MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Golden LivingCenter Bloomington	H5324059	August 25, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
9200 Nicollet Avenue S	8:00 a.m. - 6:00 p.m.	February 23, 2017
Facility City:	**Investigator's Name and Title:**	
Bloomington	Lisa Ciesinski, RN	

State:	ZIP:	County:
Minnesota	55420	Hennepin

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when s/he developed a stage IV pressure ulcer at the facility.

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

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility failed to adequately assess, monitor, and implement interventions to prevent and heal pressure ulcers. The resident re-developed coccyx/buttocks pressure ulcers, which worsened.

The resident was admitted to the facility with a sacral pressure ulcer. Staff implemented interventions to prevent the development of additional pressure ulcers. Over the next several months, the sacral pressure ulcer healed, re-developed, and healed again. New interventions were implemented; however, the resident's care plan, and direct care staff aide sheet were not kept up to date with instructions for direct staff on how frequently to turn and reposition the resident.

Approximately two months after the last pressure ulcer healed, the resident developed two stage two pressure ulcers to her/his coccyx/buttocks. Staff did not notify or obtain orders for treatment from the physician until 28 days later, when the ulcers had worsened and resident had four open areas to her/his buttocks. One week later, the resident went to the hospital due to a decrease in responsiveness and a temperature of 101.6 degrees Fahrenheit.

According to records, the hospital admitted the resident with a diagnosis of sepsis as well as a catheter associated urinary tract infection. Upon admission into the hospital, the resident's pressure ulcers had necrotic tissue with surrounding skin cellulitis. The sacral bone was exposed.

When interviewed, the nurse practitioner stated s/he had never previously examined the resident's pressure ulcers due to resident refusals. The nurse practitioner was not informed of the pressure ulcers re-development until approximately one month after staff observed the new pressure ulcers. The nurse practitioner indicated the facility's lack of monitoring, and delay in treatment contributed to the worsening of the resident's pressure ulcers.

The resident did not return to the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

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

Although the facility had pressure ulcer policies and procedures in place for physician notification, assessments, monitoring, and treatment, the facility lacked a system to ensure staff followed the policy.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Not at the facility

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ◉ Yes ○ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Bloomington Police Department

Hennepin County Attorney

Bloomington City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5324057,H5324058, and H5324059. As a result, the following deficiencies are issued for all three investigations.	F 000	F000 Golden Living Care Center Bloomington objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Golden Living Care Center Bloomington MN have caused "actual harm" or substandard quality of care.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Rutgers | TITLE: Executive Director | (X6) DATE: 10-20-16

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely notify the family and physician of the re-development of pressure ulcers for 1 of 3 (R1) resident's reviewed. This resulted in actual harm for R1, when wound care was delayed and the pressure ulcers worsened. Findings include: R1's medical record was reviewed, R1 was admitted to the facility on 10/19/16 with a sacral pressure ulcer. A 5/5/16 progress note indicated the pressure ulcer healed on 2/13/16 and re-opened on 4/16/16. A 5/11/16 progress note indicated R1's pressure ulcer healed again. R1's "Weekly skin review" dated 7/9/16, identified R1 had two new open areas to his buttocks. The first open area to R1's "crack" measured 6 centimeters (cm) long by 0.2 cm wide and was red/dark pink in color. A second open area to R1's left buttocks measured 0.3 cm wide by 0.3 cm long with 50% yellow adherent slough and 50% "red." Staff cleansed the areas with soap and water, applied a skin barrier, and a Tegafoam dressing. The medical record lacked provider notification of the pressure ulcer development, orders for treatment, or family notification. A progress note, 3 days later, on 7/12/16, indicated the open area to R1's "crack" measured 1.1 cm in length. The documentation lacked width and depth measurements. The open area to R1's left buttocks increased in size to 0.4 cm long by	F 157	F157 R1 was discharged from facility on 8/19/16. All residents receiving wound care have the potential to be affected. As of October 20, 2016 all residents with pressure injuries have been audited for evidence that the primary care provider has been notified as needed. Wound rounds will be completed by a staff RN on a weekly basis. Any wounds that are worsening in condition or show a lack of improvement will be reported as soon as possible (no longer than 24 hours) by the	

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F 157	Continued From page 2 0.4 cm wide. Both areas were beefy red in color with scant bloody drainage. Areas were cleansed with a wound cleanser and a skin barrier and a foam dressing were applied. Although the progress note identified 2 open areas, a "Weekly Nursing Summary" form dated the same date, indicated R1's skin was intact. The medical record lacked physician notification of the worsening pressure ulcers, orders for treatment, or family notification. A 8/2/16 progress note indicated R1 had "red dots to his coccyx." Scant amount of bloody drainage when cleansing with soap and a cloth. Non-compliant at times with cleansing needing staff re-approach. R1's medical record lacked provider notification or treatment orders of the pressure ulcers from the time the the pressure ulcers developed on 7/9/16, until 8/5/16, when a "Weekly Skin Review" identified a total of 4 open areas to R1's buttocks and staff notified Nurse Practitioner (NP)-O. R1's physician orders revealed a telephone order on 8/5/16, which directed to "Apply foam drsg (dressing) to coccyx open areas after washing/drying and skin prep wipe applied. Change the dressing every 3 days and as needed." On 8/9/16, a "Wound Evaluation Flow Sheet" identified an unstageable pressure ulcer to R1's coccyx measuring 4 cm x 1 cm with a depth of 0.2 cm. The area was scabbed and dark purple in color with some white discharge noted. The wound bed was 80% epithelial and 20% slough. An area on the left buttocks, superficial layer was gone. Wound bed bright red in color measuring 1 cm x 3 cm. Area on right buttocks, superficial	F 157	nurse completing wound rounds. The wound nurse will maintain and submit a weekly record of assessments for audit at IDT meeting. The interdisciplinary wound care team will meet on a weekly basis to audit the weeks wound notes for evidence that primary care provider was updated. The interdisciplinary wound team will consist of Nursing and one (1) or more of the following as clinically indicated, Social Services, Dietary, Physical Therapy, Occupational Therapy or Recreational Therapy. DNS or designee will audit five (5) random residents' general progress notes weekly for evidence that the appropriate notifications were made. Audits will continue for a period of no less than three (3) months. Results will be discussed at monthly QAPI committee. Frequency of audits will be adjusted as needed based upon these results. All licenced nurses and certified nursing assistants will be reeducated on company policy regarding PCP notification requirements. Executive Director and Director of Nursing Services are responsible for compliance. Date of Completion October 31st, 2016	

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F 157	Continued From page 3	F 157		

layer was gone. Wound bed bright red and measured 1.5 cm x 1 cm. Cleansed with wound cleanser and applied foam dressing to all three areas. R1's medical record lacked notification of the provider for the worsening pressure ulcers, or family notification.

A progress note dated 8/14/16 indicated R1's pressure ulcers worsened. "Coccyx and buttocks wound-Noted redness of buttocks with scaling patches yellow in color with serous drainage. Open Black area above coccyx. Noted foul smell coming from the wound." "Infected wound-Stage 3 with tunneling occurring." Dressing changed. "Compliant with turning schedule tonight." This was the first time R1's medical record identified family notification of the pressure ulcers.

When interviewed on 8/31/16 at 8:45 a.m. family member (FM)-Q stated she was not informed of R1's pressure ulcers until 8/14/16, when she was present for a dressing change. FM-Q stated she was shocked over the horrific smell and sight of the wound.

When interviewed on 9/6/16 at 1:05 p.m., IDON-A stated staff should have contacted the provider on 7/9/16, when staff first observed the pressure ulcers and each time R1's pressure ulcer worsened. IDON-A stated staff are expected to follow the policy and obtain wound care orders from the provider. IDON-A confirmed staff did not contact the provider when R1 re-developed the pressure ulcers and did not obtain an order for treatment until 8/5/16. In addition, family was not timely notified of the development and worsening pressure ulcers.

When interviewed on 9/20/16 at 2:20 p.m.

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F 157	Continued From page 4	F 157		

Physician (R) stated staff did not inform him R1's pressure ulcers re-developed on 7/9/16. Physician (R) stated he was unaware R1's pressure ulcers worsened. Physician (R) stated he would have expected staff to notify him for wound care orders and/or referral to a wound specialist.

When interviewed on 9/20/16 at 9:00 a.m. NP-O stated R1 had history of pressure ulcers. NP-O stated she never examined R1's pressure ulcer, as R1 had always refused. NP-O could not remember if staff informed her the pressure ulcer healed in May 2016. NP-O stated whenever she asked staff about the pressure ulcer, she was always informed the pressure ulcer was healing. NP-O stated she was not informed of the pressure ulcers which developed on 7/9/16 until 8/15/16, when for the first time, she was informed by a staff nurse the pressure ulcers had worsened. NP-O stated she examined the pressure ulcers on 8/15/16 and was taken aback at how bad the pressure ulcer had progressed. NP-O stated the pressure ulcers covered 1/2 of both buttocks, had granulation, slough, and was odorous. NP-O stated she would have expected to be notified when the new pressure ulcers developed and anytime the pressure ulcers worsened. NP-O stated the lack of monitoring and delay in treatment contributed to R1's pressure ulcers worsening.

