Electronically delivered
May 25, 2022

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: May 12, 2022

Dear Administrator:

On May 12, 2022, a 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 12, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by November 12, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 25, 2022

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: LWD911

Dear Administrator:

The above facility was surveyed on May 9, 2022 through May 12, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/9/22-5/12/22 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/9/22 - 5/12/22 a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5322083C (MN80887) H5322084C (MN82057) H5322085C (MN82803) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 06/03/2022

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		6/3/22

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F 656	Continued From page 2 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure weight monitoring was completed as identified on the care plan for 1 of 2 residents (R26) reviewed for weight loss. Findings include: R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADLs). During interview on 5/9/22 at 3:42 p.m., R26 stated she felt she was getting enough food and fluids and was working with speech therapy to help improve her swallowing. R26 voiced no concerns with unplanned weight loss or weight gain. However, R26's completed progress note, dated 4/29/22, identified the registered dietitian (RD)-A spoke with R26's family member who was concerned about R26 losing weight and muscle mass. The note outlined there had been no weight collected on R26 since admission on 4/12/22 and the newest weight entered was the exact same, at 269 lbs. The note identified, "RD questions accuracy of 4/26/22 as weights typically show some fluctuation ... spoke w/ [with] [family member] and resident, resident stated I think I've lost a little muscle and weight due to not moving	F 656	Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F656 483.21(b)(1) Develop/Implement Comprehensive Care Plan According to the statement of deficiencies (2567) “Based on interview and document review, the facility failed to ensure weight monitoring was completed as identified on the care plan for 1 of 2 residents (R26) reviewed for weight loss. 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice a. R26 i. R26 discharged from the facility on 5-13-2022	

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F 656	Continued From page 3 as much ... discussed w/ resident and daughter, recommend daily weights to obtain weight accuracy. Both parties agreed. Daily weights ordered 4/26/22 ... MD [medical doctor] notified of daily weight request." R26's Care Plan Report, printed 5/12/22, identified R26 was at risk of impaired nutritional status and unintentional weight loss. The report listed several goals for R26 which included, "Weight to remain stable 271 # [lbs] +/- 3% with no sig[nificant] wt [weight] changes," along with several interventions to help R26 meet these goals including, "DAILY WEIGHT IN PLACE 4/26/22 FOR WEIGHT ACCURACY." However, R26's Resident Vital Sign Report, printed 5/12/22, identified R26's collected and recorded weights in the medical record. This included the following since the daily weights were ordered and/or care planned by the RD: 4/26/22 - 269.00 lbs. 4/27/22 - "ADL Not Scheduled." 4/30/22 - "ADL Not Scheduled." 5/3/22 - 252.60 lbs. 5/4/22 - "ADL Not Scheduled." 5/4/22 - 253.00 lbs. 5/6/22 - "ADL Not Scheduled." 5/11/22 - "ADL Not Scheduled." There were no recorded weights, or documented refusals, for the remainder of the days not listed on the report. Further, R26's medical record was reviewed and lacked any further evidence these daily weights had been obtained and documented despite being requested and/or ordered by the RD and care planned on 4/26/22.	F 656	2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents with care planned weight monitoring may be affected by the alleged deficient practice – Completion date: 5-30-2022 b. The Director of Nursing and Dietician reviewed all residents in the facility for any weight issues and implement appropriate clinical follow up– Completion date: 5-30-2022 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur a. The Director of Nursing reviewed the policy and procedures associated with the plan of care and weights. Policy was updated to reflect current standards of care. – Completion date: 6-1-2022 b. Nurse Educator or designee educated nursing staff on the need for correct weight documentation and follow up. 6-3-2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. The Director of Nursing or designee will audit 15 residents on daily weights each week for four weeks. Then audit the residents on daily weights every month for the next three months. Continue to audit the daily weight residents quarterly and PRN for the next year. b. MDS staff to audit 15 residents each month to ensure all weight documentation is correct, entered and documented. 5. Completion Date: Friday, June 3rd,	

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F 656	Continued From page 4 When interviewed on 5/11/22 at 10:19 a.m., nursing assistant (NA)-A stated R26 had a "good appetite" and typically finished all her provided meals. NA-A stated she was aware R26 was on a daily weight, and explained it was supposed to be collected, recorded in the computer, and given to the nurse. NA-A added she was unaware if R26 had sustained any weight loss since she admitted to the nursing home. When interviewed on 5/12/22 at 9:44 a.m., registered nurse unit manager (RN)-C stated R26 was on a daily weight and the NA(s) should be obtaining it and recording it in the computer. RN-C added she believed it was happening but added, "I don't know how consistent it's been." RN-C stated she was aware some orders for daily weights had not been completed and voiced she felt the nursing home was "making strides" in improving the collection and recording of them. When interviewed on 5/12/22 at 9:56 a.m., RD-A stated R26 was weighed and showed "significant weight loss" which resulted in the discussion with R26 and her family member and the recommendation to implement a daily weight to better monitor them. The order for daily weights started on 4/26/22 and RD-A verified, "They [daily weights] have not been done consistently." Further, RD-A stated she felt, R26 was stable, getting enough nutrition and but the weights should have been completed. A facility policy on weight monitoring and/or weight management was requested but not provided.	F 656	2022	
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		6/3/22

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F 678	Continued From page 5 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting directives and medical record entries for emergency care and treatment were clarified to ensure resident wishes would be implemented in an emergent situation for 1 of 2 residents (R293) reviewed for advanced directives. Findings include: R293's HealthPartners Discharge Summary, dated 5/7/22, identified R293 admitted to the hospital for right hip pain associated with a hip fracture and listed a discharge date of 5/7/22. The summary listed a section labeled, "Assessment/Plan," for R293's discharge which included, "Code Status: DNAR [do not attempt resuscitation]." R293's electronic nursing home Face Sheet, printed 5/12/22, identified R293 had an admission diagnosis of post-hip fracture along with several other medical conditions including dementia and acute post hemorrhagic anemia (where a person quickly loses a large volume of circulating hemoglobin). Further, the Face Sheet identified R293's family member (FM)-D as their power of attorney (POA) and listed a section labeled, "Advance Directives," which recorded, "DNR - Do Not Resuscitate."	F 678	Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. 483.24(a)(3) Cardio-Pulmonary Resuscitation According to the statement of deficiencies (2567) “Based on interview and document review, the facility failed to ensure conflicting directives and medical record entries for emergency care and treatment were clarified to ensure resident wishes would be implemented in an emergent situation for 1 or 2 residents (R293) reviewed for advanced directives. 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice	

