. nursing ated R33 required staff to help and used a toothette (a an her mouth. NA-D stated te oral care for R33 this acknowledged R33 was not A-D stated mouth cares could be lunch after she R33 gets up arvation on 1/11/17, at 11:12 are in her bed following a JA-G and NA-F entered the				
	Following the provis	3 with perineal care. sion of care, NA-F left R33's eturned with a mechanical lift.				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED A. BUILDING: B. WING \_\_\_ 00112 01/12/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN VALLEY REHABILITATION AND CARE  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				
2 565	Continued From page 6	2 565						
	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							

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARL	NTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	to ensuring the care followed. To ensure DON or designee c educate staff and d ensure staff are prowritten plan of care	olicies and procedures related e plan for each resident is e ongoing compliance, the ould develop a system to evelop a monitoring system to oviding are as directed by the	2 565			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			2/21/17
	by: Based on observati review, the facility fa wound dressing foll appropriately and s	ent is not met as evidenced on, interview, and document ailed to ensure the care of a owing dialysis was provided ervices were coordinated for 2 6, R127) reviewed who were		corrected		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	2/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
2 830	Continued From pa	ige 8	2 830				
	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 vitalsThey 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.						
	licensed practical not know when R15	on 1/11/17, at 1:01 p.m. urse (LPN)-F indicated she did 56's dressing was supposed to eturning to the facility from					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	dialysis. LPN-F stat to that question. I to dialysis was on 1/9/ Review of R156's h filtering the blood) of directed to complet dialysis, monitor for access site, monitor monitor functioning fistula by palpating for bruit (buzz) daily also included, "dreschecked directing scovered with dressi	ge 9  ed, "I don't know the answer pok it off today [1/11/17, [17]] because he asked me to."  emodialysis (a process of care plan dated 12/26/16, e vital signs upon return from a complications at vascular repost-dialysis weight, and access site by checking the thrill (blood flow) and listening at the thrill (blood flow) and listening as directed by Dialysis R156 had a fistula, not an	2 830			
	administration reco included monitoring post-dialysis, and d weight, but lacked or removal of the dress.  During an interview unit manager (UM)-R156's hemodialysis admitted and had or regarding the dress dialysis center would the dressing should R156 had a fistula, noted on the care pknow when the dreshad never contacted directions as to whe During an interview.	emodialysis fistula treatment rd dated 12/16 and 1/17, for thrill and bruit daily and ocumentation of post-dialysis documentation regarding the sing following dialysis.  on 1/11/17, at 1:08 p.m. the A stated she had completed is care plan when he was hecked the intervention sing because it noted the Id direct the facility staff when I be removed. UM-A verified not an external catheter as slan, and stated she didn't ssing should be removed and the dialysis center for en to remove the dressing.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00112	B. WING	· · · · · · · · · · · · · · · · · · ·	01/1	2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 10	2 830				
		essing to R156's fistula should ne returned to the facility from					
	p.m. registered nur dialysis center state removed within a co the facility because with the fistula, and the nursing staff. R	interview on 1/12/17, at 2:32 se (RN)-FDC from Fresenius ed the dressing should be puple of hours of returning to it could cause complications this should be monitored by N-FDC indicated the facility alled the dialysis center if they					
	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 moderate cognitive	I 10/19/16, identified R127 had impairment.					
	1/8/16, included R1 Tuesday, Thursday interventions, include with three boxes: C changed at Dialysis catheter covered w Dialysis Center, or,	emodialysis care plan dated 27 received hemodialysis , and Saturday, and under ded, "Dressing Information," atheter dressing to be Center, Keep external ith dressing as directed by Remove band-aid from ning of dialysis. All three ed.					
	record, dated 12/16	emodialysis fistula treatment and 1/17, lacked direction val of the fistula dressing					
	licensed practical n	on 1/11/17, at 2:20 p.m. urse (LPN)-B stated she was ut did not know if R127 had a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			E SURVEY PLETED	
		00112	B. WING		01/	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505	EET ADDRESS, CITY, 5 5 COUNTRY CLUB DEN VALLEY, MI	B DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	fistula or an externa R127's hemodialysis when R127's dress following his dialysis:  During an observati at 2:28 p.m. R127 sprevious day and haupper arm. R127 in remove the dressing to do it. I take it off they [dialysis staff] they [dialysis	al catheter and when show is care plan, did not know ing was to be removed is.  Ion and interview on 1/11/stated he had dialysis on the dialysis on the dialysis on the dialysis and stated, "I'm suppose before I go to dialysis againstell me it should come off than infection." R127 stated didn't want to remove the or he would bleed. R127 sieve the dressing that even on the dialysis ommended the dressing that to keep the dressing on under the dialysis center a 7's concerns, and the dialysid leave the dressing on under the dialysis on the dialysis center a 17's concerns, and the dialysid leave the dressing on under the dialysis on the dialysis center a 17's concerns, and the dialysis dienter the dressing on under the dialysis on the dialysis center a 17's concerns, and the dialysis on the dialysis of the dialysis on the di	17, he d not sed in or d he e tated ing. :38 De sis, he ntil gain ysis htil			
	p.m. registered nursidialysis center states removed before R1 receives dialysis, to stated R127 needes would not bleed if the ducation should be consequences of less that the discrepancy of the discrepan	se (RN)-DDC from Davita ed the dressing should be 27 goes to bed, on the data prevent infection. RN-DD do to be reassured that he are dressing was removed a provided about the eaving the dressing on.	y he C			
	Review of the facilit	y's policy Dialysis				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY MPLETED	
		00112	B. WING		01/1	2/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE			
