Office of Health Facility Complaints Investigative Report

Facility Name:	Report Number:	Date of Visit:	
Golden Valley Rehab and CC	H5186247	August 7, 2017	
Facility Address:	Time of Visit:	Date Concluded:	
7505 Country Club Drive	9:00 a.m. to 4:45 p.m.	January 10, 2018	
Facility City:	Investigator's Name and Title:		
Golden Valley	Lissa Lin, RN, Special Investigator		

State:

Minnesota

ZIP: 55427

County: Hennepin

Nursing Home

⊠ Complaint

Allegation(s):

It is alleged that a resident was neglected when facility staff failed to provide adequate medical care for resident's PICC line. Resident was hospitalized for PICC line infection.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence neglect is substantiated. The facility failed to provide adequate medical care for the resident's peripherally inserted central catheter (PICC) line. The facility did not remove the resident's PICC line per physician's order or follow IV site and tubing care protocol. The resident developed a temperature and was sent to the hospital with an infected PICC line.

The resident had spina bifida, osteomyelitis, a colostomy, a urostomy, methicillin-resistant staphylococcus aureus (MRSA) infections, and a history of receiving IV antibiotics through an indwelling PICC line for sepsis from non-healing wounds. The PICC line is a peripherally inserted central catheter used to give intravenous medications, often antibiotics, for long-term therapy. The resident was assessed as cognitively intact, non-ambulatory, and needed the assistance of two staff for transfers and one staff for activities of daily living.

The facility assessed and implemented interventions for the resident's wounds. The resident's care plan interventions included monitoring for signs and symptoms of infection: redness, drainage, odor, pain, and temperature. The resident's care plan indicated to follow IV site and tubing care per protocol.

The resident was hospitalized and then readmitted to the facility with orders for IV antibiotics. Nursing staff assessed and documented the PICC line's patency but there was no documentation indicating the PICC line dressing was assessed, changed, or that the IV site and tubing care protocol was followed.

Facility Name: Golde	Facility Name: Golden Valley Rehab and CC									
The resident's medic		ation records did not indicate an	y PICC line dressing							
	•	er from the resident's infectious mentation found on the resident	• •							
on-call physician. The until the next morning	Five days later the resident developed a temperature. The nurse assessed the resident and contacted the on-call physician. The physician ordered labs and an x-ray for the resident. Lab services were not available until the next morning; the staff nurse contacted the on-call physician and received a telephone order to send the resident to the hospital for evaluation.									
During an interview, around the PICC line adhered to his/her s	ER staff said the resident's arr site. The PICC line was still in p kin because it was heavily soile	to the emergency room (ER) with n was red, swollen, and foul smel place but the dressing covering the ed with crusted flaky skin. Emerge dent was hospitalized elsewhere	ling drainage oozed out ne site no longer ency room staff said the							
The resident was ad	mitted to the hospital for an in	fected PICC line.								
assessed daily wheth		PICC line site should have been tresaid the PICC line should have beer.								
During an interview, are resolving.	a family member said the resi	dent has moved to a new facility	and his/her infections							
Minnesota Vulnerabl	e Adults Act (Minnesota Statu	tes, section 626.557)								
Under the Minnesota	Vulnerable Adults Act (Minne	esota Statutes, section 626.557):								
☐ Abuse	Neglect Neglect	☐ Financial Exploitation								
Substantiated ■	☐ Not Substantiated	☐ Inconclusive based on th	e following information:							
Mitigating Factors:										

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was

⊠ Neglect ☐ Financial Exploitation. This determination was based on the following:

determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse

Report Number: H5186247

possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:
State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.
Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.
Deficiencies are issued on form 2567: ▼ Yes □ No
(The 2567 will be available on the MDH website.)
State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.
State licensing orders were issued: $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$
(State licensing orders will be available on the MDH website.)
State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 & 144A were not met.
State licensing orders were issued: 🗵 Yes 🔲 No
(State licensing orders will be available on the MDH website.)
Compliance Notes:
Facility Corrective Action: The facility took the following corrective action(s):
Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