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F 678	Continued From page 6 However, located in R293's hard chart was an undated, signed Physician Orders for Life-Sustaining Treatment (POLST) which had a handwritten "X" placed next to an option which indicated, "Attempt Resuscitation / CPR (Note: selecting this option requires selecting "Full Treatment" in Section B)." The following section, "B," outlined several options for medical treatments to be completed if the patient has a pulse or is breathing including, "Full Treatment," and, "Selective Treatment," and, "Comfort-Focused Treatment (Allow Natural Death)." This had a black-colored handwritten "X" placed next to the option which directed comfort-focused treatment which was in conflict with the POLST instructions from the previous section which directed selecting CPR required "Full Treatment" be selected. The POLST was signed by FM-D and a nursing home staff member; however, was unsigned by a medical provider. R293's medical record was reviewed and lacked evidence these conflicting documents were clarified with R293, or their POA, to ensure their correct wishes would be implemented if R293 was found without a pulse and/or not breathing. On 5/10/22 at 8:37 a.m. R293's FM-D stated R293 admitted from the hospital after a hip fracture and was in the "late stages" of dementia. As a result, the hospital team and FM-D elected to make R293 a DNR and "just let her go" if she was to stop breathing or be found without a pulse. FM-D stated he recalled talking to a nurse at the nursing home about this upon R293's admission, however, could not recall any education on the POLST. Further, FM-D stated he believed the	F 678	a. R293 i. R293 has had their Advance Directive information reviewed and updated, NP has signed the documentation – Completion date: 5-10-2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents with Advance Directives may be affected by the alleged deficient practice b. The Director of Nursing reviewed all residents in the facility for any Advanced Directives and implement appropriate clinical follow up - Completion date: 5-10-2022 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur a. Director of Nursing reviewed all resident chart for Advance Directive completion and accuracy – Completion date: 5-10-2022 b. Audit all admission charts in the PDPM meeting for correct and completed Advance Directives – Completion date: 6-3-2022 c. The Director of Nursing or designee reviewed the policy and procedures associated with Advanced Directives – Completion date: 6-1-2022 d. Nursing Educator or designee educated nursing staff on the need for correct Advance Directive documentation, care, and follow up – Completion date: 6-3-2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

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	245322	A. BUILDING _____ B. WING _____	C 05/12/2022

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F 678	Continued From page 7 nurse completed the POLST located in R293's chart and was unaware CPR (i.e., full code) had been checked. FM-D verified this was incorrect and R293 should be recorded on the POLST as a DNR. When interviewed on 5/10/22 at 9:37 a.m. registered nurse (RN)-A stated he was the nurse assigned to care for R293, and explained he had only worked at the nursing home a few weeks. RN-A stated if a resident would be found without a pulse or not breathing, then he would immediately review their "face sheet" for directions on how to respond (i.e., full code or allow death). RN-A stated he could not recall what location he had been directed or trained to check when he started at the nursing home, however, would review the face sheet strictly out of habit. RN-A explained if approached with R293 being found without a pulse or not breathing, he would check R293's face sheet which directed DNR and he would not implement CPR. RN-A then reviewed R293's EMR and completed POLST and stated "those are conflicting," RN-A stated it was important to ensure advance directive information matches in all locations (i.e., EMR and POLST) otherwise, in the event of cardiac or respiratory arrest, the staff "don't know what to believe." On 5/10/22 at 1:50 p.m. the interim director of nursing (DON) stated training with nurses was completed upon hire for POLST and the advance directive process. She acknowledged this process resulted in the information being kept in "multiple places." The DON explained the POLST should be completed by the nurse upon admission, and if the resident has cognitive impairment then the family should be consulted	F 678	will not recur a. Director of Nursing or designee to audit 15 residents with Advanced Directives every week for four weeks, then every month for the next three months. Continue quarterly reviews and reviews PRN for the next year. b. Director of Nursing or designee to refer Advanced Directive audits to the QAPI committee to identify trends, make recommendations and to ensure ongoing compliance. 5. Completion Date: Friday, June 3rd, 2022	

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F 678	Continued From page 8 for wishes. The form was then sent to the medical provider for signature. When a resident experienced cardiac or respiratory arrest and their POLST was unsigned, it should be cross-checked with their physician orders which was what the nursing staff should ultimately go by for resuscitation wishes. The DON reviewed R293's POLST and EMR and stated the conflicting documentation and records made it "really not clear" what R293's wishes were and she would ensure clarification from the family was obtained. A provided Advance Directives policy, dated 12/2016, identified a resident's written advanced directives would be reviewed upon admission by the social services director or designee. If present, information about an advance directive was to be, " ... displayed prominently in the medical record." The policy outlined, the physician would provide information to the resident or legal representative regarding the resident's health status, treatment options and expected outcomes, and the resident had the right to refuse treatment adding, "A resident will not be treated against his or her own wishes." In addition, an Emergency Procedures - Cardiopulmonary Resuscitation policy, dated 2/2018, identified sudden cardiac arrest was the leading cause of death among adults and directed if an individual is found unresponsive and not breathing normally, CPR should be initiated unless obvious signs of clinically irreversible death (i.e., decapitated) or, " ... it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual." However, the policy lacked any further information or direction on where to check in the medical record	F 678		

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F 678	Continued From page 9 for this information. Further, a provided Do Not Resuscitate Order policy, dated 4/2017, identified CPR would not be used when a DNR order was in effect. These orders were to be signed by the physician and " ... maintained in the resident's medical record," using a state-approved form which included a POLST.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) dressing was monitored and changed in accordance with the standard of care to reduce the risk of complication for 1 of 1 resident (R26) reviewed for intravenous (IV) care. Findings include: A National Library of Medicine (NIH) Medline Plus article, peer-reviewed 10/2021, identified a PICC as a long, thin tube inserted through a vein into the upper arm which " ... goes into a large vein near your heart." This helped to carry nutrients or medications into the human body or draw blood, if needed. A section of the article labeled, "Dressing	F 684	Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F684 483.25 Quality of Care	6/3/22

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F 684	Continued From page 10 Changes," identified a dressing was used to reduce the risk of infection and keep the PICC insertion site dry and clean, directing "You should change the dressing about once a week." R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADLs). Further, the MDS identified R26 received intravenous (IV) medication while a resident at the nursing home. On 5/9/22 at 3:47 p.m. R26 was observed lying in bed while in her room. R26 had a visible PICC line inserted into her right inner arm which was covered with a clear dressing. The insertion site was slightly red-colored and the dressing was intact with minor peeling around the perimeter; however, a piece of paper tape was present along the bottom of the dressing which read, "05/01/22 [eight days prior]." R26 stated she was getting antibiotics through the PICC and was not sure when it was going to be removed. Further, R26 stated she was unsure how often the staff were changing the clear dressing over the insertion site but denied any symptoms of potential infection (i.e., chills, fever, respiratory difficulty). R26's Standing Orders for Skilled Nursing Facilities, dated 1/6/21, identified a section labeled, "IV Line Management," which directed, "Initiate routine IV line and site care per facility protocol." R26's Physician Order Sheet, dated May 2022, included ceftriaxone (an antibiotic) 2 gram (gm) IV twice a daily for 42 days (starting 4/6/22), along with a treatment which read, "IV THERAPY	F 684	According to the statement of deficiencies (2567) “Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) dressing was monitored and changed in accordance with the standard of care to reduce the risk of complication for 1 of 1 resident (R26) reviewed for intravenous (IV) care. 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice a. R26 i. PICC line dressing changed on 5-11-2022 1. No signs or symptoms of infection 2. No adverse effects noted ii. PICC line discontinued on 5-13-2022 1. Antibiotic therapy completed iii. R26 discharged from the facility on 5-13-2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents with peripherally inserted central catheter (PICC) may be affected by the alleged deficient practice 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur a. Director of Nursing or designee reviewed all residents in the facility for any PICC Line/Lines issues and implement appropriate clinical follow up – Completion date: 5-10-2022 b. The Director of Nursing or designee reviewed the policy and procedures associated with care and management of	