GOLDEN	VALLEY REHABILITA	ATION AND CARE	JNTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	included the contract development and in hemodialysis care prinformation necessary.  Based on observative review the facility facts assess falls and be intoxication for 1 of accidents.  Findings include:  R38's quarterly MD history of manic dep R38's admission discontained no history discharged from the R38's current physic contained no indicate contained no indicate intoxicated, further "he would sleep a low was drunk, he would when staff offered to couple minutes later right away even tho him, and then he we stated when R38's at they would go down back smelling like light puring interview on the p	odialysis), dated 7/15, ctual agreement would include inplementation of resident's plan and interchange of ary for the care of the resident.  on, interview, and document tiled to comprehensively haviors possibly related to 4 residents (R38) reviewed for 4 residents (R38) reviewed for agnoses list dated 5/12/16, y of alcoholism. R38 was a facility on 1/10/17.  cian orders, dated 1/17, tions for alcohol consumption.  1/11/16, at 12:13 a.m. nursing ated she had observed R38 stating when R38 was drunk of." NA-K stated when R38 dn't want to get out of bed o help, even to shower. A ar R38 would want to get up augh we had already asked ould be crabby about it. NA-K significant other would visit, instairs, and R38 would come	2 830				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	2/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUB VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 13	2 830				
	R38 would "yell and wouldn't be calmed down either during she thought R38's alcohol when she vistating the staff did.  During an interview stated sometimes Raggressive verbally would be more denishe just thought it vibrated practical nobserved R38 and drunk," and found a indicated R38 had a	d call the providers names," he down, and wouldn't want to lie those times. HUC-A stated significant other would bring in isited about every two days, n't check her belongings.  on 1/11/17, at 2:05 p.m. NA-H R38 would be a little more, "just wasn't his normal self," nanding, and further stated was the medications.  1/12/17, at 10:25 a.m. urse (LPN)-A stated she had his wife drinking, "both being alcohol in his room. LPN-A 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.						
	worker (SW)-B state complaints about R which the staff perf would hold narcotic minute checks. SW interventions were record. SW-B state that R38's significal but couldn't prove it was not restricted a get groceries, but h	1/12/17, at 12:31 p.m. social ed there were several 38 smelling of alcohol, for ormed random room checks, s, and would place R38 on 15 7-B acknowledged these rarely charted in R38's medical d the facility had suspicions at other would bring in alcohol t. SW-B further stated R38 and would leave the facility to ad never heard or observed ato the facility. SW-B also					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G:		SURVEY PLETED	
			A. BOILDIN	d		
		00112	B. WING _		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER	STREI	ET ADDRESS, CITY	, STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ΔΠΟΝ ΔΝΗ ("ΔΕΙ	COUNTRY CLO DEN VALLEY, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 14	2 830			
	indicated R38 had verbal agitation and behaviors caused by his drinking, which were not addressed in his care plan.					
	director of nursing become intoxicated was visiting. The D manager spoke wit bringing alcohol in, denied, but the faci conversation. The outings with his sig heard of him comir further reported stawould call the phys intoxicated. She stachair and could extrould have been re	in 1/12/17, at 1:10 p.m. the (DON) stated R38 would at when his significant other ON reported the nurse the R38's significant other at which the DON stated she lity did not have a record or DON stated R38 would go nificant other, but had never a back intoxicated. The DOM of performed room checks ician when R38 appeared ated R38 would fall out of hibit unsafe behavior which lated to alcohol use, howeld did not been	the on on on one on one one			
	following: On 7/18/16, R38 abut denied drinking On 9/4/16, R38 walcohol with his wife R38 was "intoxicate notified. On 9/6/16 and 9/7 alert and staff did nown. R38 request medication), and be given any due to allone on 10/4/16, an ID identified "staff have	appeared "drunk" and sleep any alcohol. as observed by staff drinking. The note further identifieed," and the physician was a rot see any alcohol in his rot see any alcohol in his rot and "speech slurred," and a h whiskey" was found in his ed oxycodone (narcotic paiecame angry when he was cohol consumption. T (interdisciplinary team) ne smelled alcohol on his on to note a hospitalization	oy, ng d as om. t in not			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112	B. WING	<del></del>	01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ALION AND CARL	JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	related to low blood other mention of alco by IDT. On 10/20/16, R38 and whiskey. The p gave an order to ho interact with whisked R38's Nurse's Note were reviewed for finoted to occur from On 9/4/16, at 6:05 the floor next to his his wheelchair and when staff tried to a the hospital for evaluasleep after being a R38 was working w positioning, however later that day "was and MD (medical do 9/5/16." On 9/7/16, at 6:17 lying on the floor. R wheelchair. The not check for any s/s (suse and found none On 9/11/16, at 5:3 the floor. R38 states bed and slid to the findicated R38 continus afety awareness, a without waiting for significant of significant of the significant of signific	sugar. The note made no cohol use nor any assessment was observed drinking beer hysician was notified and old medications "that will by or beer."  s, from 7/25/16 to 9/11/16, ive falls, of which three were 9/4/16 to 9/11/16 a.m. R38 was found lying on bed. R38 stated he fell out of experienced right leg pain assist him. He refused to go to luation of the leg pain and fell assisted into bed. It was noted ith therapy on wheelchair er, the note further indicated noted to be drinking alcohol octor) had all narcotics held  a.m. R38 was again found 38 stated he slid out of his te further indicated staff did igns or symptoms) alcohol	2 830			
	R38's Fall/Injury As Management Plan of indicated he had mi	sessment: Prevention and of Care updated 1/8/17, ultiple falls, would slide out of had a mental status change				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 16		2 830			
	due to "Sneaking a other mention of alc Care. The care plan assessment or spe R38 alcohol use an R38's Mood and Be Care Plan dated 6/behaviors, however verbally or physical removed from the sany previous asses R38's specific behat R38's medical reco assessment of his a complications relate subsequent falls, an A facility policy entit	Icohol to drink." There was no cohol on the Fall/Injury Plan of a lacked any previous cific interventions related to d falls.  The phavior Symptom Assessment of the fall of t				
	Premises, revised order is not obtaine removed, staff were Substance Abuse: Plan.  SUGGESTED MET director of nursing (develop and implementated to dialysis ficare related to the facould review and revised and care planned upon and revised as necessity and conduct audited to cond	THOD OF CORRECTION: The (DON) or designee evise policies and prodecures gall residents are assessed rventions are implemented pon admission and reveiwed essary. The DON or designee est to ensure ongoing esults of the audits could be				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00112	B. WING		01/12/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	reported to the qua	lity assurance committee.				