The facility's policy, dated 11/11/15, titled "Notification of Change in Resident Health Status" indicated "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:" Development of stage 2 pressure

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F 157	Continued From page 5 sore when no ulcers were previously present at stage 2 or higher. Appropriate notification time is immediate. Immediate defined as soon as possible no longer than 24 hours. In addition, notification immediately to 48 hours when a need to alter or start a new treatment.	F 157		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor, and implement interventions to prevent and heal pressure ulcers for 1 of 3 (R1) residents reviewed. This resulted in actual harm for R1, when coccyx/sacral/buttocks pressure ulcers redeveloped multiple times at the facility and worsened. Findings include: R1's medical record was reviewed, R1 was admitted to the facility on 10/19/16 with a sacral pressure ulcer. A 1/21/15 quarterly minimum data set (MDS) identified R1 was at risk for pressure ulcers and identified R1 had a stage 2	F 314	F314 R1 was discharged from facility on 8/19/16. All residents at risk of developing a pressure sore have the potential to be affected. All residents at risk of developing a pressure ulcer will be discussed at clinical stand up meeting following their admission to develop a comprehensive prevention plan. DNS or designee will review all new admission assessments within 24 hours and implement an plan of care and interventions as necessary. DNS or designee will audit five (5) random residents' charts weekly for completeness of pressure injury plan of care, interventions and nursing assistant care sheet accuracy. IDT wound care team will meet on a weekly basis to evaluate and update the plan of care for all at risk residents to ensure all appropriate preventative interventions are in place. All residents who have had a pressure injury that has healed will continue to have a skin assessment on a weekly basis and be followed by the IDT wound care team for a period of no less than four (4) weeks to minimize risk of reoccurrence. The interdisciplinary wound team will consist of	

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F 314	Continued From page 6 pressure ulcer. The MDS indicated interventions of a pressure reducing mattress, a pressure reducing wheelchair cushion, and dressing changes to heal and prevent pressure ulcers. A 5/5/16 progress note indicated the pressure ulcer healed on 2/13/16 and re-opened on 4/16/16. R1's care planned interventions for pressure ulcers, updated on 5/9/16, changed R1's bed mobility from an assist as needed (PRN) to staff assist of 1. R1's May, June and July care plan did not direct staff on the frequency of repositioning. Interventions of a pressure relieving mattress and a pressure reducing wheelchair cushion remained unchanged. A 5/11/16 progress note indicated R1's pressure ulcer was healed. R1's "Weekly skin review" dated 7/9/16, identified R1 had two new open areas to his buttocks. The first open area to R1's "crack" measured 6 centimeters (cm) long by 0.2 cm wide and was red/dark pink in color. A second open area to R1's left buttocks measured 0.3 cm wide by 0.3 cm long with 50% yellow adherent slough and 50% "red." Staff cleansed the areas with soap and water, applied a skin barrier, and a Tegafoam dressing. The medical record lacked provider notification of the pressure ulcer development, orders for treatment, staging of the pressure ulcers, or implementation of additional interventions to promote healing. A "Weekly Nursing Summary" form, dated 3 days later on 7/12/16 indicated R1's skin was intact; however, a progress note on the same date indicated the open area to R1's "crack" measured 1.1 cm in length. The documentation lacked width and depth measurements. The open area to R1's	F 314	Nursing and one (1) or more of the following as clinically indicated, Social Services, Dietary, Physical Therapy, Occupational Therapy or Recreational Therapy. QAPI committee will examine trending and analysis of pressure ulcer data on a quarterly basis. Audit results will be discussed at monthly QAPI committee. Frequency of audits will be adjusted as needed based upon these results. Executive Director and Director of Nursing Services are responsible for compliance. Date of Completion October 31st, 2016	

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F 314	Continued From page 7 left buttocks increased in size to 0.4 cm long by 0.4 cm wide. Both areas were beefy red in color with scant bloody drainage. Areas were cleansed with a wound cleanser and a skin barrier and a foam dressing were applied. The medical record lacked physician notification of the pressure ulcers, orders for treatment, or implementation of additional interventions to promote healing. A 7/14/16 MDS assessment identified R1 had 2 pressure ulcers. The MDS indicated R1 now required assistance of 2+ staff for bed mobility. Although a progress note dated 7/19/16 indicated R1 had no open areas to his buttocks, a 7/28/16 progress note indicated R1 had 2-stage 2 pressure ulcers "at this time," which are smaller than the previous week. A 8/2/16 progress note indicated R1 had "red dots to his coccyx." Scant amount of bloody drainage when cleansing with soap and a cloth. Non-compliant at times with cleansing needing staff re-approach. R1's medical record lacked documentation of a comprehensive assessment, including measurements of the pressure ulcers since 7/12/16. R1's medical record lacked provider notification or treatment orders of the pressure ulcers from the time the the pressure ulcers developed on 7/9/16, until 8/5/16, when a "Weekly Skin Review" identified a total of 4 open areas to R1's buttocks and staff notified Nurse Practitioner (NP)-O. R1's physician orders revealed a telephone order on 8/5/16, which directed to "Apply foam drsg (dressing) to coccyx open areas after washing/drying and skin prep wipe applied. Change the dressing every 3 days and as needed."	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

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F 314	Continued From page 8 R1's pressure ulcers lacked a comprehensive assessment, including measurements between 7/13/16 and 8/8/16. On 8/9/16, a "Wound Evaluation Flow Sheet" identified an unstageable pressure ulcer to R1's coccyx measuring 4 cm x 1 cm with a depth of 0.2 cm. The area was scabbed and dark purple in color with some white discharge noted. The wound bed was 80% epithelial and 20% slough. An area on the left buttocks, superficial layer was gone. Wound bed bright red in color measuring 1 cm x 3 cm. Area on right buttocks, superficial layer was gone. Wound bed bright red and measured 1.5 cm x 1 cm. Cleansed with wound cleanser and applied foam dressing to all three areas. Reposition every 2 hours. Message left for MDS coordinator to make sure care plan and nursing assistant sheets are updated. R1's medical record lacked notification of the provider for the worsening pressure ulcers. Although R1's 7/14/16 MDS indicated R1's bed mobility changed from 1 to 2+ staff assistance, the intervention was not changed on R1's care plan until 8/10/16 (27 days later.) In addition, the frequency of turning and repositioning of R1 was not added to the care plan until 8/10/16, when the care plan was updated to assist of 1-2 staff to turn and reposition every 2 hours. On 8/10/16 an additional care plan intervention directed staff to explain the risk/benefits when refusing to turn/reposition every 2 hours. When interviewed on 9/6/16 at 1:05 p.m., the interim director of nursing (IDON)- A stated nursing assistants follow aide sheets when providing cares. IDON-A stated, although the aide sheets should be updated daily with changes, staff have only been updating the aide sheets quarterly. IDON-A stated	F 314		

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F 314	Continued From page 9 R1's aide sheet lacked direction to turn and reposition R1 until 8/9/16. A progress note dated 8/14/16 indicated R1's pressure ulcers worsened. "Coccyx and buttocks wound-Noted redness of buttocks with scaling patches yellow in color with serous drainage. Open Black area above coccyx. Noted foul smell coming from the wound." "Infected wound-Stage 3 with tunneling occurring." Dressing changed. "Compliant with turning schedule tonight." R1's physician orders identified NP-O examined R1 on 8/15/16 and implemented new wound care orders. Physician (P), a wound care specialist, examined R1 on 8/16/16. The "Wound Care Specialist Evaluation" form identified a bilateral buttocks/sacrum unstageable pressure ulcer. The wound measured 14 cm x 9.5 cm with 100% eschar (necrotic tissue.) A surgical debridement was completed with a post-debridement depth of 0.6 cm. Physician-P implemented the following new daily wound care orders. After cleansing, liberally apply Santyl then calcium Alginate and cover with super absorbent foam. Use Saline wet to moist dressings twice daily until Santyl available. Low air loss mattress and ROHO cushion for chair. Vitamin C and Zinc Sulfate were ordered. R1's physician orders revealed NP-O evaluated R1 on 8/17/16 and ordered Nitrofurantoin to treat a urinary tract infection (UTI). On 8/19/16 NP-A evaluated R1 again, and ordered a CBC and BMP (lab tests.) R1 was diagnoses with a wound abscess, infection. A 8/19/16 progress note later that same day, indicated R1 became less responsive with a temperature of 101.6. Staff transferred the R1 to the hospital.	F 314		

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F 314	Continued From page 10 Hospital documentation indicated R1 was admitted with a diagnosis, which included sepsis, likely due to infected decubitus ulcer/cellulitis, as well as catheter associated urinary tract infection (UTI.) R1's August 2016 TAR and progress notes revealed R1's wound treatment was completed as ordered between 8/5/16 and 8/19/16. When interviewed on 9/6/16 at 1:05 p.m., IDON-A stated staff should have contacted the provider on 7/9/16, when staff first observed the pressure ulcers. IDON-A stated staff are expected to follow the policy and obtain wound care orders from the provider and comprehensively monitor the pressure ulcers weekly. Staff should notify the provider when a change in a pressure ulcer occurs. IDON-A confirmed staff did not timely notify the provider and obtain an order for treatment until 8/5/16, did not complete weekly comprehensive pressure ulcer assessments, and did not notify the provider when the pressure ulcers worsened. IDON-A stated R1 had a history of refusal of wound care and repositioning. IDON-A confirmed between the dates of 7/9/16 to 8/4/16, R1 did not have wound care orders to refuse. IDON-A further stated staff should have looked at other interventions, such as an air mattress sooner. When interviewed on 9/20/16 at 9:00 a.m. NP-O stated, R1 had history of pressure ulcers. NP-O stated she never examined R1's pressure ulcer, as R1 had always refused. NP-O could not remember if staff informed her the pressure ulcer healed in May 2016. NP-O stated whenever she asked staff about the pressure ulcer, she was	F 314		

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F 314	Continued From page 11 always informed the pressure ulcer was healing. NP-O stated she was not informed of the pressure ulcers which developed on 7/9/16 until 8/15/16, when for the first time, she was informed by a staff nurse the pressure ulcers had worsened. NP-O stated she examined the pressure ulcers on 8/15/16 and was taken aback at how bad the pressure ulcer had progressed. NP-O stated the pressure ulcers covered 1/2 of both buttocks, had granulation, slough, and was odorous. NP-O stated she would have expected to be notified when the new pressure ulcers developed and anytime the pressure ulcers worsened. NP-O stated the lack of monitoring and delay in treatment contributed to R1's pressure ulcers worsening. The facility's policy, undated titled "Skin Integrity Guideline", indicated a licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review. A licensed nurse documents weekly on the identified wound using the "Wound Evaluation Flow Sheet." The care plan is to be implemented, evaluated and revised based on the needs of the resident. If a patient/resident is refusing or choosing not to receive treatment, review risks, benefits and alternatives. Re-evaluate and attempt other interventions. The policy identified treatments protocol and interventions with directions to complete treatment per MD order.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F323 R15, R10, R14, R20, R12, R8, R9, R6, R11, and R4 have had smoking assessments completed. Above mentioned residents have been re-educated on smoking policy and signed a behavior contract. Room searches have been completed and smoking materials have been confiscated. All residents who smoke have the potential to be affected. All current residents will have a comprehensive smoking assessment. All current residents who wish to smoke will be required to sign an acknowledgement of the smoking policy. All new residents will be	