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F 684	Continued From page 11 - Site check, tolerance, dressing, flushes, IV type, [diagnosis] for medication, temps," to be completed "by shift" starting on 4/6/22. R26's subsequent physician order, dated 5/10/22, identified R26's infection had improved; however, R26 was to continue the IV antibiotics through 5/12/22 and have the PICC removed afterward. However, none of the reviewed physician orders outlined when or how often to change R26's PICC line dressing to ensure adequate protection of the line and reduce the risk of contamination or infection. R26's Geriatrics Follow Up Visit note, dated 4/11/22, identified R26 had a history of high blood pressure and was hospitalized for several days with a rapid decline in mental status, being diagnosed with encephalopathy and subdural empyema with associated cerebritis (inflammation of the brain in the setting of infection). The note identified on 4/8/22, R26 was found to have a DVT (deep vein thrombosis) in her arm with the PICC, so she was sent to the emergency department (ED) to have another PICC placed due to requiring ongoing antibiotics. R26's Care Plan Report, printed 5/12/22, identified R26 had an active cranial infection and listed a goal of R26 having no signs or symptoms of active infection. The care plan listed several interventions to help R26 meet this goal including monitoring for antibiotic side effects, reporting worsening symptoms to the physician, and personal protective equipment, if indicated. However, the care plan lacked any recorded interventions or care direction for the PICC line despite R26 receiving IV medication through the device since admission to the nursing home over a month prior.	F 684	PICC Lines – Completion date: 6-1-2022 c. Director of Nursing or designee educated the nursing staff on the need for correct line documentation, dressing changes, site care and follow up – Completion date: 6-3-2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. Director or Nursing or designee to audit 15 residents for PICC line/lines every week for four weeks, then every month for the next three months. Continue quarterly reviews and reviews PRN for the next year. b. Refer PICC line audits to the QAPI committee to identify trends, make recommendations and to ensure ongoing compliance. 5. Completion Date: Friday, June 3rd, 2022	

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F 684	Continued From page 12 During subsequent observation on 5/11/22 at 7:55 a.m., R26 continued to have the PICC line present in her right arm with a clear dressing. The clear dressing continued to have slight peeling present along the perimeter; however, the tape was now removed and the dressing had faint blue-colored, illegible writing on the bottom where the tape had been prior. Immediately following this observation, registered nurse (RN)-B knocked and entered R26's room to administer the scheduled antibiotic. RN-B was questioned on the PICC line dressing and voiced she had not changed it recently. When interviewed on 5/11/22 at 8:03 a.m. RN-B explained PICC line dressings were changed "per the order" provided from the physician. RN-B stated the dressing should "technically" be changed every three days for a standard of care; however, again reiterated they go by the specific physician order for each patient. This should be tracked and documented under the treatments in the medical record; however, RN-B then voiced she was not sure if she ever recalled signing it out for R26 in the past weeks. RN-B reviewed R26's treatments and verified it lacked evidence R26's PICC line dressing had been changed. RN-B expressed she had noticed there was poor charting with IV line care, including dressing changes, and she raised the issue with the infection control and prevention nurse a few weeks prior; however, had not received any follow-up or new direction since then. Further, RN-B again stated the dressing should be changed in accordance with physicians' orders and documented in the medical record. If there were no orders, then "the facility has to implement something" to ensure it's changed and	F 684		

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F 684	Continued From page 13 tracked. R26's medical record was reviewed and lacked any evidence the PICC line dressing had been changed after 4/8/22 when the new PICC was placed in the ED. On 5/11/22 at 9:03 a.m. the registered nurse unit manager (RN)-C was interviewed and explained PICC line dressings should be changed every seven days unless otherwise directed in the physician orders. R26 admitted to the nursing home with the PICC line in place and continued to receive IV antibiotics through it. RN-C stated with the dressing being first observed with a 5/1/22 date, it had likely been missed and not changed on the weekly basis it should be. Further, RN-C stated all PICC line dressing changes should be recorded in the medical record and it was important to ensure the dressing was actually being changed and recorded as "the risk of infection is huge." When interviewed on 5/12/22 at 10:15 a.m. the infection control and prevention registered nurse (RN)-D stated the facility' policy was to change a PICC line dressing "weekly" and should be entered and recorded in the physician orders and treatments of the medical record. RN-D reviewed the medical record and stated the dressing change would be a separate order and treatment aside from the general monitoring one listed. RN-D stated it was important to ensure the dressing was changed on a weekly basis to help reduce the risk of infection and added she could not recall any staff reaching out to her with concerns about IV management in the past weeks. Further, RN-D stated education was just provided to the nurses during a skills fair the	F 684		

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F 684	Continued From page 14 month prior and, again, verified the dressing should be changed weekly. A provided Central Venous Catheter Dressing Changes policy, dated 4/2016, identified transparent, semi-permeable membrane dressing were to be changed every 5 - 7 days and as needed. The date and time of the dressing change, objective description of the insertion site, and and complications from the dressing change were to be recorded in the medical record.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician recommendations and orders were clarified and addressed to provide pain medication and promote comfort for 1 of 2 residents (R297) reviewed for pain management. Findings include: R297's Face Sheet, printed 5/12/22, identified R297 admitted to the transitional care unit (TCU) of the nursing home in early May 2022 from the hospital with an admission diagnosis of displaced intertrochanteric fracture of the right femur (leg bone).	F 697	Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F697	6/3/22

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F 697	Continued From page 15 R297's Individual Resident Care Plan, dated 5/3/22, identified R297's initial care needs upon admission to the nursing home. The section of the care plan labeled, "Pain Control," identified R297 had actual pain in her right leg. However, the remainder of the section, including spaces to be pain management interventions, was left blank and not completed. On 5/9/22 at 6:37 p.m., R297 was seated in her wheelchair while in her room. R297's right leg was extended outward and R297 stated she was waiting for a heat pack from the staff as her "pain is terrible" in her right leg which stemmed from a fall prior to admission. R297 described the pain as "pins and needles" and voiced it extended down her leg into her ankle and toes. R297's Twin Cities Physicians SKILLED note, dated 5/9/22, identified R297 was seen by the physician assistant (PA) for her pain control at family' request. The note identified R297 reported poor pain control on 5/4/22, and her acetaminophen orders were changed as a result. R297's listed pain medications, as of 5/9/22, including acetaminophen 1000 milligrams (mg) three times a day and aspirin 81 mg daily for four week period. The note included dictation, "Message from [R297's family member] ... concerned about her pain control. Went to see [R297] again today and she reported her pain is okay when she is lying in bed but much worse when moving around ... Discussed with [R297's family member], and we decided some low dose oxycodone [a narcotic medication] would help her participate in therapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime." The note concluded with a section labeled, "Assessment	F 697	483.25(k) Pain Management According to the statement of deficiencies (2567) “Based on observation, interview and document review, the facility failed to ensure physician recommendations and orders were clarified and addressed to provide pain medication and promote comfort for 1 of 2 residents (R297) reviewed for pain management. 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice a. R297 i. The Director of Nursing or designee reviewed R297 for any adverse effects related to the pain medication order initiation. R297 has had their pain medications, information reviewed and updated. NP has signed the documentation – Completion date: 5-10-2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents requiring pain management may be affected by this alleged deficient practice. b. Director of Nursing or designee to review all residents in the facility for any pain medications and implement appropriate clinical follow up 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur a. Director of Nursing or designee consulted with the Pharmacist on any outstanding recommendations for the follow up of pain medications –	