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- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- Medical Records
- Care Guide
- Medication Administration Records
- ▼ Weight Records
- **X** Nurses Notes
- **X** Assessments
- N Physician Orders
- **▼** Treatment Sheets
- | Physician Progress Notes
- Social Service Notes
- **X** Skin Assessments
- **▼** Facility Incident Reports
- **X** Activities Reports
- ▼ Laboratory and X-ray Reports
- Therapy and/or Ancillary Services Records

| ADL (Activities of Daily Living) Flow Sheets Other pertinent medical records: ▼ Hospital Records Additional facility records: Staff Time Sheets, Schedules, etc. Personnel Records/Background Check, etc. | Facility Policies and Procedures Number of additional resident(s) reviewed: Two Were residents selected based on the allegation(s)? \bigcirc N/A Yes \bigcirc No Specify: Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Yes \bigcirc No \bigcirc N/A Specify: Interviews: The following interviews were conducted during the investigation: Interview with complainant(s) • Yes No \bigcirc N/A Specify: If unable to contact complainant, attempts were made on: Date: Time: Date: Time: Date: Time: Interview with family: () Yes O No ○ N/A Specify: Did you interview the resident(s) identified in allegation: ○ N/A Specify: Moved to another facility Yes No Did you interview additional residents? (•) Yes \bigcirc No Total number of resident interviews: Four Interview with staff: () Yes \bigcirc N/A \bigcirc No Specify: **Tennessen Warnings** Tennessen Warning given as required:

Yes O No Total number of staff interviews: Nine Physician Interviewed:

Yes \bigcirc No Nurse Practitioner Interviewed: No Yes Physician Assistant Interviewed: Yes No

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Interview with Alleged Perpetrator(s): O Yes \bigcirc No N/A Specify: Attempts to contact: Date: Time: Date: Time: Date: Time: If unable to contact was subpoena issued: O Yes, date subpoena was issued No Were contacts made with any of the following: ▼ Emergency Personnel □ Police Officers □ Medical Examiner □ Other: Specify Observations were conducted related to: Wound Care Personal Care Nursing Services **X** Call Light X Infection Control ▼ Use of Equipment X Medication Pass Cleanliness Dignity/Privacy Issues Safety Issues **Restorative Care** X Transfers **X** Meals X Injury Incontinence Was any involved equipment inspected: ○ Yes ○ No N/A Was equipment being operated in safe manner: () Yes \bigcirc No N/A Were photographs taken: \(\) Yes No Specify: cc: **Health Regulation Division - Licensing & Certification** Minnesota Board of Examiners for Nursing Home Administrators

Report Number: H5186247

Facility Name: Golden Valley Rehab and CC

The Office of Ombudsman for Long-Term Care

Report Number: H5186247

Hennepin County Attorney

Golden Valley Police Department

Golden Valley City Attorney



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2017

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

RE: Project Numbers: S5186032, H5186226, H5186228, H5186233

H5186240, H5186243 and H5186247

Dear Ms. Scoville:

On July 28, 2017 and October 18, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 2, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letters of July 28, 2017 and October 18, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 15, 2017.

This was based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey completed on June 15, 2017, an abbreviated standard survey completed on July 10, 2017 and lack of verification of compliance with deficiencies issued pursuant to the June 15, 2017 and July 10, 2017 abbreviated standard surveys, at the time of our July 28, 2017 notice. The most serious deficiency was found to be a widespread deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 4, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid Programs. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

Golden Valley Rehabilitation and Care Center November 22, 2017 Page 3

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 15, 2017, is to be discontinued, effective November 13, 2017. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 15, 2017, is to be discontinued, effective November 13, 2017.

Further, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 18, 2017:

- Civil Money Penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for the deficiency cited at F373, be imposed. (42 CFR 488.430 through 488.444

The CMS Region V Office will notify you of their determination regarding the recommended remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition and appeal rights.

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

Kato Combon

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Office of Health Facility Complaints File

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: ___ R-C B. WING 00112 11/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY OPCO LLC GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) 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 the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5186247. Golden Valley Rehabilation and Care Center was found in compliance with state regulations.