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F 323	Continued From page 12 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete and/or implement an individualized smoking assessment which including providing supervision and ensuring safety measures were put into place for 10 of 10 residents, (R15, R10, R14, R20, R12, R8, R9, R6, R11, and R4) who smoked unsupervised at the facility. Findings include: R15's Smoking Safety Assessment dated 8/12/16, indicated the resident had varying mental function, used a wheelchair for locomotion, had limitation in range of motion, and had a history of smoking related incidents which included the resident stating, "burned my pants outside." The interventions listed on the Smoking Safety Assessment indicated R15 was an independent smoker, and was to wear a smoking apron. R15's Progress notes indicated the following regarding smoking: 7/24/16- "Patient observed outside this writer window, smoking, this writer approached the patient et re-education provided on the smoking policy, he stated that, 'I can smoke here for its outside et off the grounds.' Showed the patient what is considered off the property, patient stated, 'I know this already.' Patient, while on his electric wheelchair went to the side walk to smoke,	F 323	required to sign an acknowledgement of the smoking policy and have a smoking assessment completed within forty eight (48) hours of admission. All staff members will be provided reeducation on smoking policy and procedures. All residents who wish to smoke will be required to use the designated smoking area during the designated times, wear a smoking apron and store their smoking materials in the designated area. A schedule will be maintained and posted in an area that is easily accessible to residents. Smoking materials will only be released to residents during the designated smoking periods or when they are signed out of the facility for a leave of absence that is expected to be greater than two hours. Residents who are non-compliant with storage provisions of smoking policy will be subject to a room searches as needed. A log of room searches and instances of smoking non-compliance will be maintained by the DNS or designee. A log of the smoking schedule and designated supervisors will be maintained by the DNS or designee.. DNS or designee will audit the supervision log and the non-compliance log on a weekly basis. Audit results will be discussed at monthly QAPI committee. Frequency of audits will be adjusted as needed based upon these results. Executive Director and Director of Nursing Services are responsible for compliance. Date of Completion October 31st, 2016	

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F 323	Continued From page 13 speeding et nearly fell out of his electric wheelchair when he jumped the curb." 7/25/16- "Pt [patient] constantly stops his tube feeding to go smoke outside." 7/27/16- "Patient in and out of his room throughout evening to go out to smoke, often going out to gazebo area despite staff reemphasizing about the no smoking policy in the facility property." 8/6/16- "Often comes out to go out for smoking cigarettes when not tired or sleeping." 8/14/16- "Patient is a smoker and did went out to smoke." 8/15/16- "Smoking was discussed and pt. [patient] understands that he needs to go to the front in order to smoke." R15's care plan dated 8/12/16, indicated the resident was, "NON-Compliance with smoking policy: new policy established 1/1/16 to a non smoking facility." Interventions included ensuring all cigarettes and lighters were kept at nursing station, and wears smoking apron when he goes out to smoke due to burning holes in his pants. During observation on 8/26/16, at 2:15 p.m. R15's clothes were observed with trained medication assistant (TMA)-E. The following areas were observed on R15's clothes: - Columbia winter coat had 1 hole in the back of the coat measuring approximately 0.8 cm x 0.8 cm. - Blue T-shirt had 1 hole in the front, bottom approximately 0.6 cm x 0.6 cm. - Black t-shirt had 2 holes in the front towards the bottom approximately 1.5 cm x 1.5 cm, and 0.8 cm x 0.8 cm. - Gray shorts had an area approximately 1 cm x 1 cm which appeared singed, however, there was	F 323		

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F 323	Continued From page 14	F 323		

not a hole going all the way through the shorts.
- Blue sweatpants had 1 hole in the crotch area of the pant measuring approximately 1 cm x 1 cm.
TMA-E stated all of the areas on R15's clothes appeared to be cigarette burn holes. TMA-E stated she was "not surprised" by the burn holes, and stated when the resident goes out to smoke, she worries about R15 because he is on so many medications he falls asleep very easily. TMA-E stated R15 "would never tell us (staff)" if he burnt himself because he knows he should not be smoking with his medical condition.

R15 was laying in bed during this time, however, he was unable to be interviewed as he continually fell asleep during interview.

When interviewed on 8/26/16, at 11:40 a.m. licensed social worker (LSW)-F stated she was aware R15 had burn holes in his clothing from cigarettes, and knew the holes, "happened since he has been here [the facility]." LSW-E stated in the past she had seen R15 smoking outside and he would try to hide the lit cigarettes under his shirt or in his lap.

R10's Smoking Safety Assessment dated 8/11/16, indicated the residents mental function varied, had dementia, used a cane, walker, or crutch for mobility, and had no history of smoking related incidents. The interventions listed were the resident was independent, wear a smoking apron, and supervised by staff.

R10's Progress Notes identified the following:
6/5/16- "Resident went out to smoke and fell on his knees when the wind blew him over as he tried to grab his stuff on his walker. Ambulatory and has permission to smoke off the grounds."

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F 323	Continued From page 15 6/27/16- "Res [resident] reported sister gave him smokes and he wasn't giving them to writer. Threw empty pack at writer. Res kept full pack and put them in pocket and zipped jacket for writer not to get smokes." R10's care plan dated 8/11/16, indicated the resident was at risk for smoking related injury related to diagnoses of dementia. Interventions included assure smoking material is extinguished prior to patient leaving smoking area, give resident up to 2 cigarettes, smoking apron will be worn while smoking, smoking only allowed during designated and monitored times per policy. During observation on 8/26/16, at 11:40 a.m. R10's clothing was observed with LSW-F. R10 had a gray zipper sweatshirt with a hole in the front measuring approximately 0.7 cm x 0.7 cm. LSW-F stated she was not aware R10 had any safety concerns with smoking, however, about a month ago R10 went out to the front of the building to smoke and slipped and fell. LSW-F stated R10 was encouraged to follow the facility smoking policy and go to the gazebo smoking area. During a follow up interview on 8/26/16, at 11:50 a.m. LSW-F stated she had just went and spoke to R10 who stated the burn holes were not from him, and the clothes were hand me downs and had the burn holes when he got them. During observation on 8/26/16, at 11:55 a.m. R10 was observed on the corner near the street out front of the building smoking. No staff were present and the resident was not wearing a smoking apron.	F 323		

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F 323	Continued From page 16 During interview and observation on 8/29/16, at 1:15 p.m. R10 was observed wearing a zippered vest. The vest had a small burn hole, approximately 0.5 cm (centimeters) x 0.5 cm. R10 stated he kept his cigarette and lighter in his room, however, occasionally staff would take them away. R10 was not sure why staff would take them. R10 also stated he had never burnt himself with a cigarette. R14's Smoking Safety Assessment dated 8/12/16, indicated the resident had mild cognitive impairment and had no smoking related incidents. The interventions listed were a smoking apron and to be supervised by staff. The Smoking Safety Assessment had a hand written note next to the interventions indicating, "Resident is refusing apron and supervision." R14's Progress Notes indicated the following: 6/7/16- "Pt. found smoking in front of sub acute courtyard door at 3:50 p.m. during non-smoking times in a non-smoking area. RT asked why are you smoking here he stated because no one is here but you. RT stated that the rules of the facility and the laws of the state of Minnesota apply all the time and asked if he knows the appropriate times of smoking. Res stated yes. Res asked 3 times to put out his cigarette and he finally put it out on his finger putting it back in his pouch that hangs around his neck with his cigarettes. RT stated that I would take his cigarettes and put them at the nursing station until the next smoke time per the smoking rules. Res refused to give them to this writer." 7/8/16- "At 11am resident was seen smoking in the courtyard during non-smoking time. RT [recreational therapist] told res that this is to non-smoking time and res stated why does it	F 323		

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F 323	Continued From page 17 matter. There is no one out here. RT explained the policy again and ask res to put out cigarette and hand me his smoking supplies to be keep at the nursing station during non-smoking times. Res put out his cigarette with his fingers and allowed me to take his supplies and give to nurse." 8/18/16- "Resident was found smoking in Gazebo outside TCU [transitional care unit] by himself with no apron on et 1502 [3:02 p.m.]. Writer reminded resident of out policy, asked that he put out his cigarette, and reminded that cigarettes and lighters need to be locked up when they are no being used." 8/25/16- "This writer saw Res out in the courtyard smoking during non-smoking times in the courtyard. Res was reminded of the smoking policy and asked to put out his cig." R14's care plan dated 8/15/16, indicated the resident was at risk for smoking related injury related to smoking independently. Interventions included assist resident to and from designated smoking area as needed, assure smoking material is extinguished prior to patient leaving smoking area, ensure smoking apron is worn while smoking at all times, and only 2 cigarettes given at each smoking time. During observation on 8/25/16, at 1:15 p.m. R14's clothes were observed with laundry aide (LA)-D. R14 was present in the room and had a pouch around his neck with a pack of cigarettes in. The following areas were noted on R14's clothes: - Right shoe- 2 holes on the top of the shoe, approximately 0.5 cm x 0.5 cm. - Left shoe- 1 hole on top of the shoe, approximately 0.5 cm x 0.5 cm. - Gold coat- 4 holes on the right front side of the	F 323		

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F 323	Continued From page 18	F 323		

coat, all measured approximately 0.8 cm x 0.8 cm.
- Gray sweatpants- 2 holes on the crotch area measuring approximately 0.5 cm x 0.5 cm and 1 cm x 1 cm.

During interview on 8/25/16, at 1:15 p.m. R14 stated the holes in the clothing were from, "Cigarettes." R14 stated he had not burned himself, but it was from, "The ashes dropping." R14 stated it had happened in the last year, since admission to the facility.