	TIME PERIOD FOR CORRECTION: Twenty one (21) days					
2 915	MN Rule 4658.0525	5 Subp. 6 A Rehab - ADLs	2 915			2/21/17
	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					
	by: Based on observati review, the facility for walking program wa	ent is not met as evidenced on, interview, and document ailed to ensure a restorative as consistently implemented (R87) reviewed for activities of		corrected		

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMI			SURVEY LETED	
		00112	B. WING		04/4	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	01/1	2/2017
	N VALLEY REHABILIT	7505 COL	INTRY CLUE			
GOLDEN	T	GOLDEN	VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 18	2 915			
	(MDS) dated 8/6/16 impairment and ide	ange Minimum Data Set 6, indicated a severe cognitive ntified R87 was independent room and in the corridor.				
		ange MDS dated 11/3/16, ot walk in his room nor in the observation period.				
		ssessment dated 11/9/16, not ambulatory at this time, r locomotion."				
		cian orders dated 1/17, potential was "good," and he ity "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.					
	Summary, signed 8 the significant chan summary contained including Restoration	ive Care Plan Review 8/26/16, was completed due to ge MDS, dated 8/6/16. The divarious care planned areas we Nursing. The summary not on a Restorative Nursing				
	identified R87 need and a walker for an	Plan of Care, dated 1/17, ling assistance of one staff abulation. There was no care plan regarding a program.				
		on 1/11/17, at 7:32 a.m.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 0.71	_,
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 19	2 915			
	already dressed an to slowly self prope was stripping the be room and offered to R87 to breakfast by	his wheelchair. R87 was d, once in wheelchair, began I to the door way. While NA-A ed linens, NA-C came into the o assist NA-A. NA-C assisted pushing him in his as not observed ambulating to				
	was observed self	on 1/11/17, at 12:51 p.m. R87 propelling in his wheelchair ter lunch. R87 was not ng 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.					
	was observed askir room. RN-B procee	on 1/12/17, at 10:12 a.m. R87 ng RN-B for a ride to the dining eded to push R87 into the ras not observed ambulating				
	stated R87 could st room; however, fur	1/12/17, at 7:30 a.m. NA-B rand and would walk in his ther stated that R87 was not walking and the staff would netimes."				
		1/12/17, at 8:06 a.m. RN-B walk with a walker, but was bendent.				
	stated R87 had a si	1/12/17, at 9:10 a.m. RN-C ignificant change MDS in provement in his mobility and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 915	5 Continued From page 20		2 915			
	then had a significate a decline in his most not ambulated during period because he and his walker had.  During interview on stated R87 was see 8/31/16, during white training. PT-A stated different walkers buunsafe with independent placing R8 program on 8/31/16 completed by the nexpected to be imp PT-A stated the fact restorative assistant.	ont change in November due to bility. She reported R87 had ang the November assessment had been unsafe to ambulate been put away after falling.  1/12/17, at 10:41 a.m. PT-A en by therapy from 8/9/16 to ch time he worked on gait d R87 had been trialed with at was ultimately assessed as andent ambulation. PT-A en a supervised walking so, which was suppose to be ursing assistants and was still lemented currently. However, ility did not have specific ts and was not aware if R87's completed consistently.				
	PT-A assisted R87 a transfer belt and tappeared eager to ambulate approxim R87 had no decline	on 1/12/17, at 10:54 a.m. to walk down the hallway with four wheeled walker. R87 ambulate and was able to ately 125 feet. PT-A reported in his ability to ambulate.				
	stated restorative p to the nursing assis NA-C was not awar walking program, fu	1/12/17, at 1:48 p.m. NA-C rograms were communicated stants by the nurse manager. The R87 had a supervised surther reporting she had in his room, but never in the				
	practical nurse (LPI programs were con "communication bo	1/12/17, at 1:54 p.m. licensed N)-A stated restorative nmunicated on the white ard," and was not aware R87 ogram. LPN-A further stated				

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PRINTED: 03/22/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00112 01/12/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 1 5 Continued From page 21 2 9 1 5 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

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(21) days

or designee could audit resident ambulation programs for ongoing compliance and report results to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty one

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING.			