Minnesota Department of Health

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

The facility is enrolled in ePOC and therefore a

TITLE

(X6) DATE

Electronically Signed

11/27/17

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ R-C B. WING 11/15/2017 00112 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY OPCO LLC GOLDEN VALLEY, MN 55427** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Continued From page 1 signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.

Minnesota Department of Health

PRINTED: 02/07/2018 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186		B. WING		1	R-C 15/2017
	NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY OPCO LLC			STREE 7505 C	COUNTRY CLUB DRIVE DEN VALLEY, MN 55427	1 11/	13/2017
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{F 000}	November 14, 201 issued relate to cor Valley Rehabilitaior compliance with 42 requirements for LoThe facility is enroll signature is not required page of the CMS-2 correction is require	revisit was conducted on 7, to follow up on deficiencies in the state of the state	{F 0	00}			
ARORATORY	DIRECTORIS OF PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

Electronically Signed

11/27/2017

PRINTED: 10/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 000	INITIAL COMMENT	rs	F(000			
F 309 SS=G	to investigate case #H5186247. As a reis issued related to is enrolled in ePOC not required at the ICMS-2567 form. EPOC will be used a 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life Quality of life is a fuapplies to all care a residents. Each refacility must provide services to attain or practicable physica well-being, consisted comprehensive assessment of a re that residents receivance with propractice, the comprehensive with propractice, the comprehensive in the comprehensive with propractice, the comprehensive in the comprehensive with propractice, the comprehensive in the comprehensive with propractice, the comprehensive must be provided to resident consistent with profits with profi	e indamental principle that and services provided to facility sident must receive and the extensive the necessary care and maintain the highest individual in the highest individual in the highest individual in the highest individual in the highest individual indiv	F3	309			
_ABORATOR\		ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 309	(I) Dialysis. The faresidents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREME by: Based on interview facility failed to ensorder to remove a part catheter (PICC) for reviewed. R1's PIC did not assess or cR1 had an increase the hospital, and winfection. Findings include: R1's medical recorbifida, osteomyelitic paraplegia, neurog colostomy, a urost central catheter (Pladminister medical R1's Brief Interview 1/27/17, with a scomild cognitive imparance of the assistance daily living (ADLs). indicated R1 had a a secondary intravehad a history of records.	age 1 goals and preferences. cility must ensure that tire dialysis receive such at with professional standards residents' goals and NT is not met as evidenced v and document review, the sure staff followed the physician peripherally inserted central rone of three residents, (R1), and the professional staff thange the PICC site dressing. In temperature, was sent to as diagnosed with a PICC line d was reviewed. R1 had spinal as, chronic pressure ulcers, enic bladder and bowel, a compand a peripherally inserted and staff thange the professional service of 13-15, indicated no or airment. R1's care plan dated and ance of two staff for transfers of one staff for activities of R1's care plan dated 5/16/17 rash to arms and legs due to be enous (IV) antibiotic allergy. R1 serving IV antibiotics through a serving IV ant	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		TE SURVEY MPLETED	
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F 309	readmitted to the far order to receive IV beginning 6/23/17 at R1's skin assessme indicated a left side forearm. A physician's order facility nursing staff (mg)/200 milliiters (hours for six days or infection in the blood R1's nursing note downward readmitted to the far IV vancomycin, and 8:00 a.m. and a skin R1's nursing note downward PICC line was pate of infection and IV vancomycin, and R1's care plan date methicillin-resistant wounds and a yeas plan interventions for monitoring for signs	ated 6/22/17 indicated R1 was acility from the hospital with an antibiotic vancomyocin at 8:00 a.m. ent form dated 6/22/17 two lumen PICC line in R1's dated 6/22/17 instructed to administer 1000 milligrams ml) of vancomycin every 12 lue to a staphylococcus	F 30	•		
	temperature. R1's of indicated to follow to protocol. R1's nursing note of vancomycin was accompled.	eare plan dated 6/27/17 he IV site and tubing care per n 6/29/17 indicated IV Iministered.	·			
	R1 had no treatmer	nt administration record (TAR)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 309	for June 2017. R1's the June 2017 med (MAR) and address buttock rashes, and 2017 MAR had no orders to assess and dressing. Copies of R1's Jurfrom the facility but R1's June 2017 MAR A physician's order nursing staff to disc 6/29/17 and removements of the staff of	s treatments were written on dication administration record sed R1's gluteal wound cares, d left arm rash. R1's June physician or hospital discharge ad/or change R1's PICC line are 2017 TAR were requested were not received. Copies of AR were received. dated 6/29/17 instructed continue R1's vancomycin on	F3	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 309	consultation note PICC line was ren cultured and had go when interviewed registered nurse (check the PICC line redness, and drain PICC line training when interviewed director of nursing managers do rour if there is a conce when interviewed member (FM)-H scondition because scaly, they had all hour, and she still hospital. FM-H sa infection has improved when interviewed medical doctor (Maily assessment PICC line whether the responsibility ophysician if staff a line dressing char MD-J said the expremoved by facility the order. When interviewed emergency room was swollen, red as well and had all the conder.	us disease physician dated 7/6/17 indicated R1's noved in the ER on 7/4/17 and gram negative bacilli present. on 08/07/2017 at 2:01 p.m., RN)-A said it was important to ne site regularly for swelling, nage. RN-A said she never had	F3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	245186	D. WING			10/	04/2017
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F 309	flowed from R1's un touched. RN-H said facility never chang RN-H said commor line dressing every is soiled or loose. The facility policy tit Device (CVAD) Dre 2016 addressed the and cares: insertior for bacteria that car infections; a transpais preferred but ster be used; transparer changed at least we wet, soiled or loose be changed every tis wet, soiled or loose be changed every tis wet, soiled or loose be changed at least e continuous therapy infusions and at lea use. A assessment infusion-related con entire arm with the include erythema, dinduration, change along vein tract and measuring the lengindicated during dresides.	ncovered PICC line site when I R1 told hospital staff the ed her PICC line dressing. In practice is to change a PICC 72 hours or when the dressing cled Central Vascular Access ssing Change dated May e following PICC line issues a site is a potential entry site in cause catheter-related arent dressing over the PICC rile gauze and tape may also not dressings need to be eakly or when the dressing is sterile gauze dressings must wo days or when the dressing se; the access site should be very two hours during before and after intermittent st once every shift when not in for signs and symptoms of applications; assessment of the indwelling vascular device trainage, swelling or of skin temperature at site or integrity of the dressing; the of the external catheter is	F	309			