During observation on 8/25/16, at 2:48 p.m. R14 was pushed out in his wheelchair to the gazebo area by an unknown staff member. The unknown staff member left R14 outside, and the resident lit up a cigarette he had obtained from a pouch hanging around his neck. R14 sat outside unsupervised, with no other residents or staff, did not have a smoking apron on, and was not near an ashtray to extinguish his cigarette. At 3:02 p.m. therapeutic recreation (TR)-B approached R14 and spoke to him until approximately 3:04 p.m., and then came into the facility, leaving R14 unsupervised smoking. At 3:05 p.m. TR-B stated R14 was not following the smoking policy because he was smoking outside of the normal smoking times, however, TR-B walked away. At approximately 3:10 p.m. R8 walked into the gazebo and began smoking. R14 was observed to throw his lit cigarette on the ground when he was finished smoking. Both R14 and R8 remained in the gazebo area smoking unsupervised until approximately 3:20 p.m., when R8 pushed R14 back in the facility.

When interviewed on 8/26/16, at 11:20 a.m. nursing assistant (NA)-C stated R14 did not need

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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) COMPLETION DATE
F 323	Continued From page 19	F 323		

to be supervised while smoking. NA-C stated she would bring R14 outside to smoke before her break, and then come back to get him when she was done with break. NA-C stated R14 kept his cigarettes and lighter with him in the pouch around his neck.

During interview on 8/26/16, at 11:40 a.m. LSW-F stated she was not aware R14 had cigarette burns in his clothes, however, stated, "It would not surprise me [if he had cigarette burns in his clothes]," as R14 had tremors at times.

During a follow up interview on 8/26/16, at 11:50 a.m. LSW-F stated she had checked with R14's family member who stated they believed the cigarette burn holes observed in R14's clothing had probably happened prior to admission to the facility.

R20's Smoking Safety Assessment dated 8/12/16, indicated the resident "sometimes" had tremors to his hands, and had no history of smoking related incidents. The interventions included smoking apron and supervised by staff. Next to the interventions it was handwritten in the resident did not want to be supervised.

R20's Progress Notes indicated the following: 6/27/16- "...Resident went outside; another resident and family member came to nurse and complaint of resident smoking on sidewalk on property in which resident has been made aware of smoking only off property; went to talk to resident; resident was updated and asked to move; resident started getting upset with staff then move to go off property though was noted to hit another family members car; resident at this time smoking off property."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 20 7/12/16- "Patient observed smoking by the parked cars (sidewalk) in front of the building. Smoking policy explained et patient verbalized understanding of the smoking policy et moved off the property to finish smoking. Patient has his cigarettes et lighter upon his person." 8/2/16- "Patient observed light cigarette outside the front door. Patient reminded that GLC [golden living center] is a smoke free facility et grounds et education provided on the facility's no smoking policy. Patient responded with the statement, 'I don't give a f--k, I ' m gonna lite up where ever." 8/26/16- "Yesterday at about 7:30 p.m. this writer observed while driving past the facility this res on the sidewalk on the property smoking." R20's care plan dated 8/15/16, indicated the resident was at risk for smoking related injury related to smoking independently. Interventions included patient not to have cigarettes or smoking materials, provide smoking apron while smoking, resident will be given up to 2 cigarettes at a time, and smoking is only allowed during designated and monitored times. During observation on 8/26/16, at 11:15 a.m. R20 was observed outside the front of the facility sitting on the corner of the sidewalk smoking. R20 was not wearing a smoking apron and there were no staff present. During interview on 8/26/16, at 12:45 p.m. R20 stated the facility told him he needs to be off facility property to smoke, so he goes to the corner and sits on the sidewalk to smoke. R20 stated he keeps his smoking materials with him and does not store them in the nurses station.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

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F 323	Continued From page 21 R12's Smoking Safety Assessment dated 8/15/16, indicated the resident had varied mental functioning and had no history of smoking related incidents. The interventions indicated the resident was, "Independent." The assessment indicated, "Resident is refusing to give up cigarettes at this time. DNS, [director of nursing services], SS [social services], and ED [executive director] all approached her and she cont [continued] to refuse." R12's Progress Note indicated the following: 6/5/16- "Resident was seen in her W/C [wheelchair] when I went on a walk and she was at Holiday gas station 12 blocks away. Then on my way back walking I saw her wheeling in her W/C with much difficulty on the sidewalk leaning towards Nicollet Ave (the street side walk is very tilted towards the street) she was stuck on a sidewalk bump. She was wearing bandanas on her hands to wheel her chair. I felt like she was at a high risk for falling into the street." 7/24/16- "This writer et another staff member approached this patient et searched her purse with her consent. Found in her possession were a pack of cigarettes et lighter." 7/24/16- "... Reminded resident to go off property when going out for smoke." 7/28/16- "SS met with res for a 1:1 to discuss importance of signing out when she goes for a smoke. Res reported, 'I couldn't find a pen or a nurse to ask.'" 8/23/16- "...Patient is a smoker, went outside the facility several times to smoke." R12's care plan dated 8/15/16, indicated the resident was at risk for smoking related injury related to attempts to obtain lighter or matches. Resident was not to smoke on campus due to a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

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F 323	Continued From page 22	F 323		

non-smoking facility but is to sign out to smoke, however, resident refused to turn in her cigarettes. The interventions included assure smoking material is extinguished prior to patient leaving smoking area, patient not to have cigarettes or smoking material with her, provide smoking apron while smoking if needed, and resident to be given up to 2 cigarettes maximum.

During observation on 8/25/16, at 11:00 a.m. R12 was observed in an electric wheelchair on the corner of the sidewalk off the facility property smoking. There were no staff present and R12 was not wearing a smoking apron.

When interviewed at 8/25/16, at 2:43 p.m. R12 stated she is not allowed to smoke on the facility property, so she goes out to the corner and smokes on the sidewalk. R12 stated staff had never come outside with her to observe her smoking. R12 stated it is difficult to dispose of the smoked cigarettes as there is no ashtray available for the residents who smoke, so they need to put the cigarette out and then throw it into the garbage on the way back into the facility.

R8's Smoking Safety Assessment dated 8/11/16, indicated the residents mental function varied, had dementia, and had no history of smoking related incidents. The interventions included a smoking apron, and to be supervised smoking by staff. The assessment also indicated, "When asking resident if she is aware of smoking policy she answered 'yes.' However resident could not remember the designated smoking times, or the fact that her cigarettes needed to be locked up in the nurses cart."

R8's Progress Notes identified the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 23 7/3/16- "Refused to let staff check room for smoking items." 7/24/16- "Found three lighters in patients possession, educated on the smoking policy et that all smoking materials are to be kept at the nursing station, she verbalized understanding." 8/11/16- "... Resident had a pack of cigarettes on her desk. This writer reminded resident of smoking policy, and asked the resident to give up her cigarettes so they could be locked up in the cart. Resident refused to give this writer the cigarettes and stated, 'I don't have to.' This writer then went to DNS and ED and asked for additional help in enforcing the policy." R8's care plan dated 7/28/16, indicated the resident was at risk for smoking related injury related to diagnoses of dementia and a history of smoking in her room. The interventions included keep all smoking material at nursing station, assure smoking material is extinguished prior to patient leaving smoking area, check room every night for smoking items, provide smoking apron while smoking, and give resident only 2 cigarettes at a time. During observation on 8/25/16, at 2:35 p.m. R8 was laying in bed sleeping. A pack of cigarettes and a lighter were laying on the bedside table. When interviewed on 8/29/16, at 11:55 a.m. R8 stated she keeps her lighter and cigarettes in her room, and staff had no concerns regarding her keeping her smoking materials with her. R9's Smoking Safety Assessment dated 8/15/16, indicated the resident had no history of smoking related incidents. The interventions listed were the resident was independent.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 24 R9's Progress Note dated 8/18/16, indicated, "...Res has also been seen crossing busy streets and sitting on curbs to smoke which can put res at risk of not being seen by cars." R9's care plan dated 8/18/16, indicated the resident understands that he can not smoke on facility grounds and thus had been seen crossing busy streets and sitting on curbs to smoke which can put the resident at risk of not being seen by cars. The interventions were to educated the resident on the risks of sitting on the curb while smoking and crossing busy streets. During observation on 8/26/16, at 11:15 a.m. R9 was observed sitting on the curb in the front of the facility smoking. There were no staff present and R9 was not wearing a smoking apron. When interviewed on 8/26/16, at 1:20 p.m. R9 stated he is not allowed to smoke on facility grounds and was directed to go out to the curb in the front of the facility to smoke. R9 was in his room, and had a pack of cigarettes, a lighter, and a half smoked cigarette sitting on the bedside stand. R6 Smoking Safety Assessment dated 8/15/16, indicated the resident had modified independence for decision making skills, had varying mental functioning, disorganized speech, and had no history of smoking related incidents. The interventions were identified as the resident was independent. R6's Progress Note dated 7/8/16, indicated, "Yesterday at about 3:30 p.m. res was seen standing in the parking lot smoking. RT reminded	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 25	F 323		

res she needed to be off of the property to smoke per smoking policy and res stated ok and moved to the sidewalk." On 5/8/16, a Progress Note indicated, "[Resident} walked inside building, into the ADNS [assistant director of nursing] office, with a lit cigarette."

R6's care plan dated 8/9/16, indicated the resident was at risk for smoking related injury related to smoking independently and resident was to smoke off property. The interventions included assure smoking material is extinguished prior to patient leaving smoking area, give up to 2 cigarettes, not to have cigarettes or smoking material, and to provide smoking apron while smoking if needed.

When interviewed on 8/26/16, at 11:45 a.m. R6 stated she will usually go out front on the curb to smoke. R6 stated she keeps her cigarettes and lighter with her, as well as her vapor cigarette.