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F 697	Continued From page 16 and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every morning and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in the plan of the corresponding progress note by the PA, and despite having been reviewed and discussed with R297's family member to help R297 have better pain control and potentially participate better with therapies. The orders were dated with a handwritten 5/9/22 by the nursing home staff. R297's subsequent Resident Vital Sign Report (for pain), dated 5/10/22 to 5/11/22, identified R297 rated her pain between a 1.0 and 2.0 (on a scale of 0-10 with "10" being the worst rating). During subsequent observation on 5/10/22 at 2:11 p.m. R297 was lying in bed while in her room. R297's eyes were closed and she appeared comfortable with no obvious grimacing or physical	F 697	Completion date: 5-23-2022 b. Director of Nursing or designee reviewed the policy and procedures associated with pain medications and physician progress notes – Completion date: 6-1-2022 c. The Director of Nursing or designee educated the nursing staff on the need for correct progress note follow up, documentation, care and follow up – Completion date: 6-3-2022 d. Progress notes will be reviewed by Medical Records for any new or alteration in ICD codes. Medical Records staff will sign off on the progress notes then give to the MDS staff. MDS staff to audit progress notes for any medication orders, appointments or treatments that may need follow up. MDS staff will sign off on the progress notes. When the note has two signatures to verify a double check it can then be scanned into the medical record. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. Director of Nursing or designee to audit 15 residents with pain medications every week for four weeks, then every month for the next three months. Continue quarterly reviews and reviews PRN for the next year. b. Director of Nursing or designee to audit 15 resident physician progress notes every week for four weeks, then every month for the next three months. Continue quarterly reviews and reviews PRN for the next year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 05/12/2022

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COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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F 697	Continued From page 17 signs or symptoms of pain present. When interviewed on 5/10/22 at 2:12 p.m. registered nurse (RN)-A stated he was assigned to care for R297 and explained she admitted to the nursing home with a hip fracture. R297 used a "pain patch" and Tylenol for pain relief, and RN-A stated there was no current order for oxycodone. RN-A reviewed R297's physician note, and corresponding physician orders, and stated the oxycodone was never started despite being listed on the note as the PA's plan to address R297's pain control. When discussing the process in place for nursing staff to review completed physician notes, RN-A stated he was unaware who, if anyone, was responsible to read the physician progress notes as the floor nurse "never had the chance to read those." RN-A stated he was unaware if the note, and corresponding orders, were clarified with the PA to ensure the correct pain control was being implemented. RN-A stated the note and corresponding orders should have been clarified to remove "confusing questions" and ensure the "actual plan" was being done to provide comfort for the resident. When interviewed on 5/10/22 at 2:30 p.m. the registered nurse unit manager (RN)-C explained physician orders were received by the health unit coordinator (HUC) and then scanned into the electronic medical record (EMR). RN-C stated there was poor communication between the nursing home and medical provider group and often staff were "never told" of who was being seen. RN-C explained there was no staff assigned or directed, to her knowledge, to review incoming physician progress notes to ensure any questions or needed clarifications are obtained,	F 697	c. Refer pain/progress note audits to the QAPI committee to identify trends, make recommendations and to ensure ongoing compliance. 5. Completion Date: Friday, June 3rd, 2022	

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F 697	Continued From page 18 and she expressed this served as another example of why they needed to improve communication with the medical provider group and nursing staff. Further, RN-C stated it was important to ensure conflicting or unclear notes and orders were clarified to provide "continuity of care" to the patient and voiced this inconsistency and potential error would not have been identified had the surveyor not brought it to their attention. On 5/12/22 at 10:36 a.m. the interim director of nursing (DON) was interviewed and stated she had investigated the issue. The PA rounded and dictated the progress note after having a discussion with R297's family member, then sent the order for the oxycodone to the incorrect inbox which caused it to not be received by the nursing home. The DON stated she discussed the situation with the PA and neither of them believed R297 was harmed as a result of the incident; however, the PA wanted to still start the medication as intended and would review R297 in a few days to ensure adequate pain control was being implemented. The DON stated she reviewed the process for order and note scanning with the medical record personnel and "moving forward," they were going to begin looking at notes and orders for inconsistencies. The DON stated it was important to ensure physician progress notes were reviewed timely and for consistency to help ensure orders weren't potentially missed. A facility' policy on pain management and/or physician order clarification was requested and not provided.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/3/22

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F 758	Continued From page 19 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 20 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as-needed (PRN) psychoactive medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R26) reviewed for unnecessary medication use. Findings include: R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had anxiety disorder, depression and post-traumatic stress disorder (PTSD). Further, R26 displayed severe cognitive impairment, demonstrated no behaviors (including rejection of care or delusions), and required extensive assistance with most activities of daily living (ADLs). R26's Physician Order Sheet, dated May 2022, included buspirone (an antianxiety medication) 30 milligrams (mg) twice a day, fluoxetine (an antidepressant medication) 10 mg once a day, and lorazepam (an antianxiety medication) 0.5 mg twice a day as-needed (PRN). The lorazepam had a listed start date of 4/6/22. R26's Care Plan Report, printed 5/12/22,	F 758	Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. F758 483.45(c)(3)(e)(1)-(5) Free from Unnecessary Psychotropic Meds/PRN Use According to the statement of deficiencies (2567) “Based on interview and document review, the facility failed to ensure as-needed (PRN) psychoactive medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R26) reviewed for unnecessary	

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F 758	Continued From page 21 identified R26 " ... is receiving antianxiety drugs on a regular basis," and listed a goal for R26 which read, "Symptoms of anxiety will be controlled with minimal side effects over the next 90 days." The care plan listed several interventions to help R26 meet this goal including providing activities, monitoring for side effects of the medications, and providing a quiet atmosphere. R26's April 2022 Medications report, dated 4/2022, identified R26's consumed medications for the month as signed out by the nursing home staff. This identified R26's lorazepam PRN order which identified it was administered once on 4/29/22 with the results being recorded, "Pain = 05 - It was administered." There was no recorded anxiety symptoms or resolution on the report. In addition, R26's May 2022 Medications report, dated 5/2022, identified R26 continued to have an active order for the PRN lorazepam, however, had received no doses in the month period thus far. However, both of these reports lacked any recorded or directed stops date for the PRN medication. R26's Interim Medication Regimen Review, dated 4/6/22, identified the consulting pharmacist had reviewed R26's physician orders and made several recommendations including, "PRN Psychotropic orders needs a 14 day stop date. Then ask MD to re-evaluate continued need for the following medication(s): Lorazepam." The completed report was signed on 4/22/22 by nursing home staff. However, R26's medical record was reviewed and lacked any recorded physician statements or clinical justification supporting the ongoing use of	F 758	medication use. 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice a. R26 i. Pharmacist consulted on 5-10-2022 for specific recommendation ii. Medication was discontinued on 5-10-2022 by the medical provider iii. R26 discharged from the facility on 5-13-2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice a. Director of Nursing or designee reviewed all residents in the facility for any outstanding psychoactive medication recommendations and implement appropriate clinical follow up – Completion date: 5-30-2022 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur a. Director of Nursing or designee consulted with the Pharmacist on any outstanding recommendations for the follow up of psychoactive medications – Completion date: 5-23-2022 b. The Director of Nursing or designee reviewed the policy and procedures associated with psychoactive medications – Completion date: 6-1-2022 c. The Director of Nursing or designee educated all nursing staff on the need for correct psychoactive documentation, care and follow up – Completion date: 6-3-2022 d. Director of Nursing or designee	

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F 758	Continued From page 22 PRN lorazepam outside of the 14-day period since it was ordered on 4/6/22 (over 30 days prior). Further, there was no evidence the medication use had been extended outside of the 14-day required timeframe (i.e., 60 days) or had a stop date determined, despite the identified concern documented by the consulting pharmacist on their medication regimen review on 4/6/22. When interviewed on 5/11/22 at 1:21 p.m. registered nurse (RN)-B stated R26 did not display any anxiety or behavioral symptoms and described her as "pretty calm and pleasant." RN-B reviewed R26's current medication orders in the electronic record and verified R26 continued to have PRN lorazepam ordered and available for administration. RN-B stated she was unsure when, or if, a stop date was determined for the medication. RN-B explained she was aware most PRN psychotropic's needed to be stopped or have new orders written after 14 days; however, she did not know "the protocol" for how lorazepam specifically was addressed. RN-B added, "I didn't even know she was on Ativan [lorazepam] to be honest." When interviewed on 5/12/22 at 9:46 a.m. registered nurse unit manager (RN)-C stated she had reviewed R26's medical record, and she acknowledged there was no stop date identified for the PRN lorazepam nor was there evidence it's use had been re-evaluated by the medical provider. As a result, RN-C stated they "have a message out to the provider" for it to be addressed. RN-C reviewed the completed medication regimen review, dated 4/6/22, and explained those reports were forwarded to the nurse managers to be addressed. R26's report	F 758	consulted with PharMerica for current recommendations related to psychoactive recommendations – Completion date: 5-23-2022 e. Director of Nursing met with the medical providers and the Medical Director to educate them on the need for proper follow up pharmaceutical recommendations-Completed 06-01-2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur a. Director of Nursing or designee to audit 15 residents with psychoactive medications every week for four weeks, then every month for the next three months. Continue quarterly reviews and reviews PRN for the next year. b. MDS staff or designee to audit 15 care plans each month for the correct psychoactive medication interventions each month. c. Refer psychoactive audits to the QAPI committee to identify trends, make recommendations and to ensure ongoing compliance. 5. Completion Date: Friday, June 3rd, 2022	

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F 758	Continued From page 23 was reviewed and signed by the physician; however, it lacked any written direction or associated notes on how to address the identified PRN lorazepam. RN-C stated it was important to ensure PRN psychotropic were provided only when needed or discontinued timely to reduce the risk of a resident developing "abnormal movements [tardive dyskinesia]." On 5/12/22 at 10:48 a.m. the interim director of nursing (DON) was interviewed. The DON explained the pharmacy recommendation was signed by the physician, however, the issue was not addressed as the physician "never checked either box" to indicate a response. As a result, they had just contacted the physician and obtained orders to discontinue the medication. The DON explained she had noticed some issues with medication management, including timely follow up on the consulting pharmacist reviews, since she started working at the nursing home and was actively working with the consulting pharmacist to get them resolved. However, the DON stated the PRN lorazepam should have been addressed with the medical provider or discontinued and explained they "have to lean back on our providers" to ensure orders or directions are given when the recommendations are made. A provided Medication Management policy, dated 1/2022, identified an unnecessary medication included any medication used for excessive duration and without adequate indication for use. The policy outlined, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should	F 758		

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F 758	Continued From page 24 document their rationale in the resident's medical record and indicate the duration for the PRN order."	F 758		

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COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/9/22-5/12/22, licensing and complaint surveys were conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H5322083C (MN80887) H5322084C (MN82057) H5322085C (MN82803) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure weight monitoring was completed as identified on the care plan for 1 of 2 residents (R26) reviewed for weight loss. Findings include: R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADLs). During interview on 5/9/22 at 3:42 p.m., R26 stated she felt she was getting enough food and fluids and was working with speech therapy to help improve her swallowing. R26 voiced no	2 565	Corrected	6/3/22

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COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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2 565	Continued From page 3 concerns with unplanned weight loss or weight gain. However, R26's completed progress note, dated 4/29/22, identified registered dietitian (RD)-A spoke with R26's family member who was concerned about R26 losing weight and muscle mass. The note outlined there had been no weight collected on R26 since admission on 4/12/22 and the newest weight entered was the exact same, at 269 lbs. The note identified, "RD questions accuracy of 4/26/22 as weights typically show some fluctuation ... spoke w/ [with] [family member] and resident. Resident stated I think I've lost a little muscle and weight due to not moving as much ... discussed w/ resident and daughter, recommend daily weights to obtain weight accuracy. Both parties agreed. Daily weights ordered 4/26/22 ... MD [medical doctor] notified of daily weight request." R26's Care Plan Report, printed 5/12/22, identified R26 was at risk of impaired nutritional status and unintentional weight loss. The report listed several goals for R26 which included, "Weight to remain stable 271 # [lbs] +/- 3% with no sig[nificant] wt [weight] changes," along with several interventions to help R26 meet these goals including, "DAILY WEIGHT IN PLACE 4/26/22 FOR WEIGHT ACCURACY." However, R26's Resident Vital Sign Report, printed 5/12/22, identified R26's collected and recorded weights in the medical record. This included the following since the daily weights were ordered and/or recommended by the RD: 4/26/22 - 269.00 lbs. 4/27/22 - "ADL Not Scheduled." 4/30/22 - "ADL Not Scheduled."	2 565		

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	00183	A. BUILDING: _____ B. WING _____	C 05/12/2022

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2 565	Continued From page 4 5/3/22 - 252.60 lbs. 5/4/22 - "ADL Not Scheduled." 5/4/22 - 253.00 lbs. 5/6/22 - "ADL Not Scheduled." 5/11/22 - "ADL Not Scheduled." There were no recorded weights, or documented refusals, for the remainder of the days not listed on the report. Further, R26's medical record was reviewed and lacked any further evidence these daily weights had been obtained and documented despite being requested and/or ordered by the RD on 4/26/22. When interviewed on 5/11/22 at 10:19 a.m., nursing assistant (NA)-A stated R26 had a "good appetite" and typically finished all her provided meals. NA-A stated she was aware R26 was on a daily weight, and explained it was supposed to be collected, recorded in the computer, and given to the nurse. NA-A added she was unaware if R26 had sustained any weight loss since she admitted to the nursing home. When interviewed on 5/12/22 at 9:44 a.m., registered nurse unit manager (RN)-C stated R26 was on a daily weight and the NA(s) should be obtaining and recording it in the computer. RN-C added she believed it was happening but added, "I don't know how consistent it's been." RN-C stated she was aware some orders for daily weights had not been completed and voiced she felt the nursing home was "making strides" in improving the collection and recording of them. When interviewed on 5/12/22 at 9:56 a.m., RD-A stated R26 was weighed and showed "significant weight loss" which resulted in the discussion with R26 and her family member and the recommendation to implement a daily weight to	2 565		

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2 565	Continued From page 5 better monitor them. The order for daily weights started on 4/26/22 and RD-A verified, "They [daily weights] have not been done consistently." Further, RD-A stated she felt, R26 was stable and getting enough nutrition but the weights should have been completed. A facility policy on weight monitoring and/or weight management was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		6/3/22

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) dressing was monitored and changed in accordance with the standard of care to reduce the risk of complication for 1 of 1 resident (R26) reviewed for intravenous (IV) care. Findings include: A National Library of Medicine (NIH) Medline Plus article, peer-reviewed 10/2021, identified a PICC as a long, thin tube inserted through a vein into the upper arm which " ... goes into a large vein near your heart." This helped to carry nutrients or medications into the human body or draw blood, if needed. A section of the article labeled, "Dressing Changes," identified a dressing was used to reduce the risk of infection and keep the PICC insertion site dry and clean, directing "You should change the dressing about once a week." R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADLs). Further, the MDS identified R26 received intravenous (IV) medication while a resident at the nursing home. On 5/9/22 at 3:47 p.m. R26 was observed lying in bed while in her room. R26 had a visible PICC line inserted into her right inner arm which was covered with a clear dressing. The insertion site was slightly red-colored and the dressing was intact with minor peeling around the perimeter;	2 830	Corrected	

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2 830	Continued From page 7 however, a piece of paper tape was present along the bottom of the dressing which read, "05/01/22 [eight days prior]." R26 stated she was getting antibiotics through the PICC and was not sure when it was going to be removed. Further, R26 stated she was unsure how often the staff were changing the clear dressing over the insertion site but denied any symptoms of potential infection (i.e., chills, fever, respiratory difficulty). R26's Standing Orders for Skilled Nursing Facilities, dated 1/6/21, identified a section labeled, "IV Line Management," which directed, "Initiate routine IV line and site care per facility protocol." R26's Physician Order Sheet, dated May 2022, included ceftriaxone (an antibiotic) 2 gram (gm) IV twice a daily for 42 days (starting 4/6/22), along with a treatment which read, "IV THERAPY - Site check, tolerance, dressing, flushes, IV type, [diagnosis] for medication, temps," to be completed "by shift" starting on 4/6/22. R26's subsequent physician order, dated 5/10/22, identified R26's infection had improved; however, R26 was to continue the IV antibiotics through 5/12/22 and have the PICC removed afterward. However, none of the reviewed physician orders outlined when or how often to change R26's PICC line dressing to ensure adequate protection of the line and reduce the risk of contamination or infection. R26's Geriatrics Follow Up Visit note, dated 4/11/22, identified R26 had a history of high blood pressure and was hospitalized for several days with a rapid decline in mental status, being diagnosed with encephalopathy and subdural empyema with associated cerebritis	2 830		

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2 830	Continued From page 8 (inflammation of the brain in the setting of infection). The note identified on 4/8/22, R26 was found to have a DVT (deep vein thrombosis) in her arm with the PICC, so she was sent to the emergency department (ED) to have another PICC placed due to requiring ongoing antibiotics. R26's Care Plan Report, printed 5/12/22, identified R26 had an active cranial infection and listed a goal of R26 having no signs or symptoms of active infection. The care plan listed several interventions to help R26 meet this goal including monitoring for antibiotic side effects, reporting worsening symptoms to the physician, and personal protective equipment, if indicated. However, the care plan lacked any recorded interventions or care direction for the PICC line despite R26 receiving IV medication through the device since admission to the nursing home over a month prior. During subsequent observation on 5/11/22 at 7:55 a.m., R26 continued to have the PICC line present in her right arm with a clear dressing. The clear dressing continued to have slight peeling present along the perimeter; however, the tape was now removed and the dressing had faint blue-colored, illegible writing on the bottom where the tape had been prior. Immediately following this observation, registered nurse (RN)-B knocked and entered R26's room to administer the scheduled antibiotic. RN-B was questioned on the PICC line dressing and voiced she had not changed it recently. When interviewed on 5/11/22 at 8:03 a.m. RN-B explained PICC line dressings were changed "per the order" provided from the physician. RN-B stated the dressing should "technically" be changed every three days for a standard of care;	2 830		

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2 830	Continued From page 9 however, again reiterated they go by the specific physician order for each patient. This should be tracked and documented under the treatments in the medical record; however, RN-B then voiced she was not sure if she ever recalled signing it out for R26 in the past weeks. RN-B reviewed R26's treatments and verified it lacked evidence R26's PICC line dressing had been changed. RN-B expressed she had noticed there was poor charting with IV line care, including dressing changes, and she raised the issue with the infection control and prevention nurse a few weeks prior; however, had not received any follow-up or new direction since then. Further, RN-B again stated the dressing should be changed in accordance with physicians' orders and documented in the medical record. If there were no orders, then "the facility has to implement something" to ensure it's changed and tracked. R26's medical record was reviewed and lacked any evidence the PICC line dressing had been changed after 4/8/22 when the new PICC was placed in the ED. On 5/11/22 at 9:03 a.m. the registered nurse unit manager (RN)-C was interviewed and explained PICC line dressings should be changed every seven days unless otherwise directed in the physician orders. R26 admitted to the nursing home with the PICC line in place and continued to receive IV antibiotics through it. RN-C stated with the dressing being first observed with a 5/1/22 date, it had likely been missed and not changed on the weekly basis it should be. Further, RN-C stated all PICC line dressing changes should be recorded in the medical record and it was important to ensure the dressing was actually being changed and recorded as "the risk of	2 830		

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2 830	Continued From page 10 infection is huge." When interviewed on 5/12/22 at 10:15 a.m. the infection control and prevention registered nurse (RN)-D stated the facility' policy was to change a PICC line dressing "weekly" and should be entered and recorded in the physician orders and treatments of the medical record. RN-D reviewed the medical record and stated the dressing change would be a separate order and treatment aside from the general monitoring one listed. RN-D stated it was important to ensure the dressing was changed on a weekly basis to help reduce the risk of infection and added she could not recall any staff reaching out to her with concerns about IV management in the past weeks. Further, RN-D stated education was just provided to the nurses during a skills fair the month prior and, again, verified the dressing should be changed weekly. A provided Central Venous Catheter Dressing Changes policy, dated 4/2016, identified transparent, semi-permeable membrane dressing were to be changed every 5 - 7 days and as needed. The date and time of the dressing change, objective description of the insertion site, and and complications from the dressing change were to be recorded in the medical record. ALSO: Based on observation, interview, and document review, the facility failed to ensure physician recommendations and orders were clarified and addressed to provide pain medication and promote comfort for 1 of 2 residents (R297) reviewed for pain management. Findings include:	2 830		

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2 830	Continued From page 11 R297's Face Sheet, printed 5/12/22, identified R297 admitted to the transitional care unit (TCU) of the nursing home in early May 2022 from the hospital with an admission diagnosis of displaced intertrochanteric fracture of the right femur (leg bone). R297's Individual Resident Care Plan, dated 5/3/22, identified R297's initial care needs upon admission to the nursing home. The section of the care plan labeled, "Pain Control," identified R297 had actual pain in her right leg. However, the remainder of the section, including spaces to be pain management interventions, was left blank and not completed. On 5/9/22 at 6:37 p.m., R297 was seated in her wheelchair while in her room. R297's right leg was extended outward and R297 stated she was waiting for a heat pack from the staff as her "pain is terrible" in her right leg which stemmed from a fall prior to admission. R297 described the pain as "pins and needles" and voiced it extended down her leg into her ankle and toes. R297's Twin Cities Physicians SKILLED note, dated 5/9/22, identified R297 was seen by the physician assistant (PA) for her pain control at family' request. The note identified R297 reported poor pain control on 5/4/22, and her acetaminophen orders were changed as a result. R297's listed pain medications, as of 5/9/22, including acetaminophen 1000 milligrams (mg) three times a day and aspirin 81 mg daily for four week period. The note included dictation, "Message from [R297's family member] ... concerned about her pain control. Went to see [R297] again today and she reported her pain is okay when she is lying in bed but much worse	2 830		

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2 830	Continued From page 12 when moving around ... Discussed with [R297's family member], and we decided some low dose oxycodone [a narcotic medication] would help her participate in therapies with less pain. Since she reported the pain is also bad in the middle of the night, will schedule a dose for bedtime." The note concluded with a section labeled, "Assessment and Plan," which outlined several new recommendations including oxycodone 2.5 mg twice a day (every morning and bedtime) for seven days then consider a reduction. However, R297's corresponding Twin Cities Physicians order sheet, dated 5/9/22, identified the (PA) orders from the 5/9/22 visit. These included: 1) Lidocaine 4% patches to be applied to R297's right hip for 12 hours, then removed for 12 hours; 2) Diclofenac topical gel 1% (an anti-inflammatory medication) applied to the right hip four times a day; and, 3) Apply ice to the right hip in 20 minute increments four time a day for three days. The completed physician orders did not include any orders for oxycodone despite being listed in the plan of the corresponding progress note by the PA, and despite having been reviewed and discussed with R297's family member to help R297 have better pain control and potentially participate better with therapies. The orders were dated with a handwritten 5/9/22 by the nursing home staff. R297's subsequent Resident Vital Sign Report (for pain), dated 5/10/22 to 5/11/22, identified R297 rated her pain between a 1.0 and 2.0 (on a	2 830		

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2 830	Continued From page 13 scale of 0-10 with "10" being the worst rating). During subsequent observation on 5/10/22 at 2:11 p.m. R297 was lying in bed while in her room. R297's eyes were closed and she appeared comfortable with no obvious grimacing or physical signs or symptoms of pain present. When interviewed on 5/10/22 at 2:12 p.m. registered nurse (RN)-A stated he was assigned to care for R297 and explained she admitted to the nursing home with a hip fracture. R297 used a "pain patch" and Tylenol for pain relief, and RN-A stated there was no current order for oxycodone. RN-A reviewed R297's physician note, and corresponding physician orders, and stated the oxycodone was never started despite being listed on the note as the PA's plan to address R297's pain control. When discussing the process in place for nursing staff to review completed physician notes, RN-A stated he was unaware who, if anyone, was responsible to read the physician progress notes as the floor nurse "never had the chance to read those." RN-A stated he was unaware if the note, and corresponding orders, were clarified with the PA to ensure the correct pain control was being implemented. RN-A stated the note and corresponding orders should have been clarified to remove "confusing questions" and ensure the "actual plan" was being done to provide comfort for the resident. When interviewed on 5/10/22 at 2:30 p.m. the registered nurse unit manager (RN)-C explained physician orders were received by the health unit coordinator (HUC) and then scanned into the electronic medical record (EMR). RN-C stated there was poor communication between the nursing home and medical provider group and	2 830		

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2 830	Continued From page 14 often staff were "never told" of who was being seen. RN-C explained there was no staff assigned or directed, to her knowledge, to review incoming physician progress notes to ensure any questions or needed clarifications are obtained, and she expressed this served as another example of why they needed to improve communication with the medical provider group and nursing staff. Further, RN-C stated it was important to ensure conflicting or unclear notes and orders were clarified to provide "continuity of care" to the patient and voiced this inconsistency and potential error would not have been identified had the surveyor not brought it to their attention. On 5/12/22 at 10:36 a.m. the interim director of nursing (DON) was interviewed and stated she had investigated the issue. The PA rounded and dictated the progress note after having a discussion with R297's family member, then sent the order for the oxycodone to the incorrect inbox which caused it to not be received by the nursing home. The DON stated she discussed the situation with the PA and neither of them believed R297 was harmed as a result of the incident; however, the PA wanted to still start the medication as intended and would review R297 in a few days to ensure adequate pain control was being implemented. The DON stated she reviewed the process for order and note scanning with the medical record personnel and "moving forward," they were going to begin looking at notes and orders for inconsistencies. The DON stated it was important to ensure physician progress notes were reviewed timely and for consistency to help ensure orders weren't potentially missed. A facility' policy on pain management and/or physician order clarification was requested and	2 830		

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2 830	Continued From page 15 not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for pain management, physician order process, and PICC line care; then educate direct care staff and conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		6/3/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure as-needed (PRN) psychoactive medications were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R26) reviewed for unnecessary medication use. Findings include: R26's admission Minimum Data Set (MDS), dated 4/12/22, identified R26 had anxiety disorder, depression and post-traumatic stress disorder (PTSD). Further, R26 displayed severe cognitive impairment, demonstrated no behaviors (including rejection of care or delusions), and required extensive assistance with most activities of daily living (ADLs). R26's Physician Order Sheet, dated May 2022, included buspirone (an antianxiety medication) 30 milligrams (mg) twice a day, fluoxetine (an antidepressant medication) 10 mg once a day, and lorazepam (an antianxiety medication) 0.5 mg twice a day as-needed (PRN). The lorazepam had a listed start date of 4/6/22. R26's Care Plan Report, printed 5/12/22, identified R26 " ... is receiving antianxiety drugs on a regular basis," and listed a goal for R26 which read, "Symptoms of anxiety will be controlled with minimal side effects over the next 90 days." The care plan listed several interventions to help R26 meet this goal including providing activities, monitoring for side effects of the medications, and providing a quiet atmosphere.	21540	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00183	A. BUILDING: _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(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
21540	Continued From page 17 R26's April 2022 Medications report, dated 4/2022, identified R26's consumed medications for the month as signed out by the nursing home staff. This identified R26's lorazepam PRN order which identified it was administered once on 4/29/22 with the results being recorded, "Pain = 05 - It was administered." There was no recorded anxiety symptoms or resolution on the report. In addition, R26's May 2022 Medications report, dated 5/2022, identified R26 continued to have an active order for the PRN lorazepam, however, had received no doses in the month period thus far. However, both of these reports lacked any recorded or directed stops date for the PRN medication. R26's Interim Medication Regimen Review, dated 4/6/22, identified the consulting pharmacist had reviewed R26's physician orders and made several recommendations including, "PRN Psychotropic orders needs a 14 day stop date. Then ask MD to re-evaluate continued need for the following medication(s): Lorazepam." The completed report was signed on 4/22/22 by nursing home staff. However, R26's medical record was reviewed and lacked any recorded physician statements or clinical justification supporting the ongoing use of PRN lorazepam outside of the 14-day period since it was ordered on 4/6/22 (over 30 days prior). Further, there was no evidence the medication use had been extended outside of the 14-day required timeframe (i.e., 60 days) or had a stop date determined, despite the identified concern documented by the consulting pharmacist on their medication regimen review on 4/6/22. When interviewed on 5/11/22 at 1:21 p.m.	21540		

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	00183	A. BUILDING: _____ B. WING _____	C 05/12/2022

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COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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21540	Continued From page 18 registered nurse (RN)-B stated R26 did not display any anxiety or behavioral symptoms and described her as "pretty calm and pleasant." RN-B reviewed R26's current medication orders in the electronic record and verified R26 continued to have PRN lorazepam ordered and available for administration. RN-B stated she was unsure when, or if, a stop date was determined for the medication. RN-B explained she was aware most PRN psychotropic's needed to be stopped or have new orders written after 14 days; however, she did not know "the protocol" for how lorazepam specifically was addressed. RN-B added, "I didn't even know she was on Ativan [lorazepam] to be honest." When interviewed on 5/12/22 at 9:46 a.m. registered nurse unit manager (RN)-C stated she had reviewed R26's medical record, and she acknowledged there was no stop date identified for the PRN lorazepam nor was there evidence it's use had been re-evaluated by the medical provider. As a result, RN-C stated they "have a message out to the provider" for it to be addressed. RN-C reviewed the completed medication regimen review, dated 4/6/22, and explained those reports were forwarded to the nurse managers to be addressed. R26's report was reviewed and signed by the physician; however, it lacked any written direction or associated notes on how to address the identified PRN lorazepam. RN-C stated it was important to ensure PRN psychotropic were provided only when needed or discontinued timely to reduce the risk of a resident developing "abnormal movements [tardive dyskinesia]." On 5/12/22 at 10:48 a.m. the interim director of nursing (DON) was interviewed. The DON explained the pharmacy recommendation was	21540		

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21540	Continued From page 19 signed by the physician, however, the issue was not addressed as the physician "never checked either box" to indicate a response. As a result, they had just contacted the physician and obtained orders to discontinue the medication. The DON explained she had noticed some issues with medication management, including timely follow up on the consulting pharmacist reviews, since she started working at the nursing home and was actively working with the consulting pharmacist to get them resolved. However, the DON stated the PRN lorazepam should have been addressed with the medical provider or discontinued and explained they "have to lean back on our providers" to ensure orders or directions are given when the recommendations are made. A provided Medication Management policy, dated 1/2022, identified an unnecessary medication included any medication used for excessive duration and without adequate indication for use. The policy outlined, "PRN orders for psychotropic drugs are limited to 14 days. Exception: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for as-needed psychotropic medication use; then educate staff and audit records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		

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COVENANT LIVING OF GOLDEN VALLEY CAR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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21942	Continued From page 20	21942		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. This had the potential to affect all 57 residents in the facility. Findings include: Review of the facility document Family Council Agenda indicated the date was 10/22/19. During an interview on 5/10/22, at 2:40 p.m. the social worker (SW) stated there was no attempt to have a family council during COVID-19. SW stated there were no other attempts. During an interview on 5/10/22, at 3:30 p.m. the administrator stated the last time there was a family council was on 10/22/19.	21942	Corrected	6/3/22

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21942	Continued From page 21 Although a family council policy was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review facility systems for family council and work on promotion and encouragement of this group on an annual basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		

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	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	**5825 ST CROIX AVENUE** **GOLDEN VALLEY, MN 55422**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/10/2022. At the time of this survey, Covenant Living Of Golden Valley & Rehabilitation 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/03/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Covenant Living of Golden Valley is a 1-story building with no basement that was built in 1960 and was determined to be of Type II(000) construction. Additions were built in 1963, 1970, 1976, and 1998 and were all determined to be of Type II(000) construction. This building houses State Licensed only beds that are private pay, but because they are not separated by 2-hour fire rated construction, that portion will be included in the survey. The facility shares a common wall	K 000		

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K 000	Continued From page 2 with an assisted living occupancy, but is separated by 2-hour rated construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification. The facility has a capacity of 88 beds and had a census of 59 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 345	K345 - Semiannual Fire Alarm Inspections Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted	6/2/22

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K 345	Continued From page 3 On 05/10/2022 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility had not been completing semiannual fire alarm inspections. An interview with Regional Director of Facilities Management verified this deficient finding at the time of discovery.	K 345	at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. 1. A detailed description of the corrective action taken or planned to correct the deficiency a. The facility has completed Annual fire alarm inspections using Johnson Controls, a life safety equipment contractor. The Annual fire inspection was completed 2/16/2022. The Semiannual fire alarm inspection was added to the facilities Life Safety Inspection Calendar on 6/2/22. The Semiannual fire alarm inspection will be scheduled within six (6) months from the completion of the Annual fire inspection of 2/16/2022. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. The Semiannual fire alarm inspection will be scheduled within six (6) months from the completion of the Annual fire inspection. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. The Semiannual fire inspection has been added to the facilities Life Safety Inspection Calendar that is monitored regularly. The FMD/designee will report	

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K 345	Continued From page 4	K 345	the results of the Semiannual fire alarm inspection to the QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance a. The Director of Facilities Management or designee will be responsible to review the Life Safety Inspection Calendar ensuring that the Semiannual fire alarm inspection will be scheduled within six (6) months from the completion of the Annual fire inspection, results will be reported to QAPI committee. 5. Completion date a. Thursday, June 2nd, 2022.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per	K 372	K372 – A Penetration in The Smoke Barrier Caused By An Electrical Conduit	6/3/22

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K 372	Continued From page 5 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/10/2022 between 09:00 AM and 12:00 PM, it was revealed by observation that there was a penetration in the smoke barrier caused by electrical conduit above the ceiling near Room 156. An interview with the Regional Director of Facilities Management verified this deficient finding at the time of discovery.	K 372	Above The Ceiling Near Room 156 Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. 1. A detailed description of the corrective action taken or planned to correct the deficiency a. The facility has hired a General Contractor to appropriately Fire Stop the penetration in the smoke barrier caused by an electrical conduit above the ceiling near room 156. The Director of Facilities Management review the site with the General Contractor on Thursday, June 2. The General Contractor has agreed to appropriately Fire stop the penetration no later than Friday, June 10. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Going forward, Facility Maintenance Staff; The Director of Facilities Management, the Maintenance Supervisor and the Skilled Maintenance Technician will inspect the smoke barriers above the ceiling grid Annually and each time electric or low voltage wiring is done	

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K 372	Continued From page 6	K 372	in the facility by contractors. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. This inspection is on the Life Safety Inspection Calendar. Electricians and low voltage contractors will be supervised by Facility Maintenance Staff to ensure that penetrations are appropriately Fire stopped. 4. Identify who is responsible for the corrective actions and monitoring of compliance a. The Director of Facilities Management or designee will be responsible to review the Life Safety Inspection Calendar ensuring that the Annual inspection of the smoke barriers above the ceiling grid is completed. 5. Completion date a. The General Contractor has agreed to appropriately Fire stop the penetration no later than Friday, June 10.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		6/3/22

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COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	**5825 ST CROIX AVENUE** **GOLDEN VALLEY, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 7 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/10/2022 between 09:00 AM and 12:00 PM, it was revealed by observation that the oxygen storage room had both full and empty oxygen cylinders being stored in the same location and	K 923	K923 - Gas Equipment - Cylinder and Container Storage Covenant Living of Golden Valley Care and Rehabilitation respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Minnesota Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/10/2022**

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K 923	Continued From page 8 was not segregated. An interview with the Regional Director of Facilities Management verified this deficient finding at the time of discovery.	K 923	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. 1. A detailed description of the corrective action taken or planned to correct the deficiency a. Corrective action was that the full and empty oxygen cylinders have been separated and signage was created and posted. b. Facilities maintenance has consulted with the building architect regarding oxygen room storage and expansion 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Facilities staff removed excessive equipment from the room. Oxygen tanks were placed in holders and separated. Facility has consulted with respiratory providers to update equipment needs. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. The Director of Nursing or designee will audit the oxygen room five times a week for three months. b. The Director of Nursing or designee completed education with the nursing staff and the Housekeeping Supervisor on the need for separating full and empty oxygen tanks □ Completion date: 6-3-2022 4. Identify who is responsible for the corrective actions and monitoring of compliance a. The Director of Nursing and the Director of Facilities Management b. Audits will be reviewed by the QAPI	

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K 923	Continued From page 9	K 923	Committee to identify trends, make recommendations, and ensure ongoing compliance 5. Completion date: Friday, June 3rd, 2022	