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: __ C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE 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 the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** A complaint investigation was conducted to investigate complaint #H5186245, #H5186546 and #H5186247. As a result, the following correction orders are issued related to case #H5186247. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of

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

TITLE

(X6) DATE

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
	INVEST.	00112	B. WING	B. WING		, 4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	AHON AND CARL	INTRY CLUE VALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	http://www.health.s obul.htm The Stat delineated on the a Department of Hea electronically. Althonecessary for State the word "corrected Then indicate in the process, under the date your orders wine electronically subm Department of Hea	Ith orders being submitted bugh no plan of correction is Statutes/Rules, please enter "in the box available for text. e electronic State licensure heading completion date, the II be corrected prior to itting to the Minnesota lth.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			
	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 t	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 ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to ens order to remove a p catheter (PICC) for	and document review, the ure staff followed the physician peripherally inserted central one of three residents, (R1), C was not removed and staff				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			A. DOILDING.	THE THIRD THE		:
	100	00112	B. WING		1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	AHON AND CARL	INTRY CLUB VALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	COMPLETE DATE
2 830	Continued From pa	ge 2	2 830			
	R1 had an increase	hange the PICC site dressing. in temperature, was sent to as diagnosed with a PICC line				
	Findings include:					
	bifida, osteomyelitis paraplegia, neurogocolostomy, a urostocentral catheter (PI administer medicat R1's Brief Interview 1/27/17, with a scomild cognitive impa 1/27/17 indicated Prequired the assistance daily living (ADLs). indicated R1 had a a secondary intravehad a history of reco	d was reviewed. R1 had spina s, chronic pressure ulcers, enic bladder and bowel, a omy and a peripherally inserted CC) line placed in a forearm to ions for extended periods. To feet of 13-15, indicated no or irment. R1's care plan dated ance of two staff for transfers of one staff for activities of R1's care plan dated 5/16/17 rash to arms and legs due to enous (IV) antibiotic allergy. R1 eiving IV antibiotics through a s from non-healing wounds.				
	readmitted to the fa	lated 6/22/17 indicated R1 was acility from the hospital with an antibiotic vancomyocin at 8:00 a.m.				
		ent form dated 6/22/17 two lumen PICC line in R1's			:	
	facility nursing staff (mg)/200 milliiters (dated 6/22/17 instructed to administer 1000 milligrams (ml) of vancomycin every 12 due to a staphylococcus datream.				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
			A. BOILDING.			.						
00112		00112	B. WING		C 10/04/2017							
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE								
GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY MN 55427												
GOLDEN VALLEY, MN 55427 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)												
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLETE DATE							
2 830	Continued From page 3		2 830									
	R1's nursing note dated 6/22/17 indicated R1 was readmitted to the facility with an order to receive IV vancomycin, an antibiotic, beginning 6/23/17 at 8:00 a.m. and a skin assessment was done. R1's nursing note dated 6/26/17 indicated the											
		nt with no signs or symptoms /ancomycin was administered.										
	methicillin-resistant wounds and a yeas plan interventions for monitoring for signs increased redness, temperature. R1's of	d 6/27/17 indicated R1 had staphyloccus aureus (MRSA) trash to buttocks. R1's care or R1's wounds included and symptoms of infection: drainage, odor, pain and eare plan dated 6/27/17 he IV site and tubing care per										
	R1's nursing note o vancomycin was ac	n 6/29/17 indicated IV Iministered.										
	for June 2017. R1's the June 2017 med (MAR) and address buttock rashes, and 2017 MAR had no	nt administration record (TAR) at treatments were written on ication administration record sed R1's gluteal wound cares, at left arm rash. R1's June onlysician or hospital discharge ad/or change R1's PICC line										
		were requested were not received. Copies of R were received.										
		dated 6/29/17 instructed continue R1's vancomycin on the PICC line.										
	R1's primary physic	cian progress note dated										

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED						
		00112	B. WING									
			10/04/2017			14/2011						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
GOLDEN VALLEY REHABILITATION AND CARI												
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 (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE						
2 830	Continued From page 4		2 830									
	7/3/17 indicated R1 6/18/17 to 6/22/17 f	was hospitalized from for sepsis. The progress note usceptible to sepsis.										
	assessment and re communication for indicated R1 had a The nurse notified t	nd situation, background, commendation (SBAR) n, both dated 7/4/2017 temperature of 102 degrees. the on-call physician and o send R1 to the hospital for										
	7/4/17 indicated R1 ER was a concern than doriented but dissible in R1's left arm uncovered. The clession longer sticking to R heavily soiled with contents.	om (ER) progress note dated 's condition on arrival at the to hospital staff. R1 was alert sheveled. The PICC line was and the insertion site was ar Tegaderm dressing was no 1's skin because it was so crusted flaking skin. R1's PICC ated 6/22/17, 12 days earlier.										
	PICC line was remo	s disease physician ated 7/6/17 indicated R1's oved in the ER on 7/4/17 and am negative bacilli present.										
	registered nurse (R check the PICC line	on 08/07/2017 at 2:01 p.m., N)-A said it was important to e site regularly for swelling, age. RN-A said she never had t the facility.										
	director of nursing (managers do round	on 8/7/2017 at 3:41 p.m., the (DON)-F said the unit ling with the wound doctor and she would look at it.										
		on 9/12/17 at 1:37 p.m., family id she was upset about R1's										

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PRINTED: 10/05/2017 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: C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARL GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 830 Continued From page 5 2 830 condition because she looked pale, her skin was scaly, they had already cleaned her up for an hour, and she still looked bad when she got to the hospital. FM-H said R1 lives at a new facility; her infection has improved and her skin is healing. When interviewed on 9/25/17 at 10:00 a.m., medical doctor (MD)-J said there should be a daily assessment and documentation of R1's PICC line whether used or not. MD-J said it was the responsibility of nursing staff to contact a physician if staff are not sure about R1's PICC line dressing changes or PICC line removal. MD-J said the expectation was R1's PICC line be removed by facility nursing staff within 24 hours of the order. When interviewed on 10/02/17 at 9:00 a.m., emergency room RN-H said R1's left upper arm was swollen, red and tender on arrival at the emergency room. Yellow, foul-smelling pus flowed from R1's uncovered PICC line site when touched. RN-H said R1 told hospital staff the facility never changed her PICC line dressing. RN-H said common practice is to change a PICC line dressing every 72 hours or when the dressing is soiled or loose. The facility policy titled Central Vascular Access Device (CVAD) Dressing Change dated May

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2016 addressed the following PICC line issues and cares: insertion site is a potential entry site for bacteria that can cause catheter-related infections; a transparent dressing over the PICC is preferred but sterile gauze and tape may also be used; transparent dressings need to be changed at least weekly or when the dressing is wet, soiled or loose; sterile gauze dressings must be changed every two days or when the dressing is wet, soiled or loose; the access site should be

PRINTED: 10/05/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: ___ C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 6 2 830 assessed at least every two hours during continuous therapy, before and after intermittent infusions and at least once every shift when not in use. A assessment for signs and symptoms of infusion-related complications; assessment of the entire arm with the indwelling vascular device include erythema, drainage, swelling or induration, change of skin temperature at site or along vein tract and integrity of the dressing: measuring the length of the external catheter is indicated during dressing changes or if signs/symptoms of complications are present. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary. educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days. 21850 21850 MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac. Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in

section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited

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The facility policy titled Central Vascular Access Device (CVAD) Dressing Change dated May 2016 addressed the following PICC line issues and cares: insertion site is a potential entry site for bacteria that can cause catheter-related infections; a transparent dressing over the PICC is preferred but sterile gauze and tape may also be used; transparent dressings need to be changed at least weekly or when the dressing is

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CAR! GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 21850 21850 Continued From page 8 wet, soiled or loose; sterile gauze dressings must be changed every two days or when the dressing is wet, soiled or loose; the access site should be assessed at least every two hours during continuous therapy, before and after intermittent infusions and at least once every shift when not in use. A assessment for signs and symptoms of infusion-related complications; assessment of the entire arm with the indwelling vascular device include erythema, drainage, swelling or induration, change of skin temperature at site or along vein tract and integrity of the dressing: measuring the length of the external catheter is indicated during dressing changes or if signs/symptoms of complications are present. R1's medical record was reviewed. R1 had spina bifida, osteomyelitis, chronic pressure ulcers, paraplegia, neurogenic bladder and bowel, a colostomy, a urostomy and a peripherally inserted central catheter (PICC) line placed in a forearm to administer medications for extended periods. R1's Brief Interview of Mental Status dated 1/27/17, with a score of 13-15, indicated no or mild cognitive impairment. R1's care plan dated 1/27/17 indicated R1 was non-ambulatory and required the assistance of two staff for transfers and the assistance of one staff for activities of daily living (ADLs). R1's care plan dated 5/16/17 indicated R1 had a rash to arms and legs due to a secondary intravenous (IV) antibiotic allergy. R1 had a history of receiving IV antibiotics through a PICC line for sepsis from non-healing wounds. R1's nursing note dated 6/22/17 indicated R1 was readmitted to the facility from the hospital with an order to receive IV antibiotic vancomyocin beginning 6/23/17 at 8:00 a.m. R1's skin assessment form dated 6/22/17

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 21850 21850 Continued From page 9 indicated a left side two lumen PICC line in R1's forearm. A physician's order dated 6/22/17 instructed facility nursing staff to administer 1000 milligrams (mg)/200 milliters (ml) of vancomycin every 12 hours for six days due to a staphylococcus infection in the bloodstream. R1's nursing note dated 6/22/17 indicated R1 was readmitted to the facility with an order to receive IV vancomycin, an antibiotic, beginning 6/23/17 at 8:00 a.m. and a skin assessment was done. R1's nursing note dated 6/26/17 indicated the PICC line was patent with no signs or symptoms of infection and IV vancomycin was administered. R1's care plan dated 6/27/17 indicated R1 had methicillin-resistant staphyloccus aureus (MRSA) wounds and a yeast rash to buttocks. R1's care plan interventions for R1's wounds included monitoring for signs and symptoms of infection: increased redness, drainage, odor, pain and temperature. R1's care plan dated 6/27/17 indicated to follow the IV site and tubing care per protocol. R1's nursing note on 6/29/17 indicated IV vancomycin was administered. R1 had no treatment administration record (TAR) for June 2017. R1's treatments were written on the June 2017 medication administration record (MAR) and addressed R1's gluteal wound cares. buttock rashes, and left arm rash. R1's June 2017 MAR had no physician or hospital discharge orders to assess and/or change R1's PICC line dressing.

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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: __ C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7505 COUNTRY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) 21850 Continued From page 10 21850 Copies of R1's June 2017 TAR were requested from the facility but were not received. Copies of R1's June 2017 MAR were received. A physician's order dated 6/29/17 instructed nursing staff to discontinue R1's vancomycin on 6/29/17 and remove the PICC line. R1's primary physician progress note dated 7/3/17 indicated R1 was hospitalized from 6/18/17 to 6/22/17 for sepsis. The progress note indicated R1 was susceptible to sepsis. R1's nursing note and situation, background, assessment and recommendation (SBAR) communication form, both dated 7/4/2017 indicated R1 had a temperature of 102 degrees. The nurse notified the on-call physician and received an order to send R1 to the hospital for evaluation. R1's emergency room (ER) progress note dated 7/4/17 indicated R1's condition on arrival at the ER was a concern to hospital staff, R1 was alert and oriented but disheveled. The PICC line was still in R1's left arm and the insertion site was uncovered. The clear Tegaderm dressing was no longer sticking to R1's skin because it was so heavily soiled with crusted flaking skin. R1's PICC line dressing was dated 6/22/17, 12 days earlier. A hospital infectious disease physician consultation note dated 7/6/17 indicated R1's PICC line was removed in the ER on 7/4/17 and cultured and had gram negative bacilli present. When interviewed on 08/07/2017 at 2:01 p.m., registered nurse (RN)-A said it was important to check the PICC line site regularly for swelling, redness, and drainage. RN-A said she never had

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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: __ C B. WING 00112 10/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARI GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 21850 Continued From page 11 21850 PICC line training at the facility. When interviewed on 8/7/2017 at 3:41 p.m., the director of nursing (DON)-F said the unit managers do rounding with the wound doctor and if there is a concern she would look at it. When interviewed on 9/12/17 at 1:37 p.m., family member (FM)-H said she was upset about R1's condition because she looked pale, her skin was scaly, they had already cleaned her up for an hour, and she still looked bad when she got to the hospital. FM-H said R1 lives at a new facility; her infection has improved and her skin is healing. When interviewed on 9/25/17 at 10:00 a.m., medical doctor (MD)-J said there should be a daily assessment and documentation of R1's PICC line whether used or not, MD-J said it was the responsibility of nursing staff to contact a physician if staff are not sure about R1's PICC line dressing changes or PICC line removal. MD-J said the expectation was R1's PICC line be removed by facility nursing staff within 24 hours of the order. When interviewed on 10/02/17 at 9:00 a.m., emergency room RN-H said R1's left upper arm was swollen, red and tender on arrival at the emergency room. Yellow, foul-smelling pus flowed from R1's uncovered PICC line site when touched. RN-H said R1 told hospital staff the facility never changed her PICC line dressing. RN-H said common practice is to change a PICC line dressing every 72 hours or when the dressing is soiled or loose. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review

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