R11's Smoking Safety Assessment dated 8/11/16, indicated the resident had modified independence for decision making skills, had limitation in range of motion, and had a history of smoking related incidents of smoking in bed; however, written on the assessment indicated this was at home and resident stated she had never done this at the facility. The interventions were identified as the resident was independent.

R11's Progress Notes indicated the following:
6/2/16- "... [Resident] is independent with her electric w/c and goes out side to smoke."
8/16/16- "Independently propels electric w/c outside for smoking and down to dinner in dining room."
8/26/16- "Yesterday evening at about 7:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

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F 323	Continued From page 26	F 323		

this writer was driving past the facility and observed res smoking on the property in the parking lot."

R11's care plan dated 8/15/16, indicated the resident was at risk for smoking related injury related, "enjoys smoking. Resident is not to smoke on property." The interventions included assist to and from designated smoking area as needed, ensure smoking material is extinguished prior to patient leaving smoking area, offer smoking aprons for safety as needed, and resident will be given up to 2 cigarettes at a time.

During observation on 8/26/16, at 10:45 a.m. R11 was observed smoking on the curb outside of the facility. R11 did not have a smoking apron on and no staff were present.

When interviewed on 8/29/16, at 1:10 p.m. R11 stated she kept her cigarettes and lighter in her room. R11 stated some staff will take them away from her, but usually she just keeps them in her room.

R4 had no Smoking Safety Assessment completed.

An investigation submitted to the state agency dated 8/5/16, indicated R4 stated he was left outside for three hours on July 30th, 2016 to smoke. According to the investigation, the resident had requested staff assistance to be brought outside to smoke, and R4 was provided a pendent call light (a call light that can be brought with a resident to summons help) and a cell phone to alert staff when he was ready to come back in. The resident stated he had called the facility for assistance back into the building,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 27 however, no one answered his call. The facility investigation determined R4 was brought outside by staff and left unattended to smoke, however, after interviewing multiple staff, it was unable to be determined the amount of time the resident was left outside. R4's Progress Notes indicated the following: 5/27/16- "Has a tendency to ask staff to push him to smoke outside despite reiterations from nurse, does not want to use nicotine patch." 6/5/16- "[Resident] goes out and smokes which is against the policy of the facility and says he does not do it even though he smells of smoke." 6/14/16- "This writer approached by staff expressing concern over the smoking policy et how they feel (guilty) they are not supporting it when asked by this patient to be taken outside. Once outside, this patient lights up et begins smoking. Education provided on the facility's non smoking policy, et effective date of 1/1/16, patient verbalized understanding but continues to keep his smoking materials in his room d/t refusal to give them to nursing staff. Writer did educate patient not to light up a cigarette in his room d/t oxygen tank being present, he verbalized understanding. Patient is aware that staff will no longer take him outside for the purpose of smoking." 7/17/16- "..."Found pt smoking in gazebo. When I asked pt to give me his cigarettes, he denied having any cigarettes or lighter/ matches." 7/18/16- "Yesterday in the AM resident was seen smoking in the courtyard." 7/24/16- "Patient observed sitting outside in the smoking area with a lit cigarette, denies smoking despite patient claims of 'not smoking.' Patient educated on the smoking policy et patient verbalized understand."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

R4's care plan dated 8/5/16, indicated the resident was non-compliant with the facility's non smoking policy. Interventions included resident was not to be left alone outside unattended while smoking even if he asks to be left alone, and to encourage compliance with continued education regarding the facility's non-smoking policy.

When interviewed on 9/7/16, at 8:20 a.m. family member (FM)-H stated R4 had been brought out to the curb in the wheelchair and was told to use his cell phone to call the facility when he was ready to come back in. FM-H stated R4 called the facility for assistance to come back in the facility, but staff were not answering the phone. FM-H stated R4 was blind, and was unfamiliar with the surroundings so was unable to get back in without assistance. FM-H stated R4 sat outside for several hours in the heat, and finally called a family member to come to the facility to assist him back into the building.

When interviewed on 8/25/16, at 11:50 a.m. registered nurse (RN)- L stated staff did not supervise residents smoking, and if a resident wanted to smoke and they were not grandfathered in, they needed to go off facility grounds to smoke.

When interviewed on 8/25/16, at 2:20 p.m. licensed practical nurse (LPN)-I stated she had never seen any smoking aprons in the facility, nor had she been told any residents were required to wear smoking aprons or be supervised when smoking.

When interviewed on 8/25/16, at 2:25 p.m. RN-J stated most of the residents who smoked were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 29	F 323		

independent. RN-J was not aware if the facility had smoking aprons, and had not seen any residents wearing one.

During interview on 8/25/16, at 2:30 p.m. RN-M stated she was not aware of any residents who needed to be supervised while smoking, and was not aware of any smoking aprons at the facility.

When interviewed on 8/25/16, at 3:00 p.m. RN-K stated the facility is a non-smoking facility, however, if a resident is able to independently go off the facility grounds and smoke, and they sign out, they are able to smoke. RN-K stated residents are supposed to turn in there smoking materials to be locked up in the nurses station, however, most residents keep their smoking materials with them. RN-K stated she had never seen a smoking apron at the facility, nor had she been instructed any residents needed to be supervised and/ or wear a smoking apron while smoking.

During interview on 8/25/16, at 3:40 p.m. area vice president (AVP)-G stated the facility had decided to go to a non-smoking facility at the beginning of 2016, and grandfathered the residents who lived in the facility at the time to continue smoking. However, in March 2016, the facility decided to go back to a smoking facility, so the smoking policy was implemented. AVP-G stated all residents who smoke should be following the smoking policy, including wearing a smoking apron and keeping their smoking materials at the nurses station. AVP-G stated the facility was not implementing the smoking policy so management had recently been meeting to discuss training staff and implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 323	Continued From page 30 The facility policy titled Smoking and Tobacco Use Guideline dated 3/24/16, indicated, "Patients and Residents of Golden Living are permitted to smoke in the designated area only. Each LivingCenter will specify the smoking area. Smoking outside the LivingCenter designated smoking area is strictly prohibited. Patients/ Residents may smoke only at the designated times. Each LivingCenter will develop and specify the smoking times. Smoking will be supervised by a staff member. Smoking garments/ aprons will be worn by all residents while smoking for safety." "Patients and Residents who smoke must be able to do so safely. Periodic assessment evaluates the individuals ability to smoke safely in a supervised setting. Cigarettes, E-cigarettes, Cigars, Pipes, hookahs, Vaporizers (aka "vapes"), chewing tobacco, snuff and lighters must be kept at the nursing station for the specific patient/ resident. NO matches are permitted in the building at any time. At the designated times, the smoking materials are taken to the smoking area by staff." "For those residents who smoke, a care plan will be initiated and reviewed on a quarterly basis or as needed."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R4) was free from a significant medication error when a	F 333	F333 R4's medical record has been reviewed and is receiving all medications as ordered. All residents receiving medication have the potential to be affected. Nursing staff will be reeducated on medication administration policy and procedure with emphasis on exercising the "six rights of medication administration". DNS or designee will audit five (5) medication administration passes for accuracy per week. Medication errors will be tracked electronically. Trending and analysis of error data will be reviewed monthly at QAPI committee to identify opportunities for improvement. Audit results will be discussed at monthly QAPI committee. Frequency of audits will be adjusted as needed based upon these results. Executive Director and Director of Nursing Services are responsible for compliance. Date of Completion October 31st, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 31	F 333		

nurse administered the wrong insulin type and the wrong insulin dose.

Findings include:

R4's admission Minimum Data Set (MDS) dated 5/21/16, indicated the resident had no cognitive impairment, required extensive staff assistance with all activities of daily living (ADLs), had diagnoses including diabetes mellitus, and received insulin injections all 7 days of the lookback period.

R4's care plan dated 8/5/16, indicated the resident was blind in both eyes, and had diagnoses of type one diabetes and was insulin dependent.

R4's Physician orders for August 2016, which were signed by the physician on 8/4/16, indicated R4 was on the following insulin injections:
-Insulin Aspart (Novolog, rapid acting insulin) to be given according to sliding scale with meals, as well as to give 1 unit per carbohydrate choice with snacks.
- Insulin Aspart to be given at bedtime per sliding scale according to the residents blood sugar result.
- Insulin Glargine (Lantus, long acting insulin) 16 units at bedtime.
- Insulin Glargine 30 units one time a day. The physician orders did not specify the time the insulin was to be given.

R4's Medication Administration Record for August 2016, indicated R4 received insulin Glargine solution, 30 units one time a day at 8:00 a.m.

R4's Progress Note dated 8/9/16, at 1:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 32	F 333		

indicated the resident was given Novolog insulin, and "Had insulin reaction. Glucose [blood sugar] 51, too much insulin." R4 was given orange juice, graham crackers, coke, and a sandwich. R4's blood sugar was identified as "42" and the resident was given glucagon 1 mg IM (intramuscular). R4's blood sugar increased to 107.

R4's Progress Note dated 8/9/16, at 5:44 p.m. indicated, "Patient had called EMS [emergency medical services] on his own to go to hospital. Family present at bedside. EMS discussed with patient and patient states he does not want to return to facility..."

R4's Progress Note dated 8/10/16, at 3:45 p.m. indicated, "Resident was given too much insulin from medication error. Resident was given 25 u [units] of short acting insulin instead of scheduled 25 u of long acting insulin...Resident went to 51 blood sugar and no further. Nurse acted accordingly by admitting mistake, and managing through orange juice and glucagon injection. Resident came back up to the 100's fairly quickly. [Resident] never lost consciousness and was able to speak with nursing throughout the process." "Physician was updated and family updated. Resident discharged later in the day per choice. Nursing managed insulin episode." Although R4's Physician orders and MAR indicated the order for the short acting insulin (Aspart) was for R4 to receive 30 units, it was identified the nurse administered 25 units.