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARL	JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 22	2 920			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs		2 920			2/21/17
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility fi needs (shaving) or of 3 residents (R12	ent is not met as evidenced ion, interview and document ailed to ensure grooming oral cares were provided for 2 0, R33) reviewed, who were aff assistance with activities of		corrected		
	11/7/16, identified F consciousness, see decisions, and requidressing, and persodependent for bathin R120 did not exhibit care. R120's ADL/Mobility included, "will be not daily." R120's nursing ass R120 was to receive mornings and was dressing, grooming During an observat R120 was lying in belevated. R120 had	inimum Data Set (MDS) dated R120 had altered level of verely impaired ability to make sired extensive assistance for onal hygiene, and was totally ing. The MDS further identified it behaviors of rejection of y Care Plan, last updated 1/17, eat, clean and well groomed istant care sheet included e a bath on Wednesday dependent on staff for 1, and bathing. ion on 1/10/17, at 10:06 a.m. bed with the head of the bed I several one-half inch to and black facial hairs under				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	R120 was lying in the her chin remained. During interview on assistant (NA)-L staneeded, once a we stated she had give morning, but did no because her superduring interview on practical nurse (LP attended to her facilike when staff did in During observation facial hair under R1 During interview on stated she perform that morning, but do During interview on stated R120's facial removed, but, "The They do the most in facial hair don't get On 1/12/17, at 3:01 (F)-A stated it would aware that she had "always kept them never shaved them always wondered a big deal about it." During interview on manager (UM)-A stalways shave resided R33's diagnosis as dated 11/23/16, inc.  The Care Area Ass	ion on 1/11/17, at 7:16 a.m. bed and the facial hairs under 1/11/17, at 9:11 a.m. nursing ated residents were shaved, if ek on their bath day. NA-Len R120 a bed bath early that it shave R120's facial hair visor had not told her to do so. 1/11/17, at 9:15 a.m. licensed N)-F stated R120's family fal hair because R120 did not it. on 1/12/17, at 9:24 a.m. the 120's chin, remained. 1/12/17, at 10:09 a.m. NA-O ed personal cares for R120 did not shave her facial hair. 1/12/17, at 10:48 a.m. LPN-G I hair should have been y [NAs] just don't have time. Inportant things, but things like done. "  p.m. R120's family member do bother R120 if she was facial hair because she clean." FM-A added, "I have [R120's facial hairs]. I've bout them, but never made a 1/12/17, at 4:40 p.m. unit ated she expected NAs to ents when needed.  identified on the face sheet luded Alzheimer's dementia.	2 920			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112	B. WING		01/1	2/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	R33 required assist and bathing. The C difficulty communic anticipated R33's n R33's care plan, resproblem area and care daily and PRN required the physical During observation nursing assistant (N resident's room to a After washing R33's area, NA-D and NA straightened her clock A small basket on the bathroom door was unopened package NA-E briefly left R3 mechanical lift to trathe wheel chair. Sea.m., NA-E pushed the hall and to the confered oral care.  During interviewed nursing assistant (N staff to help her clee "toothette" (a mouth NA-D stated she did R33 this morning, a was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares could also be gets up from her national states and the residual she was not offered oral cares.	stance with dressing, grooming CAA further indicated R33 had ating needs and staff eeds.  vised 1/17, identified an ADLs directed staff to provide oral (as needed), and that R33 al assistance of staff.  on 1/11/17, at 7:29 a.m.  NA)-D and NA-E entered the assist R33 with morning ADLs. Is face, hands and perineal and perineal are dressed R33, then othing, and combed R33's hair. The dresser near the R33's observed to contain several dof toothettes (mouth swabs). Is face and returned with a constant of the wheel chair at 7:42 R33 out of the room, down dining room. At no time during cares was R33 provided or on 1/11/17, at 9:10 a.m., NA)-D stated R33 required an her teeth, and used a newab) to clean her mouth. It do not complete oral care for and also acknowledged R33 I care. NA-D stated mouth a done before lunch after R33 ap.	2 920			
	a.m. R33 was awak	rvation on 1/11/17, at 11:12 se in her bed following a NA-G and NA-F entered the				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ΔΙΙΟΝ ΔΝΙ) (:ΔΚΙ		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	the provision of carquickly returned wit NA-G positioned a stransferred her from chair. NA-G placed head, then exited the chair out of the roor care, R33 was neith cares.  During interview on stated she did not perfect the care when she and noon meal. NA-G is her mouth cleaned morning.  In an interview on 1 practical nurse (LPI the aides to complete brushing, combing face, for residents with stated at a very mire completed at least in the would expect be least, the care be on the Review of the facility revised 10/16, inclusing the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the residents. The care ded support when the residents with the	3 with perineal care. Fe, NA-F left R33's room ha mechanical lift. No sling under R33, then he the bed into R33's will a stocking cap on R3 he room, pushing R33'm. During this provisioner provided nor offered 1/11/17, at 11:34 a.m. brovide R33 with any ord NA-F got R33 up for stated she thought R33 when she got up in the lift with the lift was a sic grooming, like of hair, and washing on who need assistance. In the morning and even the morning and even the morning and even the lift was a sic cares be done, or	m and A-F and heel 33's s wheel on of ed oral . NA-G ral the 3 had e censed expect e teeth f the LPN-C e to be ening. In LPN-B a stated r at eeds, es to ent eeds of ne ms their	2 920	DEL ROILING!)		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			A. BOILDING.				
		00112	B. WING		01/1	2/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 920	CareShave." Also compliance with ind during daily rounds outcomes."  SUGGESTED MET The director of nurs review policies and shaving/grooming/of the assessed need education to nursin directed by the care develop and implemensure ongoing complete the control of the care develop and implementations.	es but is not limited toMouth o included, "Observe dividualized interventions and monitor resident  THOD OF CORRECTION: sing (DON) or designee could procedures for providing oral care needs as directed by s of residents and provide g staff to follow cares as e plan. The facility could ment an auditing system to	2 920				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization progression of the control of the control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization progression of the control of the contr	O Subp. 4 A-I Infection Control and procedures. The infection list include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and so of infectious diseases; disprecautions systems to emission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 18.0810, and policies and lent care practices to assist in	21390			2/21/17	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
(V4) ID	SLIMMARV STA	ATEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21390	Continued From pa	ige 27	21390			
	the prevention and F. the development of the develo	treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and				
	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:			corrected		
	registered nurse (R and donned gloves with a green baske and a glucometer (I levels in the blood), an alcohol prep pad disposable lancet, measure R27's bloodid not clean or dison R27.	on 1/11/17, at 7:43 a.m. RN)-A washed RN-A's hands . RN-A went into R27's room t with lancets, alcohol wipes, devise used to measure sugar . RN-A wiped R27's finger with d and poked finger with a RN-A used a glucometer to od sugar level, hovever, RN-A infect the glucometer after use				
	R98's blood sugar	R98's room and checked with the same green basket r. RN-A did not clean or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUB			
(X4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
21390	Continued From pa	ge 28	21390			
	disinfect glucomete	r after use on R98.				
	R60's blood sugar vand the same glucodisinfect the glucon RN-A then went to R70's blood sugar vand the same glucodisinfect the glucon During observation brought the green becart and put the gree glucometer in the box and the same put the gree glucometer in the box and the same glucometer in the same glucometer i	R60's room and checked with the same green basked ometer. RN-A did not clean or neter after use on R60.  R70's room and checked with the same green basket ometer. RN-A did not clean or neter after use on R70.  on 1/11/17, at 7:55 a.m. RN-A basket to the north medication een basket with the used ottom drawer and locked the diwent to assist another staff.				
	stated she cleaned alcohol wipe betwee a Sani wipe (germic used also on the glucometer. RN-A the policy on glucor clean them with. Ri wipes and wiped the wipe and placed it is bottom of the north. When interviewed a director of nursing (should be wiped withen wrapped in a cominutes and after the in the cart to be sto shared glucometer each resident's use	on 1/12/17, at 4:40 p.m. the (DON) stated the glucometer that a purple top Sani cloth and clean wet Sani cloth for two wo minutes put the glucometer red. The DON stated the should be disinfected between				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00112	B. WING		01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Disinfect/Decontam staff to disinfect the following use on ea 1-Use the disinfect parts of the glucom 2-Remove gloves. 3-Perform hand hyo 4-Don clean gloves 5-Obtain a second 6-Use the wipe to c glucometer for the 17-Place the glucom Allow the meter to r required by the main before completing a 8-Remove gloves. 9-Perform hand hyo	ninate dated 7/2015, directed e glucometer with the wipes ach resident. Staff were to: ant wipe to clean all external leter with gloves on.  giene.  wipe and fresh paper towel. Elean all external parts of the second cleaning. The effect on the fresh paper towel. The remain wet for the contact time nufacturer's recommendation another glucose test.  giene.  er in appropriate storage until	21390			
	The director of nursing develop and implement and staff training repractices. The quacould perform rand compliance.	THOD OF CORRECTION: sing (DON) or designee could ment policies and procedures elated to infection control ality assurance committee om audits to ensure  R CORRECTION: Twenty one				
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease	21426			2/21/17

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SU COMPLET		
		00112	B. WING		01/12/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
21426	Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia be maintained by the	ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance nation of the guidelines.	21426			
	by: Based on interview facility failed to com screen and initial T for 5 of 5 employee NA-J) reviewed. In complete initial TB chest x-ray timely, of 5 (R183, R166) r testing.  Findings include:  EMPLOYEE SYMP TEST  Licensed practical r 12/6/16. LPN-D's e Baseline TB Screen Workers (HCWs), v	and document review, the aplete initial Tuberculosis (TB) suberculin Skin Testing (TST) as (LPN-D, NA-A, NA-I, RN-D, addition, the facility failed to symptom screen and obtain a and complete initial TST on 2 residents reviewed for TB  PTOM SCREEN AND SKIN  Purchase (LPN)-D was hired apployee file contained a aning Tool for Health Care which was completed, but was ening tool indicated LPN-D had		corrected		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURV COMPLETED	
			7.1. 20.23			
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ALION AND CARE	JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	received the first TS was no indication or TST had been read been administered, administration and Nursing assistant (INA-A's employee fi Reading, dated 4/1. TB. However, NA-A contain a Baseline Care Workers and symptom screen had symptom sc	ST on 12/5/16; however, there in the screening tool that the streening tool for the screening tool for Health there was no evidence a streening tool for the streening tool for the screening tool for the	21426			
		to the facility on 12/9/16.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00112	B. WING		01/1	2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB				
			VALLEY, MN		~		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	6 Continued From page 32		21426				
	Baseline Screening completed on 12/10 indication R183 had TST, as all fields to results were left bla						
	Review of R166's n Baseline Screening completed on 9/22/ admission. In additi tool indicated R166 TST, so a chest x-r negative, the chest	to the facility on 9/8/16. nedical record indicated a Tool for Patients had been 16, two weeks after his on, a hand written note on the was not a candidate for a ay was obtained. Although x-ray was obtained on ee 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."						
	director of nursing of policy was to perform step TST on new are further stated TST's admission of resident employees, and rear reported the evening responsible for ensured the evening responsible for ensured the evening responsible for ensured the step of TST's. The DON further the facility of the policy of	1/12/17, at 2:46 p.m. the (DON) stated the facility's m a symptom screen and two dmissions and new hires. She is should be done upon ents, upon hire of new ad within 48 to 72 hours. DON ag shift supervisor was uring TB screens and testing y new admission, and the insible for administering the rther reported that in ity had identified a problem testing and they were working					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		, ,	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		00112		B. WING		01/1	12/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21426	on an action plan to throughout the who During interview on director of human reducember they had screening and testing. The DHR stated the process for TB testing on TB screening employees to get TDHR reported he weemployees, address their TB testing done every other week Temployees. The DHC clinic on 12/21/16 with 1/18/17, and were set the street of	o address TB testing le building.  1/12/17, at 2:53 p.m. esource (DHR) stated identified employee may a not being come facility created a neing including getting including getting including getting is, and working with ST's/chest x-rays corress working on a letter sing the expectation the inc. He further reported inc. He further reported inc. He stated they had the with the next one scheet in the process of creening and testing the stated they had the control of the inc.	d that in TB npleted. w caught mpleted. r to to get d offering e initial	21426			
04505	The director of nurs in-service staff regaregulations for heal ensure compliance.  TIME PERIOD FOR (21) days.	R CORRECTION: Tw	d Ilosis audit to enty-one	24525			0.04.44.7
21565	Medications Self Ad Subp. 4. Self-adm self-administer med resident assessment care as required in	5 Subp. 4 Administrated min inistration. A resident dications if the compressive and comprehensive parts 4658.0400 and this practice is safe a	t may ehensive e plan of	21565			2/21/17

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 34	21565			
	is a written order fro	om the attending physician.				
	by: Based on observati review, the facility for practice of self adm safe for 1 of 1 resid medications left on administer.	ent is not met as evidenced on, interview, and document ailed to determine if the ninistration of medications was lent (R156) observed to have his bedside table to self		corrected		
	Findings include:					
	diagnoses of endoc	ecord identified R156 included carditis (inflammation of the enal disease, and major r.				
	dated 1/5/17, include with making decision living and had no poterm memory. In act R156 required extermobility and dressing the mobility and dressin	Minimum Data Set (MDS) ded R156 was independent ons regarding tasks of daily roblems with short and long dition, the MDS identified nsive assistance with bed ng, and required supervision eting, and personal hygiene.				
	R156's room was d covering his head. was on his bedside medication cup con	ion on 1/12/17, at 8:53 a.m. ark and the blankets were R156's covered breakfast tray table, and a clear plastic Itaining three white and blue the breakfast tray.				
	at 8:58 a.m. unit ma room. R156 had tak on his bedside table the garbage can be	ion and interview on 1/12/17, anager (UM)-A entered R156's ken the medications that were a and threw the plastic cup into side the bed. R156 told UM-A e into the room, and because				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CARL	INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 35	21565			
	on the table. UM-A the nurse to leave to "No, I was actually subt I covered my her During an interview registered nurse (Registered nurse (Registered nurse) in R156 sat up so her them, and then her I have stayed in the reswallowed the med During an interview	on 1/12/17, at 1:42 p.m. the				
	stay with residents medications unless	(DON) stated nurses should until they swallow their they have been assessed to eir own medications.				
	physician's order, d acetate [Phoslo] 66 mg) by mouth/per to meals." The clinical Self-Medication Da	linical record included a ated 12/29/16, for "calcium 7mg [milligrams] 3 caps (2001 ube three times daily with record also included a ta Collection and Assessment, ich identified R156, "prefers ster."				
	p.m. the DON state for self administration determined that he administer his median	nterview on 1/12/17, at 3:48 d when R156 was assessed on that the resident had wanted the facility staff to ications. The DON added that ave left them for R156 to take.				