When interviewed on 9/8/16 at 10:25 a.m. registered nurse (RN)-M stated she had administered the wrong insulin type to R4 on 8/9/16. RN-M stated she had not worked with R4

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F 333	Continued From page 33 often, and had not administered the residents insulin for several weeks. RN-M stated all of the residents insulin was in pen form, not vials, and she had taken the wrong insulin out of the medication cart. RN-M stated she noticed the wrong insulin was given when she returned to the medication cart, and immediately notified the director of nursing and provided R4 with snacks to increase his blood sugar. The facility insulin procedure titled Insulin Tip Sheet dated February 2009, indicated Aspart (Novolog, rapid acting insulin) had an onset time of 15 minutes or less, a peak time of 0.5- 1 hour, and duration of 3 to 6.5 hours. Insulin Glargine (Lantus, long acting insulin), had a onset time of 2 to 4 hours, and a duration of 20-24 hours.	F 333		

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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: A complaint investigation was conducted to investigate complaint #H5324057, H5324058, and H5324059. As a result, the following correction orders are issued for all three investigations.	2 000	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.	

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2 000	Continued From page 1	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's	2 265		

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2 265	Continued From page 2 legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to timely notify the family and physician of the re-development of pressure ulcers for 1 of 3 (R1) resident's reviewed. This resulted in actual harm for R1, when wound care was delayed and the pressure ulcers worsened.	2 265		

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2 265	Continued From page 3 Findings include: R1's medical record was reviewed, R1 was admitted to the facility on 10/19/16 with a sacral pressure ulcer (PU.) A 5/5/16 progress note indicated the pressure ulcer healed on 2/13/16 and re-opened on 4/16/16. A 5/11/16 progress note indicated R1's pressure ulcer healed again. R1's "Weekly skin review" dated 7/9/16, identified R1 had two new open areas to his buttocks. The first open area to R1's "crack" measured 6 centimeters (cm) long by 0.2 cm wide and was red/dark pink in color. A second open area to R1's left buttocks measured 0.3 cm wide by 0.3 cm long with 50% yellow adherent slough and 50% "red." Staff cleansed the areas with soap and water, applied a skin barrier, and a Tegafoam dressing. The medical record lacked provider notification of the pressure ulcer development, orders for treatment, or family notification. A progress note, 3 days later, on 7/12/16, indicated the open area to R1's "crack" measured 1.1 cm in length. The documentation lacked width and depth measurements. The open area to R1's left buttocks increased in size to 0.4 cm long by 0.4 cm wide. Both areas were beefy red in color with scant bloody drainage. Areas were cleansed with a wound cleanser and a skin barrier and a foam dressing were applied. Although the progress note identified 2 open areas, a "Weekly Nursing Summary" form dated the same date, indicated R1's skin was intact. The medical record lacked physician notification of the worsening pressure ulcers, orders for treatment, or family notification. A 8/2/16 progress note indicated R1 had "red dots to his coccyx." Scant amount of bloody drainage	2 265		

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2 265	Continued From page 4 when cleansing with soap and a cloth. Non-compliant at times with cleansing needing staff re-approach. R1's medical record lacked provider notification or treatment orders of the pressure ulcers from the time the the pressure ulcers developed on 7/9/16, until 8/5/16, when a "Weekly Skin Review" identified a total of 4 open areas to R1's buttocks and staff notified Nurse Practitioner (NP)-O. R1's physician orders revealed a telephone order on 8/5/16, which directed to "Apply foam drsg (dressing) to coccyx open areas after washing/drying and skin prep wipe applied. Change the dressing every 3 days and as needed." On 8/9/16, a "Wound Evaluation Flow Sheet" identified an unstageable pressure ulcer to R1's coccyx measuring 4 cm x 1 cm with a depth of 0.2 cm. The area was scabbed and dark purple in color with some white discharge noted. The wound bed was 80% epithelial and 20% slough. An area on the left buttocks, superficial layer was gone. Wound bed bright red in color measuring 1 cm x 3 cm. Area on right buttocks, superficial layer was gone. Wound bed bright red and measured 1.5 cm x 1 cm. Cleansed with wound cleanser and applied foam dressing to all three areas. R1's medical record lacked notification of the provider for the worsening pressure ulcers, or family notification. A progress note dated 8/14/16 indicated R1's pressure ulcers worsened. "Coccyx and buttocks wound-Noted redness of buttocks with scaling patches yellow in color with serous drainage. Open Black area above coccyx. Noted foul smell coming from the wound." "Infected wound-Stage 3 with tunneling occurring." Dressing changed.	2 265		

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2 265	Continued From page 5 "Compliant with turning schedule tonight." This was the first time R1's medical record identified family notification of the pressure ulcers. When interviewed on 8/31/16 at 8:45 a.m. family member (FM)-Q stated she was not informed of R1's pressure ulcers until 8/14/16, when she was present for a dressing change. FM-Q stated she was shocked over the horrific smell and sight of the wound. When interviewed on 9/6/16 at 1:05 p.m., IDON-A stated staff should have contacted the provider on 7/9/16, when staff first observed the pressure ulcers and each time R1's pressure ulcer worsened. IDON-A stated staff are expected to follow the policy and obtain wound care orders from the provider. IDON-A confirmed staff did not contact the provider when R1 re-developed the pressure ulcers and did not obtain an order for treatment until 8/5/16. In addition, family was not timely notified of the development and worsening pressure ulcers. When interviewed on 9/20/16 at 2:20 p.m. Physician (R) stated staff did not inform him R1's pressure ulcers re-developed on 7/9/16. Physician (R) stated he was unaware R1's pressure ulcers worsened. Physician (R) stated he would have expected staff to notify him for wound care orders and/or referral to a wound specialist. When interviewed on 9/20/16 at 9:00 a.m. NP-O stated R1 had history of pressure ulcers. NP-O stated she never examined R1's pressure ulcer, as R1 had always refused. NP-O could not remember if staff informed her the pressure ulcer healed in May 2016. NP-O stated whenever she asked staff about the pressure ulcer, she was	2 265		

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2 265	Continued From page 6 always informed the pressure ulcer was healing. NP-O stated she was not informed of the pressure ulcers which developed on 7/9/16 until 8/15/16, when for the first time, she was informed by a staff nurse the pressure ulcers had worsened. NP-O stated she examined the pressure ulcers on 8/15/16 and was taken aback at how bad the pressure ulcer had progressed. NP-O stated the pressure ulcers covered 1/2 of both buttocks, had granulation, slough, and was odorous. NP-O stated she would have expected to be notified when the new pressure ulcers developed and anytime the pressure ulcers worsened. NP-O stated the lack of monitoring and delay in treatment contributed to R1's pressure ulcers worsening. The facility's policy, dated 11/11/15, titled "Notification of Change in Resident Health Status" indicated "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is:" Development of stage 2 pressure sore when no ulcers were previously present at stage 2 or higher. Appropriate notification time is immediate. Immediate defined as soon as possible no longer than 24 hours. In addition, notification immediately to 48 hours when a need to alter or start a new treatment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses or designee could review and if necessary revise the facility policy and procedure for physician and family notification of changes in a resident's condition. Education could be provided to licensed nursing	2 265		

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2 265	Continued From page 7 personnel of when to notify the physician. The administrator, director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor, and implement interventions to prevent and heal pressure ulcers for 1 of 3 (R1) residents reviewed. This resulted in actual harm for R1, when coccyx/sacral/buttocks pressure ulcers redeveloped multiple times at the facility and worsened.	2 900		

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2 900	Continued From page 8 Findings include: R1's medical record was reviewed, R1 was admitted to the facility on 10/19/16 with a sacral pressure ulcer. A 1/21/15 quarterly minimum data set (MDS) identified R1 was at risk for pressure ulcers and identified R1 had a stage 2 pressure ulcer. The MDS indicated interventions of a pressure reducing mattress, a pressure reducing wheelchair cushion, and dressing changes to heal and prevent pressure ulcers. A 5/5/16 progress note indicated the pressure ulcer healed on 2/13/16 and re-opened on 4/16/16. R1's care planned interventions for pressure ulcers, updated on 5/9/16, changed R1's bed mobility from an assist as needed (PRN) to staff assist of 1. R1's May, June and July care plan did not direct staff on the frequency of repositioning. Interventions of a pressure relieving mattress and a pressure reducing wheelchair cushion remained unchanged. A 5/11/16 progress note indicated R1's pressure ulcer was healed. R1's "Weekly skin review" dated 7/9/16, identified R1 had two new open areas to his buttocks. The first open area to R1's "crack" measured 6 centimeters (cm) long by 0.2 cm wide and was red/dark pink in color. A second open area to R1's left buttocks measured 0.3 cm wide by 0.3 cm long with 50% yellow adherent slough and 50% "red." Staff cleansed the areas with soap and water, applied a skin barrier, and a Tegafoam dressing. The medical record lacked provider notification of the pressure ulcer development, orders for treatment, staging of the pressure ulcers, or implementation of additional interventions to promote healing.	2 900		

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2 900	Continued From page 9 A "Weekly Nursing Summary" form, dated 3 days later on 7/12/16 indicated R1's skin was intact; however, a progress note on the same date indicated the open area to R1's "crack" measured 1.1 cm in length. The documentation lacked width and depth measurements. The open area to R1's left buttocks increased in size to 0.4 cm long by 0.4 cm wide. Both areas were beefy red in color with scant bloody drainage. Areas were cleansed with a wound cleanser and a skin barrier and a foam dressing were applied. The medical record lacked physician notification of the pressure ulcers, orders for treatment, or implementation of additional interventions to promote healing. A 7/14/16 MDS assessment identified R1 had 2 pressure ulcers. The MDS indicated R1 now required assistance of 2+ staff for bed mobility. Although a progress note dated 7/19/16 indicated R1 had no open areas to his buttocks, a 7/28/16 progress note indicated R1 had 2-stage 2 pressure ulcers "at this time," which are smaller than the previous week. A 8/2/16 progress note indicated R1 had "red dots to his coccyx." Scant amount of bloody drainage when cleansing with soap and a cloth. Non-compliant at times with cleansing needing staff re-approach. R1's medical record lacked documentation of a comprehensive assessment, including measurements of the pressure ulcers since 7/12/16. R1's medical record lacked provider notification or treatment orders of the pressure ulcers from the time the the pressure ulcers developed on 7/9/16, until 8/5/16, when a "Weekly Skin Review" identified a total of 4 open areas to R1's buttocks and staff notified Nurse Practitioner (NP)-O. R1's physician orders revealed a telephone order on	2 900		

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2 900	Continued From page 10 8/5/16, which directed to "Apply foam drsg (dressing) to coccyx open areas after washing/drying and skin prep wipe applied. Change the dressing every 3 days and as needed." R1's pressure ulcers lacked a comprehensive assessment, including measurements between 7/13/16 and 8/8/16. On 8/9/16, a "Wound Evaluation Flow Sheet" identified an unstageable pressure ulcer to R1's coccyx measuring 4 cm x 1 cm with a depth of 0.2 cm. The area was scabbed and dark purple in color with some white discharge noted. The wound bed was 80% epithelial and 20% slough. An area on the left buttocks, superficial layer was gone. Wound bed bright red in color measuring 1 cm x 3 cm. Area on right buttocks, superficial layer was gone. Wound bed bright red and measured 1.5 cm x 1 cm. Cleansed with wound cleanser and applied foam dressing to all three areas. Reposition every 2 hours. Message left for MDS coordinator to make sure care plan and nursing assistant sheets are updated. R1's medical record lacked notification of the provider for the worsening pressure ulcers. Although R1's 7/14/16 MDS indicated R1's bed mobility changed from 1 to 2+ staff assistance, the intervention was not changed on R1's care plan until 8/10/16 (27 days later.) In addition, the frequency of turning and repositioning of R1 was not added to the care plan until 8/10/16, when the care plan was updated to assist of 1-2 staff to turn and reposition every 2 hours. On 8/10/16 an additional care plan intervention directed staff to explain the risk/benefits when refusing to turn/reposition every 2 hours. When interviewed on 9/6/16 at 1:05 p.m., the interim director of nursing (IDON)- A stated nursing assistants follow	2 900		

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2 900	Continued From page 11 aide sheets when providing cares. IDON-A stated, although the aide sheets should be updated daily with changes, staff have only been updating the aide sheets quarterly. IDON-A stated R1's aide sheet lacked direction to turn and reposition R1 until 8/9/16. A progress note dated 8/14/16 indicated R1's pressure ulcers worsened. "Coccyx and buttocks wound-Noted redness of buttocks with scaling patches yellow in color with serous drainage. Open Black area above coccyx. Noted foul smell coming from the wound." "Infected wound-Stage 3 with tunneling occurring." Dressing changed. "Compliant with turning schedule tonight." R1's physician orders identified NP-O examined R1 on 8/15/16 and implemented new wound care orders. Physician (P), a wound care specialist, examined R1 on 8/16/16. The "Wound Care Specialist Evaluation" form identified a bilateral buttocks/sacrum unstageable pressure ulcer. The wound measured 14 cm x 9.5 cm with 100% eschar (necrotic tissue.) A surgical debridement was completed with a post-debridement depth of 0.6 cm. Physician-P implemented the following new daily wound care orders. After cleansing, liberally apply Santyl then calcium Alginate and cover with super absorbent foam. Use Saline wet to moist dressings twice daily until Santyl available. Low air loss mattress and ROHO cushion for chair. Vitamin C and Zinc Sulfate were ordered. R1's physician orders revealed NP-O evaluated R1 on 8/17/16 and ordered Nitrofurantoin to treat a urinary tract infection (UTI). On 8/19/16 NP-A evaluated R1 again, and ordered a CBC and BMP (lab tests.) R1 was diagnoses with a wound abscess, infection. A 8/19/16 progress note later	2 900		

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2 900	Continued From page 12 that same day, indicated R1 became less responsive with a temperature of 101.6. Staff transferred the R1 to the hospital. Hospital documentation indicated R1 was admitted with a diagnosis, which included sepsis, likely due to infected decubitus ulcer/cellulitis, as well as catheter associated urinary tract infection (UTI.) R1's August 2016 TAR and progress notes revealed R1's wound treatment was completed as ordered between 8/5/16 and 8/19/16. When interviewed on 9/6/16 at 1:05 p.m., IDON-A stated staff should have contacted the provider on 7/9/16, when staff first observed the pressure ulcers. IDON-A stated staff are expected to follow the policy and obtain wound care orders from the provider and comprehensively monitor the pressure ulcers weekly. Staff should notify the provider when a change in a pressure ulcer occurs. IDON-A confirmed staff did not timely notify the provider and obtain an order for treatment until 8/5/16, did not complete weekly comprehensive pressure ulcer assessments, and did not notify the provider when the pressure ulcers worsened. IDON-A stated R1 had a history of refusal of wound care and repositioning. IDON-A confirmed between the dates of 7/9/16 to 8/4/16, R1 did not have wound care orders to refuse. IDON-A further stated staff should have looked at other interventions, such as an air mattress sooner. When interviewed on 9/20/16 at 9:00 a.m. NP-O stated, R1 had history of pressure ulcers. NP-O stated she never examined R1's pressure ulcer, as R1 had always refused. NP-O could not remember if staff informed her the pressure ulcer	2 900		

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2 900	Continued From page 13 healed in May 2016. NP-O stated whenever she asked staff about the pressure ulcer, she was always informed the pressure ulcer was healing. NP-O stated she was not informed of the pressure ulcers which developed on 7/9/16 until 8/15/16, when for the first time, she was informed by a staff nurse the pressure ulcers had worsened. NP-O stated she examined the pressure ulcers on 8/15/16 and was taken aback at how bad the pressure ulcer had progressed. NP-O stated the pressure ulcers covered 1/2 of both buttocks, had granulation, slough, and was odorous. NP-O stated she would have expected to be notified when the new pressure ulcers developed and anytime the pressure ulcers worsened. NP-O stated the lack of monitoring and delay in treatment contributed to R1's pressure ulcers worsening. The facility's policy, undated titled "Skin Integrity Guideline", indicated a licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review. A licensed nurse documents weekly on the identified wound using the "Wound Evaluation Flow Sheet." The care plan is to be implemented, evaluated and revised based on the needs of the resident. If a patient/resident is refusing or choosing not to receive treatment, review risks, benefits and alternatives. Re-evaluate and attempt other interventions. The policy identified treatments protocol and interventions with directions to complete treatment per MD order. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure	2 900		

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2 900	Continued From page 14 they are receiving the necessary treatment/services and monitoring to prevent pressure ulcers from developing and to promote healing of pressure ulcers. Also to ensure the provider is contacted when a pressure ulcer develops or worsens. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and	21545		

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21545	Continued From page 15 precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R4) was free from a significant medication error when a nurse administered the wrong insulin type and the wrong insulin dose. Findings include: R4's admission Minimum Data Set (MDS) dated 5/21/16, indicated the resident had no cognitive impairment, required extensive staff assistance with all activities of daily living (ADLs), had diagnoses including diabetes mellitus, and received insulin injections all 7 days of the lookback period.	21545		

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21545	Continued From page 16 R4's care plan dated 8/5/16, indicated the resident was blind in both eyes, and had diagnoses of type one diabetes and was insulin dependent. R4's Physician orders for August 2016, which were signed by the physician on 8/4/16, indicated R4 was on the following insulin injections: -Insulin Aspart (Novolog, rapid acting insulin) to be given according to sliding scale with meals, as well as to give 1 unit per carbohydrate choice with snacks. - Insulin Aspart to be given at bedtime per sliding scale according to the residents blood sugar result. - Insulin Glargine (Lantus, long acting insulin) 16 units at bedtime. - Insulin Glargine 30 units one time a day. The physician orders did not specify the time the insulin was to be given. R4's Medication Administration Record for August 2016, indicated R4 received insulin Glargine solution, 30 units one time a day at 8:00 a.m. R4's Progress Note dated 8/9/16, at 1:00 p.m. indicated the resident was given Novolog insulin, and "Had insulin reaction. Glucose [blood sugar] 51, too much insulin." R4 was given orange juice, graham crackers, coke, and a sandwich. R4's blood sugar was identified as "42" and the resident was given glucagon 1 mg IM (intramuscular). R4's blood sugar increased to 107. R4's Progress Note dated 8/9/16, at 5:44 p.m. indicated, "Patient had called EMS [emergency medical services] on his own to go to hospital. Family present at bedside. EMS discussed with patient and patient states he does not want to	21545		

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21545	Continued From page 17 return to facility..." R4's Progress Note dated 8/10/16, at 3:45 p.m. indicated, "Resident was given too much insulin from medication error. Resident was given 25 u [units] of short acting insulin instead of scheduled 25 u of long acting insulin...Resident went to 51 blood sugar and no further. Nurse acted accordingly by admitting mistake, and managing through orange juice and glucagon injection. Resident came back up to the 100's fairly quickly. [Resident] never lost consciousness and was able to speak with nursing throughout the process." "Physician was updated and family updated. Resident discharged later in the day per choice. Nursing managed insulin episode." Although R4's Physician orders and MAR indicated the order for the short acting insulin (Aspart) was for R4 to receive 30 units, it was identified the nurse administered 25 units. When interviewed on 9/8/16 at 10:25 a.m. registered nurse (RN)-M stated she had administered the wrong insulin type to R4 on 8/9/16. RN-M stated she had not worked with R4 often, and had not administered the residents insulin for several weeks. RN-M stated all of the residents insulin was in pen form, not vials, and she had taken the wrong insulin out of the medication cart. RN-M stated she noticed the wrong insulin was given when she returned to the medication cart, and immediately notified the director of nursing and provided R4 with snacks to increase his blood sugar. The facility insulin procedure titled Insulin Tip Sheet dated February 2009, indicated Aspart (Novolog, rapid acting insulin) had an onset time of 15 minutes or less, a peak time of 0.5- 1 hour, and duration of 3 to 6.5 hours. Insulin Glargine	21545		

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21545	Continued From page 18 (Lantus, long acting insulin), had a onset time of 2 to 4 hours, and a duration of 20-24 hours. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper insulin administration. Nursing staff could be educated on the procedure and importance of insulin administration. The DON or designee, along with the pharmacist, could audit insulin administration on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21545		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by:	21850		