	Administration, revi	y's policy, Medication sed 3/16, included, "Remain til all medication is taken."				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00112		B. WING		01/1	2/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21565	SUGGESTED MET The director of nurs review and re-educ assessments for re designee could aud staff/resident comp TIME PERIOD FOR (21) days	THOD OF CORRECT sing (DON) or designer ate staff on self-adminication passes liance.  R CORRECTION: Tw	ee could nistration for	21565			2/21/17	
21620	in accordance with  This MN Requirements: Based on observation review, the facility factories were labeled approfor 1 of 2 residents  Findings include:  R27's admission re R27's diagnoses in and hypertension.  R27's physician or condicated humulin Fimprove blood sugary 90 units subcutance breakfast.  During observation registered nurse (R	part 6800.6300.  ent is not met as evice on, interview, and do ailed to ensure medipriately prior to admir	denced cument cations nistration  ndicated rt failure,  117, d to to inject ore .m. with humulin	21020	corrected		2/21/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00112	B. WING		01/1	2/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 CO	DDRESS, CITY, S UNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	During interview on stated R27's humul labeled correctly. Forders are for 90 ur R27. RN-A stated to relabeled the humul units not 85 units of have never seen not changes, the pharminsulin pen with the A facility policy 4.5 ligible Discontinuing Ordestaff to attach a "Crithe existing quantity" SUGGESTED MET The director of nurse could in-service all medication use on the requirements as with the state of the service and the ser	1/11/17, at 7:40 a.m. RN-A in R insulin pen was not RN-A stated the physician hits of humulin R to be given to the pharmacy should have lin R insulin pen to have 90 humulin R. RN-A stated, "I we labels come with dose hacy would have to relabel the correct dose."  Reordering, Changing, and rs, dated 10/31/16, directed hange in Directions" sticker to	21620			
21675	(21) days  MN Rule 4658.1410	) Linen	21675			2/21/17
	and transport linens of infection according program and policies 4658.0800. These comply with the mathe laundering equinclude a wash form	must handle, store, process, so as to prevent the spreading to the infection control es as required by part laundering policies must nufacturer's instructions for pment and products and nula addressing the time, hardness, bleach, and final				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00112	B. WING		01/1	12/2017
_	PROVIDER OR SUPPLIER	ATION AND CARE 7505 C	ADDRESS, CITY, OUNTRY CLU EN VALLEY, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21675	Continued From pa	ge 38	21675			
	by: Based on observati review, the facility fa items were consisted spread of infection.	ent is not met as evidenced on, interview, and document ailed to ensure soiled laundrently contained to prevent the This had the potential to who lived on the 1st floor of	/	corrected		
	Findings include					
	2:07 p.m. the 1st floinspected. The local laundry cart, approximate and 4' high, and was opening of a stainle cart overflowed with laundry items. The bed spreads, various cloths and bed mat laundry items were were ripped, their con the floor of the soiled bed pads we side of the cart, and	ur of the facility on 1/9/17, at or, soiled utility room was ked room housed a plastic kimately 4' (feet) by 5' wide, is positioned under the ess steel laundry chute. The hagged and unbagged items included bed sheets, is sizes of bath towels, wash tress pads. Most of the bagged, but numerous bags ontents laying in the cart and oiled utility room. Visibly re draped in and along the drone of the bed pads was and among other towels on the	ı			
	housekeeping man room was full, and tun-bagged laundry laundry and towels the chutes were me and when the bags	/9/17 at 2:09 p.m. the ager (HM) stated the laundry there was bagged and in the cart, and some other on the floor. The HM stated etal, and had some edges on were sent down the chute, and the laundry spilled out.				
	During a later obse	rvation on 1/9/17, at 6:45 p.n	n.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED	
		00112	B. WING		01/	12/2017
	PROVIDER OR SUPPLIER  VALLEY REHABILIT	ATION AND CARE 7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21675	the 1st floor soiled overfilled with launch bagged laundry iter were also observed.  During observation at 10:34 a.m., a hor resident room acrosutility room. The la again observed over was backed up with laundry, all tied, and gown, were all observed on the laundry cart done a couple of tir sees the soiled launcame down the chuun-bagged, soiled laundry chute went items" were to be bushed when interview on stated carts in the stremoved three times overflowing. The HI bags do rip, and that tightly. The HM stat always bag soiled la staff were trained owere new people wome the HM then state opportunity" for state of soiled linen.  A facility policy, Infectioner, effective July	utility room cart was not dry, and contained mostly ins. Several large bath towels I in the cart, unbagged.  the next morning on 1/10/17 usekeeper was working in as from the 1st floor soiled undry cart in the room was erfilled, and the laundry chute in laundry. Five bags of d a visibly soiled hospital erved on the floor in the room.  On 1/10/17, at 10:55 a.m.  B stated she was swapping s, which was a task that was ne every day. HK-B stated she adry as mostly bagged when it atte, but has often seen aundry. The HK-B stated the to the 4th floor, and added "all	21675			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ΔΠΟΝ ΔΝΟ (:ΔΒΙ	INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21675	Continued From pa	ge 40	21675			
	precautions would be soiled linens. The p was to be bagged a	e policy indicated standard per followed when handling solicy directed all soiled linen and collected by cart at the tervals, and not allow hampers				
	The director of environmental serveducation to all invodevelop a monitorir	THOD FOR CORRECTION: ronmental services could ne policies and procedures dling. The director of ices or designee could provide blved staff. The facility could no system to ensure ongoing port the findings to the quality ee.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			2/21/17
	provide housekeep necessary to mainta comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting,				
	by: Based on observati review, the facility fa sanitary toilet in the	on, interview and document ailed to maintain a clean and shower room on the 1st floor ntial to affect 26 residents who		corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG:		(X3) DATE SURVEY COMPLETED		
		00110	B. WING		04/	10/0017
		00112			01/1	12/2017
NAME OF	PROVIDER OR SUPPLIER		•	Y, STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ΔΠΟΝ ΔΝΗ (:ΔΕΙ	COUNTRY CL DEN VALLEY, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	age 41	21695			
	utilized the shower					
	Findings include:					
	resident shower/ba facility was inspected hallway led into the entrance, a full priviceiling to the floor. wash cloths were of and there was a toil. The floor area and behind the toilet was was an unidentified substance which convalls behind and all floor between the wapproximately 8" (in with this same, unknown that the converse of	on 1/9/17, at 7:24 p.m. the athroom on the 1st floor of the d. A large door from the reshower room, and upon eacy curtain hung from the Three large bath towels an observed scattered on the filet in the corner of the room wall directly to the left of an as heavily soiled. The soiling, brown-colored and covered and adhered to the long side the toilet. The tile wall and toilet, an area inches) x 20", was also cover and substance. Although on the substance of the s	he main and loor, m. and ang e			
	nursing assistant (N presence of the soi corner of the showe as the towels on the NA-I stated she wo	on 1/9/17, at 7:27 p.m. NA)-I acknowledged the iled wall and floors in the er room near the toilet, as the floor in the shower room. Indered if someone got sick it needed to be cleaned.				
	resident exited from she ambulated pas pointed to the room the mess was in the shower room. Upo 1st floor bathroom/ the area, the walls	at 1/10/17, at 10:52 a.m. and the shower/bathroom, and the surveyor, the resident is stated it was "the third date bathroom and pointed to in a subsequent review of the shower after the resident land floor area surrounding the was found the previous designed.	t y" the he eft the			

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AND BLAN OF CORRECTION LINES.		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		01/1	12/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 CO	DDRESS, CITY, S UNTRY CLUE I VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21695	heavily soiled and upon asked about the so room/bathroom, lice stated she saw a recarlier, and indicate the bathroom dirty. bathroom she state she would get some LPN-E also stated is shower rooms were was unaware of the how long the 1st flow During interview on housekeeper (HK)-cleaned everyday. know why the 1st flow also stated those reshowers were clear daily.  During interview abshower/bathroom of stated she thought to who can clean whousekeeping cannursing would have (bowel movement), disinfect an area. Lestaff, that shower for stated whoever for communicated rights should have taken and then let housekeep During interview on	1/10/17, at 11:01 a.m. when iled resident shower ensed practical nurse (LPN)-E esident use the bathroom ed the resident may have got When LPN-E looked at the ed, "Oh, my God!" and added eone to clean it up right away. resident bathrooms and e cleaned on a daily basis, but emess in this bathroom, or for bathroom had been dirty.  1/10/17, at 1:53 p.m. A stated shower rooms were HK-A stated shower rooms were HK-A stated she did now for shower was not clean, and esident bathrooms and fined, mopped and disinfected out the unclean 1st floor in 1/12/17, at 7:18 a.m. LPN-B there was some confusion as that. LPN-B stated for clean bodily fluids, and to initially clean up any BM then notify housekeeping to LPN-B stated with all the new form got missed. LPN-B and the mess should have the away, and one of the nurses action, cleaned it themselves, seeping know.				
	housekeeping man	ager (HM) stated that did not clean bodily fluids, that				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00112	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ALION AND CARL	INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	blood borne policy, been some mis-cor aides and staff. Th some kind of staff is staff need to be edu was good to have the A facility document, bloodborne Pathogundated, indicated that is contaminated of blood or other bonursing personnel of decontamination. If their employees "and decontaminated are A facility document, Inc, Housekeeping provided direction for Cleaning." Included to "clean and sanitisfloor."  SUGGESTED MET The director of main bathrooms were clemaintenance could to ensure ongoing of assurance committed monitor the effective staff.	ne HM explained the facility but stated there must have munication between the e HM stated they need to do nservice, and it was something ucated on, and also stated it his brought to staff's attention.  If the Health Service Group, ens Employee Handbook, "Any equipment or furniture d with visibly large quantities odily fluids will be referred to of the client facility for The document further indicated to only to clean previously eas"  Healthcare Services Group, Inservice, dated 1/1/2000, or "7-Step Daily Washroom d in the inservice was direction are commode" and "damp mop of the director of develop a monitoring system compliance. The quality ee could develop a system to	21695			
21942	MN St. Statute 144. Resident and Famil	A.10 Subd. 8b Establish ly Councils	21942			2/21/17

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From pa	ge 44	21942			
	boarding care home advisory council an fewer than three pe participating. If one function, the nursin home shall docume council or councils year. This subdivisi	council. Each nursing home or e shall establish a resident d a family council, unless resons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ites provided by section in 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.			corrected		
	change in the direct and there was no edirector's paperwork attempt to form a fayear.  Review of the facility dated 7/15, included recruitment and not and the facility of the facility dated 7/15, included the facility of the facilit	If there had been a recent tor of social services position vidence in the previous k that there had been an amily council during the past by's policy, Family Council, d, "Conduct continual cify families/resident				
	for meetings: Send families and reside	d post a routine time and place notification to all current nt representativesPost lace in center lobby using the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00112			B. WING		01/	01/12/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN VALLEY REHABILITATION AND CARE  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	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE	
21942	Family Council Mee brochures or fliers to to other families and they see when they SUGGESTED MET director of nursing ( review or revise pol staff regarding form	eting NoticeProduc hat council members d resident represent	s can give atives  FION: The ee could tion for Council.	21942			