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21850	Continued From page 19 Based on interview and document review, the facility failed to ensure 1 of 2 (R1) residents reviewed remained free of maltreatment,when the facility neglected to comprehensively assess, monitor, implement interventions to prevent and heal, timely notify the provider of the re-development of pressure ulcer, which resulted in the pressure ulcers worsening. Findings include: R1's medical record was reviewed, R1 was admitted to the facility on 10/19/16 with a sacral pressure ulcer. A 1/21/15 quarterly minimum data set (MDS) identified R1 was at risk for pressure ulcers and identified R1 had a stage 2 pressure ulcer. The MDS indicated interventions of a pressure reducing mattress, a pressure reducing wheelchair cushion, and dressing changes to heal and prevent pressure ulcers. A 5/5/16 progress note indicated the pressure ulcer healed on 2/13/16 and re-opened on 4/16/16. R1's care planned interventions for pressure ulcers, updated on 5/9/16, changed R1's bed mobility from an assist as needed (PRN) to staff assist of 1. R1's May, June and July care plan did not direct staff on the frequency of repositioning. Interventions of a pressure relieving mattress and a pressure reducing wheelchair cushion remained unchanged. A 5/11/16 progress note indicated R1's pressure ulcer was healed. R1's "Weekly skin review" dated 7/9/16, identified R1 had two new open areas to his buttocks. The first open area to R1's "crack" measured 6 centimeters (cm) long by 0.2 cm wide and was red/dark pink in color. A second open area to R1's left buttocks measured 0.3 cm wide by 0.3	21850		

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21850	Continued From page 20 cm long with 50% yellow adherent slough and 50% "red." Staff cleansed the areas with soap and water, applied a skin barrier, and a Tegafoam dressing. The medical record lacked provider notification of the pressure ulcer development, orders for treatment, staging of the pressure ulcers, or implementation of additional interventions to promote healing. A "Weekly Nursing Summary" form, dated 3 days later on 7/12/16 indicated R1's skin was intact; however, a progress note on the same date indicated the open area to R1's "crack" measured 1.1 cm in length. The documentation lacked width and depth measurements. The open area to R1's left buttocks increased in size to 0.4 cm long by 0.4 cm wide. Both areas were beefy red in color with scant bloody drainage. Areas were cleansed with a wound cleanser and a skin barrier and a foam dressing were applied. The medical record lacked physician notification of the pressure ulcers, orders for treatment, or implementation of additional interventions to promote healing. A 7/14/16 MDS assessment identified R1 had 2 pressure ulcers. The MDS indicated R1 now required assistance of 2+ staff for bed mobility. Although a progress note dated 7/19/16 indicated R1 had no open areas to his buttocks, a 7/28/16 progress note indicated R1 had 2-stage 2 pressure ulcers "at this time," which are smaller than the previous week. A 8/2/16 progress note indicated R1 had "red dots to his coccyx." Scant amount of bloody drainage when cleansing with soap and a cloth. Non-compliant at times with cleansing needing staff re-approach. R1's medical record lacked documentation of a comprehensive assessment, including measurements of the pressure ulcers since	21850		

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21850	Continued From page 21 7/12/16. R1's medical record lacked provider notification or treatment orders of the pressure ulcers from the time the the pressure ulcers developed on 7/9/16, until 8/5/16, when a "Weekly Skin Review" identified a total of 4 open areas to R1's buttocks and staff notified Nurse Practitioner (NP)-O. R1's physician orders revealed a telephone order on 8/5/16, which directed to "Apply foam drsg (dressing) to coccyx open areas after washing/drying and skin prep wipe applied. Change the dressing every 3 days and as needed." R1's pressure ulcers lacked a comprehensive assessment, including measurements between 7/13/16 and 8/8/16. On 8/9/16, a "Wound Evaluation Flow Sheet" identified an unstageable pressure ulcer to R1's coccyx measuring 4 cm x 1 cm with a depth of 0.2 cm. The area was scabbed and dark purple in color with some white discharge noted. The wound bed was 80% epithelial and 20% slough. An area on the left buttocks, superficial layer was gone. Wound bed bright red in color measuring 1 cm x 3 cm. Area on right buttocks, superficial layer was gone. Wound bed bright red and measured 1.5 cm x 1 cm. Cleansed with wound cleanser and applied foam dressing to all three areas. Reposition every 2 hours. Message left for MDS coordinator to make sure care plan and nursing assistant sheets are updated. R1's medical record lacked notification of the provider for the worsening pressure ulcers. Although R1's 7/14/16 MDS indicated R1's bed mobility changed from 1 to 2+ staff assistance, the intervention was not changed on R1's care plan until 8/10/16 (27 days later.) In addition, the	21850		

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21850	Continued From page 22 frequency of turning and repositioning of R1 was not added to the care plan until 8/10/16, when the care plan was updated to assist of 1-2 staff to turn and reposition every 2 hours. On 8/10/16 an additional care plan intervention directed staff to explain the risk/benefits when refusing to turn/reposition every 2 hours. When interviewed on 9/6/16 at 1:05 p.m., the interim director of nursing (IDON)- A stated nursing assistants follow aide sheets when providing cares. IDON-A stated, although the aide sheets should be updated daily with changes, staff have only been updating the aide sheets quarterly. IDON-A stated R1's aide sheet lacked direction to turn and reposition R1 until 8/9/16. A progress note dated 8/14/16 indicated R1's pressure ulcers worsened. "Coccyx and buttocks wound-Noted redness of buttocks with scaling patches yellow in color with serous drainage. Open Black area above coccyx. Noted foul smell coming from the wound." "Infected wound-Stage 3 with tunneling occurring." Dressing changed. "Compliant with turning schedule tonight." R1's physician orders identified NP-O examined R1 on 8/15/16 and implemented new wound care orders. Physician (P), a wound care specialist, examined R1 on 8/16/16. The "Wound Care Specialist Evaluation" form identified a bilateral buttocks/sacrum unstageable pressure ulcer. The wound measured 14 cm x 9.5 cm with 100% eschar (necrotic tissue.) A surgical debridement was completed with a post-debridement depth of 0.6 cm. Physician-P implemented the following new daily wound care orders. After cleansing, liberally apply Santyl then calcium Alginate and cover with super absorbent foam. Use Saline wet to moist dressings twice daily until Santyl available. Low air loss mattress and ROHO	21850		

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21850	Continued From page 23 cushion for chair. Vitamin C and Zinc Sulfate were ordered. R1's physician orders revealed NP-O evaluated R1 on 8/17/16 and ordered Nitrofurantoin to treat a urinary tract infection (UTI). On 8/19/16 NP-A evaluated R1 again, and ordered a CBC and BMP (lab tests.) R1 was diagnoses with a wound abscess, infection. A 8/19/16 progress note later that same day, indicated R1 became less responsive with a temperature of 101.6. Staff transferred the R1 to the hospital. Hospital documentation indicated R1 was admitted with a diagnosis, which included sepsis, likely due to infected decubitus ulcer/cellulitis, as well as catheter associated urinary tract infection (UTI.) R1's August 2016 TAR and progress notes revealed R1's wound treatment was completed as ordered between 8/5/16 and 8/19/16. When interviewed on 9/6/16 at 1:05 p.m., IDON-A stated staff should have contacted the provider on 7/9/16, when staff first observed the pressure ulcers. IDON-A stated staff are expected to follow the policy and obtain wound care orders from the provider and comprehensively monitor the pressure ulcers weekly. Staff should notify the provider when a change in a pressure ulcer occurs. IDON-A confirmed staff did not timely notify the provider and obtain an order for treatment until 8/5/16, did not complete weekly comprehensive pressure ulcer assessments, and did not notify the provider when the pressure ulcers worsened. IDON-A stated R1 had a history of refusal of wound care and repositioning. IDON-A confirmed between the dates of 7/9/16 to 8/4/16, R1 did not have wound care orders to	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(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
21850	Continued From page 24 refuse. IDON-A further stated staff should have looked at other interventions, such as an air mattress sooner. When interviewed on 9/20/16 at 9:00 a.m. NP-O stated, R1 had history of pressure ulcers. NP-O stated she never examined R1's pressure ulcer, as R1 had always refused. NP-O could not remember if staff informed her the pressure ulcer healed in May 2016. NP-O stated whenever she asked staff about the pressure ulcer, she was always informed the pressure ulcer was healing. NP-O stated she was not informed of the pressure ulcers which developed on 7/9/16 until 8/15/16, when for the first time, she was informed by a staff nurse the pressure ulcers had worsened. NP-O stated she examined the pressure ulcers on 8/15/16 and was taken aback at how bad the pressure ulcer had progressed. NP-O stated the pressure ulcers covered 1/2 of both buttocks, had granulation, slough, and was odorous. NP-O stated she would have expected to be notified when the new pressure ulcers developed and anytime the pressure ulcers worsened. NP-O stated the lack of monitoring and delay in treatment contributed to R1's pressure ulcers worsening. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review, revise, develop and implement policies and procedures to ensure staff provided cares and services to ensure residents were free from neglect. In addition random audits could be conducted and staff training provided to ensure residents were free from maltreatment. TIME PERIOD FOR CORRECTION: Twenty one	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00169	A. BUILDING: _____ B. WING _____	C 09/30/2016

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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
21850	Continued From page 25 (21) days.	21850		

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

OHFC

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245324 Y1	A. Building B. Wing Y2	12/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	10/31/2016	LSC	10/31/2016	LSC	10/31/2016
ID Prefix F0333	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(m)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LK/mm	12/12/2016	29249	12/02/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00169 Y1	A. Building B. Wing Y2	12/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265	Correction	ID Prefix 20900	Correction	ID Prefix 21545	Correction
Reg. # MN Rule 4658.0085	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.1320 A.B.C	Completed
LSC	10/31/2016	LSC	10/31/2016	LSC	10/31/2016
ID Prefix 21850	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144.651 Subd. 14	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LK/mm	12/12/2016	29249	12/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO