CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00112

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

MEDICARE/MEDICAID PROVID (L1)		(L3) BROOKVIE	DRESS OF FACILITY WAVILLACENT FRY CLUB DRIVE ALLEY, MN	ER	(L6) 55427	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA 09	ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
• •	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 10 07 X-Ray 11	NF ICF/IID RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	144 (L18) 144 (L17)	Compliance1. A B. Not in Con		:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNI 144 (L37) (L38)	F 19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REM	IADVS (IE ADDI ICADI	E SHOW I TO CANCE	ELL ATION DATE).			
See Attached Remarks	IARKS (IF AFFLICABL	E SHOW LIC CANCE	ELLATION DATE).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Jennifer Bahr, HFE NE I	I	1	1/22/2017	(L19)	Shellae Dietrich, Certific	ation Specialist 02/17/2018 (L20)
			(` '	Shellae Dietrich, Certific OFFICE OR SINGLE ST.	(L20)
	PART II - TO BE	C COMPLETED 20. COM	(ONAL	OFFICE OR SINGLE ST. 21. 1. Statement of Finan	ATE AGENCY cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00112

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5186

Due to previous noncompliance for abbreviated standard surveys completed June 15, 2017 and July 10, 2017, this Department imposed

• State Monitoring effective August 2, 2017. (42 CFR 488.422)

In addition, MDH recommended and CMS concurred with the imposition of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

On October 4, an abbreviated standard survey was completed and the most serious deficiencies were cited at a S/S of G at F309.

On October 5, 2017, an extended survey was completed and the most serious deficiencies were cited at a S/S of J at F309 and F373. This is a no opportunity to correct (NOTC), and this Department previously imposed the Category 1 remedy of State monitoring, effective August 2, 2017.

We also recommended the following enforcement action to the CMS RO for imposition:

- CMP for the deficiency cited at F373.
- CMP for the deficiency cited at F309.

The abbreviated standard and the extended survey both cited F309, for different patients, for differing reasons.

On November 15, 2017, Post Certification Revisits (PCRs) were completed by this Department and the Office of Health Facility Complaints, verifying that all health deficiencies have been corrected. Therefore, MDH discontinued State Monitoring as of November 15, 2017. Additionally, as a result of the revisit findings, MDH recommended the following actions to the CMS RO and CMS RO concurred:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective October 13, 2017 be rescinded
- CMP for the deficiency cited at F373 remain in effect.
- CMP for the deficiency cited at F309 remain in effect.

Due to imposition of Mandatory DPNA, the facility also incurred two years of NATCEP loss.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245186

November 22, 2017

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

Dear Ms. Scoville:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 13, 2017 the above facility is certified for:

144 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2017

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

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

H5186240, H5186243 and H5186247

Dear Ms. Scoville:

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

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

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

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

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

Golden Valley Rehabilitation and Care Center November 22, 2017 Page 2

On October 5, 2017, an extended survey was completed at your facility by the Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid programs. The facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby significant corrections were required.

As a result of finding that your facility continued to not be in substantial compliance we notified you that the Category 1 remedy of State monitoring would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of July 28, 2017 and October 18, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017, would remain in effect. (42 CFR 488.417 (b))
- Civil Money Penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for the deficiency cited at F373, be imposed. (42 CFR 488.430 through 488.444)

On November 15, 2017, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on June 15, 2017, an abbreviated standard survey completed on October 4, 2017, and an extended survey completed October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 13, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard surveys of June 15, 2017, July 10, 2017 and October 4, 2017 and our extended survey completed on October 5, 2017, effective November 13, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective November 13, 2017.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letters of July 28, 2017 and October 18, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017, be discontinued effective November 13, 2017. (42 CFR 488.417 (b)) Golden Valley Rehabilitation and Care Center November 22, 2017 Page 3

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

Office of Health Facility Complaints File



Protecting, Maintaining and Improving the Health of A II Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On November 14, 2017,
(Name)(Please Print) (Name) (Please Print) (Title)(Please Print) Fortis Management, the Notice of Penalty Assessment dated and licensing orders issued to:
the Notice of Fehalty Assessment dated and neersing orders issued to.
Golden Valley Rehabilitation and Care Center 7505 Country Club Drive Golden Valley, MN 55427
The Penalty Assessments and licensing orders attached hereto have been corrected as of
Signed: Name)(Please Print) Director of Operations, Date 1/-1/7 (Name)(Please Print) (Title)(Please Print) Fortis Managemit
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On November 14, 2017,
(Name)(Please Print) (Title)(Please Print) of the Division of Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessme dated and issued to:
Golden Valley Rehabilitation and Care Center 7505 Country Club Drive Golden Valley, MN 55427
The Notice of Penalty Assessment was handed to West Rivitain (Name)(Please Print) (Title)(Please Print) Farting
Signed: (Name)(Please Print) (Title)(Please Print) Date

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: X11C

${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AGENCY	Facility ID: 00112	
MEDICARE/MEDICAID PROVIDER (L1) 245186 2.STATE VENDOR OR MEDICAID NO (L2) 254908000		3. NAME AND ADI (L3) GOLDEN VA (L4) 7505 COUNT (L5) GOLDEN VA	LLEY REHABII TRY CLUB DRIV	LITATION	AND CARE CENTER (L6) 55427	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
	05/2017 (L34)	7. PROVIDER/SUF 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	05 HHA 06 PRTF	09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35)	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	12/31	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNI (L37) (L38) 16. STATE SURVEY AGENCY REMA: Mandatory DOPNA is effective 09	F 19 SNF (L39) RKS (IF APPLICABLE S	X B. Not in Comprehents a	nce With quirements Based On: cceptable POC pliance with Program and/or Applied Waive IID (L43)		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director	
17. SURVEYOR SIGNATURE	hr, HFE NE I	<u> </u>	10/31/2017	(L19)	18. STATE SURVEY AGENCY AP Kate Johns Ton, Property of the state of t	ogram Specialist 11/06/2017	[_20]
19. DETERMINATION OF ELIGIBILE 1. Facility is Eligible to F 2. Facility is not Eligible	TY Participate	20. COM	D BY HCFA RE		21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above :		
22. ORIGINAL DATE OF PARTICIPATION 08/31/1973 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension	DATE E SANCTIONS	4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change	
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)			00-Active	
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		_
	(L28)	06301		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	E	Posted 11/06/2017 Co.		

DETERMINATION APPROVAL

(L33)

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on October 25, 2017.

October 25, 2017

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

Re: Project # O468, 6DS5, X11C1

Dear Ms. Bleskacek:

On October 5, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a survey of your facility for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10.

If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

State licensing orders issued pursuant to the previous abbreviated standard survey completed on July 10, 2017, found not corrected at the time of this October 5, 2017 revisit and subject to penalty assessment are as follows:

S0565 Comprehensive Plan of Care; Use	\$300.00
S0800 Nursing Personnel; Staffing Requirements	\$300.00
S1665 Physical Environment	\$200.00
S1855 Patients & Residents Of Hc Fac.Bill Of Rights	\$250.00

State licensing orders issued pursuant to the previous abbreviated standard survey completed on October 4, 2017, found not corrected at the time of this October 5, 2017 revisit and subject to penalty assessment are as follows:

S0830 Adequate And Proper Nursing Care; General \$350.00

The details of the violations noted at the time of this revisit completed on October 5, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$1400.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 3333 W Division, #212 St Cloud Mn 56301.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

Shellae Dietrich, Licensing and Certification Program

Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted October 18, 2017

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

RE: Project Numbers S5186032, H5186226, H5186228, H5186233, H5186240, H5186243, and H5186247

Dear Ms. Bleskacek:

On July 28, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective August 2, 2017. (42 CFR 488.422)

On July 28, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS) Region IV Office, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

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

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on June 15, 2017, and continuing noncompliance at the time of the abbreviated standard survey completed on July 10, 2017. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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

On October 5, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and on October 13, 2017, a survey was completed by the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified on October 5, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us

Phone: (320) 223-7338 Fax: (320) 223-7348

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us

Phone: (651) 201-4204 Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following

circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR d eficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. On July 28, 2017, we informed you that the following enforcement remedies were imposed:

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

In addition, as a result of the continued non-compliance identified at the time of the October 4, 2017 abbreviated standard survey and the October 5, 2017, extended survey the Department recommended the enforcement remedies listed below to the CMS Region IV Office for imposition:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F373. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have

Golden Valley Rehabilitation And Care Center October 18, 2017
Page 5
received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Valley Rehabilitation and Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 15, 2017. This prohibition is not subject to appeal. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and

conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

PRINTED: 11/01/2017 FORM APPROVED OMB NO. 0938-0391

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LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

10/26/2017

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

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	regulations has bee your verification. 483.10(g)(14) NOT	en attained in accordance with	F 000 F 157			11/13/17
SS=D	(g)(14) Notification (i) A facility must im consult with the resconsistent with his representative(s) w (A) An accident invresults in injury and physician intervention (B) A significant charmonal, or psychos deterioration in heastatus in either lifeclinical complication (C) A need to alter a need to discontinus treatment due to accommence a new for (D) A decision to transident from the fastassing in the f	of Changes. Immediately inform the resident; sident's physician; and notify, or her authority, the resident when there is- colving the resident which is the potential for requiring ion; ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or				

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resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility falled to ensure the resident's representative was notified timely of medication changes, updates on condition and treatment requiring injection of medication for 1 of 1 resident (R16) reviewed for notification of change. Findings include: R16's quarterly Minimum Data Set (MDS) completed on 7/13/17, identified moderate cognitive impairment and moderate depression. R16's Admission Record dated 5/1/17, identified family member (FM)-A as Emergency Contact #1, Responsible Party, and POA-Financial, with a hand written, undated entry identifying "legal guardian." During interview on 10/2/17, at 3:51 p.m. FM-A stated the facility had called when a recent fall occurred, but notification had not been made related to medication on drofers.	F 157	resident and the rewhen there is- (A) A change in rocas specified in §48 (B) A change in restate law or regulate) (10) of this sect (iv) The facility multiple update the addression phone number of the This REQUIREME by: Based on interview facility failed to ensure requiring injection resident (R16) review facility failed to ensure requiring injection resident (R16) review facility failed to ensure requiring injection resident (R16) review facility failed to ensure requiring injection resident (R16) review facility failed to ensure family member (FN Responsible Party hand written, undarguardian." During interview of stated the facility hoccurred, but notificate the facility hoccurred the facility ho	esident representative, if any, om or roommate assignment is 3.10(e)(6); or sident rights under Federal or ations as specified in paragraph ion. In the street of and periodically is (mailing and email) and the resident representative(s). In the sure the resident's is not met as evidenced in and document review, the sure the resident's is notified timely of medication on condition and treatment of medication for 1 of 1 is ewed for notification of change. In the sure that is a seriod of the sure that is a seriod in the sure that is a sure that is a seriod in the sure that is a sure t	F 15	R-16 has had notification of medical changes made to resident and/or responsible party. Residents with new medication or delated have documented notification of result and/or responsible party. Visual cue been added to resident's medical refor those residents with a guardian at those identified by social service of the requesting updates. LN staff have been re-educated on the notification of change policy and procedure to include medication changes of medical and resident/responsible party notification of changes of medical and resident/responsible party notification changes weekly for 4 we then monthly for 2 months for documentation of notification. Audits be forwarded to the QAPI committees.	ers will ident e has cord and family the anges. bhone eations cation. s of eeks	

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	reviewing the pharm she visited routinel	ecame aware of it when macy statement. FM-A stated y and interacted with staff with r during visit or via a phone		DON to monitor compliance.		
	identified medication discontinue Cogen lessen the side effermedications) and comedication used to review of nursing p	an's orders of 7/16/17, on changes were made to tin (a medication used to ects of antipsychotic change to amantadine (a treat Parkinson's disease). A rogress notes did not identify de, nor did it identify notification nges.				
	Seroquel 100 millig orders for one table for psychotic behav progress notes did	an's orders noted R16 was on grams (mg) on 8/22/17, with et every four hours as needed viors. A review of nursing not reflect the new order or A of the new medication.				
	9/3/17, indicated R Seroquel which had needed basis (PRN drug which was ord FM-A was contacted state and of medical documentation idea	sing progress note dated 16 was given a dose of d been ordered on an as N). Seroquel is an antipsychotic dered for psychotic symptoms. ed to inform of R16's mood ation administration. The ntified FM-A stated there had hanges based on psychiatric				
	dated 9/15/17, and joint injection. The	note on R16's record was addressed physician visit for note did not reflect the A regarding the interventions				

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F 164 SS=D	10/5/17, at 9:52 a.m nursing (ADON)-B completed when the A policy was reques physician orders ar parties/family mem medication orders in 483.10(h)(1)(3)(i); 4 PRIVACY/CONFID 483.10 (h)(I) Personal prival medical treatment, communications, p meetings of family does not require the room for each resident	n. the assistant director of stated this should have been e orders were processed. Sted for transcription of an notification of responsible bers of change in condition or out was not received. 183.70(i)(2) PERSONAL ENTIALITY OF RECORDS acy includes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private	F 164			11/13/17

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	of personal and me provided at	s the right to refuse the release edical records except as ner applicable federal or state			
	information contain	et keep confidential all ned in the resident's records, orm or storage method of the			
	(i) To the individual representative whe	, or their resident ere permitted by applicable law;			
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	neglect, or domesti activities, judicial and law enforcement pupurposes, research medical examiners a serious threat to by and in compliance	th activities, reporting of abuse, ic violence, health oversight administrative proceedings, urposes, organ donation purposes, or to coroners, funeral directors, and to avert health or safety as permitted ce with 45 CFR 164.512. NT is not met as evidenced			
	Based on observareview, the facility f	tion, interview and document failed to provide personal esidents (R121) during rsonal cares.		R-121 will have privacy maintaine all cares provided as indicated on care plan.	his/her
	Finding include:			Residents that reside in the facility the potential to be affected and will	

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F 164	R121's diagnoses orders dated 9/28 Alzheimer's deme Minimum Data So indicated R121 w required the phys bed mobility, eatin personal hygiene had a stage 4 predepth involving betissue). During observation nursing assistant and pulled the win when registered r RN-B began to gachange to R121's the room, and clottle front onto itse R121's legs. NAthe bed, while NA exit side of bed to back to the windofaced the wall, whon his stomach, the and cleansed R12 R121's genital and dispose of the wall bedding and clotte R121 in bed, his gatter than the setting up supplies the set of the setting up supplies the set of the set of the wall setting up supplies the set of the set of the wall setting up supplies the set of the set of the wall setting up supplies the set of the s	s, as identified on physician's 8/17, included early onset entia. A significant change et (MDS) dated 8/18/17, as totally dependent upon and ical assistance of two staff for ng, dressing, toileting and. The MDS also indicated R121 essure ulcer (open wound, with one, muscle and supporting on on 10/3/17, at 11:06 a.m. (NA)-B was in R121's room, andow drapes shut to begin cares nurse (RN)-B entered the room. At the supplies for a dressing awound as NA-D also entered esed the door behind her. At any on the exit side the bed, R121's incontinent brief, rolling elf, and tucked it between else stood on the opposite side of any on the soiled brief, than ow side. NA-B held R121 as he held R121 as he held R121 as he held R121's bottom with a cloth. Next, and ning while NA-B stood next to genitals now fully exposed. At RN-B finished gathering and the for the dressing change, R121 his mid body including genitals his mid body including genitals.	F 10	receive personal privacy of cares. LN and NARs will receive regarding dignity and privacy dignity and privacy during care. Nurse managers and DO personal care audits to acprivacy during care on earesidents will be audited weeks then monthly for 2 Partners will interview resprivacy and dignity with cainterviews will be shared facility's meeting structure if needed. Finding of observations a be forwarded to the QAPI monthly for 2 months for continued quality improved DON to monitor compliant	e education acy needs of N will complete ddress resident ch unit. 3 weekly for 4 months. Caring sidents weekly on ares. Results of during the e for corrections nd interviews will committee opportunities of ement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245186	B. WING			10	/05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER	,	7505 COUN	DRESS, CITY, STATE, ZIP C NTRY CLUB DRIVE VALLEY, MN 55427		
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F 164	were uncovered a passed. NA-B re and made no atterwaited for RN-B. dressing change, on his left side, fa R121's wound. ER121's genitals remade no attempt exposed body are application of a to from the bed and genitals still fully resumed cares a at 11:24 a.m., nin change began. For a full minute following R121's R121's private bot though a bed she accessible to use	and fully exposed; a full minute emained standing next to R121, empt to cover R121 while she At 11:16 a.m., RN-B started the and NA-B rolled and held R121 acing the wall as RN-B tended to During the entire treatment, emained exposed, and NA-B to provide cover for R121's eas. At 11:22 a.m., following op dressing, RN-B stepped away R121 was rolled on his back, exposed. NA-D and NA-B and placed a new brief on R121 to minutes after the dressing before, then during, and dressing change, staff allowed ody area to be exposed, even set, gown, and other towels were	F	64			
	stated to help gua have to shut the of sheet to cover [R during cares and uncovered for a lo	ard a resident's privacy staff door, pull the curtain, and use a 121]. NA-B acknowledged that dressing change, R121 was left ong time, was exposed, and hould have covered him up					
	assistant director residents should possible during th ADON stated she	ew on 10/4/17, at 9:23 a.m. the of nursing (ADON) stated be covered to the extent ne provision of cares. The econsidered this "a matter of cy" for R121, and for all					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(3) DATE SURVEY COMPLETED	
		245186	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 164	July 2015, directed when receiving trea	nge 8 Infidentiality and Privacy, dated Infidentiality and Privacy, dated Information to the state of the	F 164		
F 176 SS=D	(c)(7) The right to s the interdisciplinary §483.21(b)(2)(ii), ha practice is clinically	elf-administer medications if team, as defined by as determined that this	F 176		11/13/17
	by: Based on observar review, the facility fassess for the safe medications for 1 or observed to have malso self administer. Findings include: R48's quarterly Minimidicated R48 was During observation had a bottle of nitro on her bedside table. R48's Self- Medica Assessment dated to administer all medicated to safely self. R48's physician or owas okay to leave for the safely self.	tion, interview and document ailed to comprehensively ty of self administration of f 1 resident (R48) who was nedications at bedside and red oral medications. Timum Data Set dated 6/17/17, cognitively intact. on 10/1/17, at 9:57 a.m. R48 glycerin 0.4 milligrams (mg)		R48 has been assessed for ability to administer medications. Like residents were identified as self administering medications have been assessed for ability to perform task independently. LN's have been educated on the neer residents to have a self-medication assessment, physician order, interdisciplinary team review and an individualized self – medication progrin place prior to the initiation of a self-medication program. Medication competencies will be completed upon and annually to observe for medication practices to include ensuring residentaking medications as prescribed or documentation reflects differently. DON / designee will audit 5 resident self – administer medication weekly for weeks then monthly for 2 months to ensure assessments, physician order care planning and LN nurse knowled self – administration programs. Resident	rams pass n hire on ts are who for 4 r, ge of

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F 176	nursing failed to co ensure R48 was so nitroglycerin on he During observation registered nurse (F medications in a co poured the pills on proceeded to check medications were administrating ther was also noted on During interview of stated she did not medications becauthem at the bedsid she was a hospice On 10/3/17, at 10:2 medications could if there was a nurs a physician's order chart, RN-A stated assessment indicanitroglycerin at the medications for he During follow- up in a.m. RN-E stated to left at R48's bedsic omeprazole (treatureflux disease) 40	omplete an assessment to afe to administer the rown. In on 10/1/17, at 10:19 a.m. RN)-E handed R48 her morning lear cup and left the room. R48 to her bedside table and left the self-m. The bottle of nitroglycerin the bedside table. In 10/3/17, at 10:20 a.m. RN-E stay to observe R48 take her use it was "alright" to leave le and indicated it was because a patient. In 10/3/17, at 10:20 a.m. RN-E stay to observe R48 take her use it was "alright" to leave le and indicated it was because a patient. In 10/3/17, at 10:20 a.m. RN-E stay to observe R48 take her use it was "alright" to leave le and indicated it was because a patient. In 10/3/17, at 10:20 a.m. RN-E stay to observe R48 take her use it was "alright" to leave le and indicated it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient. In 10/3/17, at 10:40 a.m. RN-E stay to observe R48 take her use it was because a patient.	F 176	,	d ments.	
	tablets of Tylenol (capsules of diltiaze angina and certain mg, duloxetine (tre	ate (narcotic) 15 mg, two pain reliever) 500 mg, two em (treat high blood pressure, heart rhythm disorders) 180 eat major depressive disorder,) psules of gabapentin (treat				

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		245186	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	10.00.2011
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F 176	nerve pain) 400 mg	· •	F 176		
F 241 SS=D	483.10(a)(1) DIGN INDIVIDUALITY (a)(1) A facility must resident in a mann promotes maintenather quality of life reindividuality. The fapromote the rights This REQUIREME by: Based on observative review, the facility of clothing were donnexposed skin for 1 addition, the facility hygiene was maint 2 of 5 residents (R. Findings include: R10's Face Sheet (stroke), neuromust bladder, and hemipside due to CVA. A (MDS) dated 9/14/cognitively intact, a assistant of two states and the right of the right.	st treat and care for each er and in an environment that ance or enhancement of his or cognizing each resident's acility must protect and of the resident. NT is not met as evidenced tion, interview and document failed to ensure resident's ed and covered residents of 5 residents (R10). In a failed to ensure personal ained in a dignified manner for 55, R2) reviewed for dignity. Indicated diagnoses of CVA scular dysfunction of the olegia (weakness) of the left equarterly Minimum Data Set 17, indicated R10 was and required extensive off for dressing and grooming. Indicated the service of the facility wearing a soiled smoking gapron hung to R10's right,	F 241	Resident#55 has been provided with clothing to allow for covering of abdon when sitting in her wheelchair. Reside #2 and #10 have been provided with / assisted with personal cares to ensure hygiene is maintained in a dignified manner. Resident #2 and #10 have h care plan interventions implemented to provide staff with direction on encourar resident to allow for personal cares. The facility has assisted residents in nof clothing to promote dignified covering of self with the procurement of needed clothing. Residents identified as need assistance with ADL's has been provided with cares. Care plans have been reviewed and updated to include interventions to promote resident allowance / participation with ADL's. Staff has been provided with educatio regarding the donning of clothing to promote dignity and covering of expositions.	ad o o o o o o o o o o o o o o o o o o o

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		245186	B. WING		10/	05/2017	
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, Z 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	P CODE		
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F 241	stomach and urosattached to the alwas observed to pastor, sitting out exposed. On 10/4/17, at 6:5 sitting in the facilifacing the door. Fwhich was hiked urostomy fully exhim that his stombut his clothes ar transferred from lift, the cloth on the shirt up as he is lift that if his urostom bag may rupture. During an intervienursing assistant R10 this morning out. We try to pull always cover his A review of the G sheet (undated), 9/11/17), lacked of staff to assure R2 stomach and ostological properties of the G sheet (undated), 9/11/17), lacked of staff to assure R2 stomach and ostological properties of the G sheet (undated), 9/11/17), lacked of staff to assure R2 stomach and ostological properties of the G sheet (undated), 9/11/17), lacked of staff to assure R2 stomach and ostological properties of the G sheet (undated), 9/11/17), lacked of staff to assure R3 stomach and ostological properties of the G sheet (undated), 9/11/17), lacked of staff to assure R3 stomach and ostological properties of the G sheet (undated), 9/11/17 (undated), 9/11/	art pulled up exposing his stomy (device to collect urine, odomen). At 10:03 a.m., R10 leave the facility to visit with a side, stomach and urostomy still of 1 a.m. R10 was observed again by main entrance. R10 was R10 was wearing a red polo shirt up to just below his chest, with bosed. R10 stated it bothered ach and urostomy are exposed, etight. R10 further stated, when need to wheel chair (WC) with the need to wheel chair will peel off. New on 10/4/17, at 12:36 p.m. (NA)-E stated she had assisted and added, "Yes, his belly sticks a shirt down, but it does not belly."	F 2	skin and appliances, per cares to promote cleanin management of incontine grooming / cleanliness of DON / designee will obseresident per week for 4 wonthly for 2 months to provided in a manner to during cares and in manner should be brought to monthly x 3 months for copportunities for quality in DON to monitor for comp	g of fingernails, ence and overall fresidents. erve cares on 5 weeks then assure cares are promote dignity ner of dress. O QAPI committee ontinued improvements.		

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NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER				75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
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F 241	was informed the fabuying new clothes ever occurred. SS-with laundry service have been educate when his stomach During an interview verified that he was refused. R10 stated going to be buying On the same day, a checking with laund purchased only 2-3 In review of a facilit (effective July 2015 efforts between the party to ensure clothes)	ples" clothes. SS-A stated he amily/guardians would be so but was unaware if this had A stated that he would check es. SS-A stated that floor staffed to adjust R10's clothing and ostomy are exposed. If you not	F2	241			
	had moderate cogrextensive assistant hygiene. The MDS (seven or more epi but at least one epi incontinent of urine dementia and depr						
	had moderate cogrextensive assistant hygiene. The MDS (seven or more epi but at least one epi incontinent of urine dementia and depr	nitive impairment and needed ce with dressing and personal identified R55 was frequently isodes of urinary incontinence, isode of continent voiding)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 241	brown substance of fingernails on her of fingernails on her of substance of fingernails on her of substance of the substance	doorway to her room. A dark was noted to be under her long right hand. n on 10/1/17, at 11:10 a.m. R55 wheelchair by the elevators R55 smelled strongly of urine be saturated in the area of her elevator and nursing desk. d a shower the night before. A unce remained under her	F 24	1			
	8/5/17, indicated F well groomed daily	care plan, last reviewed on R2 would be neat, clean and r. The care plan directed staff to al hygiene, grooming, dressing					

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F 241	and undressing wi care plan indicated and ADLs and at t care plan lacked a R2's Urinary Conti 8/4/17, indicated F refuses to wear in occasionally soils would lie in bed ar the bed and refuse however, the care staff should handle	age 14 th physical assistance. The d R2 was resistant to therapy imes refused shaving. The approaches to refusal of cares. In ence care plan, last reviewed R2 was incontinent and resident continent products and self. A behavior indicated R2 and urinate soiling himself and led to be changed was noted, plan did not address how the let the behavior, other than to change his clothing.	F 2	41			
	was standing at the strong urine smell saturated with uring as the right lower suncombed and still Multiple staff were desk and staff did room and assist word word his hair. At 3 lying on his right swere saturated with strong odor of uring in the hallway.	en on 10/2/17, at 2:10 p.m. R2 e nursing desk and had a . His sweatpants were he in the front and back, as well side of his shirt. R2 hair was cking up in multiple places. Hocated around the nursing not offer to take R2 back to his rith changing his clothing or 3:00 p.m. R2 was observed ide in bed, the back of his pants th urine. R2's room had a he present that could be smelled					
	hallway in front of were untied, his haup in multiple place the back of the cothe other. ADON-Atie his shoes. R2 a	the nursing desk, his shoes air was uncombed and sticking es, his gray t-shirt had a tear in llar from one side of the neck to A approached R2 and offered to allowed ADON-A to tie his DON-A did not offer to take him					

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F 241	back to his room a comb his hair. On 10/4/17, at 6:5 dining room watch uncombed and wa His gray t-shirt had front. R2 was in the when he walked dand laid in bed. Sta offer to change his this time. During interview or services assistant that he had contact new shoes and the pair. SS-A stated h R2's clothing and h for help in obtainin was a resident's righowever, R2 would holes in his clothin During interview or stated R2 frequent and would soil his stated R2 needed and assisted with the refusals were to be aware when R2 was assistance with car R2 due to the lack although R2 was of did not assist him who did. NA-G stabut needed hands	age 15 Ind help him change his shirt or If a.m. R2 was sitting in the ing television. His hair was a sticking up in multiple places. If a quarter sized hole in the edining room until 9:06 a.m. own the hall towards his room aff did not approach R2 and a shirt or comb his hair, during in 10/4/17, at 8:47 a.m. social (SS)-A stated R2 had a brother sted in the past about getting the brother bought him a new see had not notified R2's brother, genew clothing. SS-A stated it ght to wear what they wanted, if never complain about having geness they were really large. In 10/4/17, at 9:12 a.m. NA-G ally removed his incontinent pad clothing with urine. NA-G to be checked every two hours onleting needs, and any enchanted. Further, staff are as soiled, and needed res but were unable to assist of staffing. NA-G stated on her group this morning she with cares, and wasn't sure ted he was fairly independent on assistance frequently and omb his hair and assist with	F 24				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	·	
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F 242 SS=D	staff approached h During interview or ADON-A stated it was to walk around in used added urine odor, sholes and messy h The facility policy Findicated: "The cert to a dignified existe communication wit services inside and must protect and presidentDignity/S Participation. You he from the facility in a environment that penhances dignity a your individuality." 483.10(f)(1)-(3) SERIGHT TO MAKE (f)(1) The resident schedules (including health care and preconsistent with his and plan of care are of this part. (f)(2) The resident about aspects of his are significant to the (f)(3) The resident members of the content of the conten	im. 10/5/17, at 9:39 a.m. vas unacceptable for a person rine soiled clothing. ADON-A soiled clothing, clothes with air were undignified. Resident Rights dated 7/15, after promotes the resident right ence, self determination, and hand access to persons and doutside the center. The center romote the rights of each elf Determination and have the right to receive care a manner and in an romotes, maintains, or and respect in full recognition of a sleeping and waking times), by orders of health care services or her interests, assessments, and other applicable provisions whas a right to make choices is or her life in the facility that	F 24			11/13/17

	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE						
		245186	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE FOLDEN VALLEY, MN 55427		
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F 242	This REQUIREMENt by: Based on observatoreview, the facility factorices for 1 or 4 restricted from the facility failed to residents (R162) resi	ion, interview and document ailed to honor medication time esidents (R48). In addition, honor food choices for 1 of 4 viewed for choices. imum Data Set (MDS) dated R48 was cognitively intact and of anxiety and depression. 10/1/17, at 3:45 p.m. R48 her evening medications given by were scheduled for 8:00 sit took a really long time to the tions. R48 stated the nurses is told she had to come ask for on 10/2/17, at 7:52 p.m. R48 wheelchair next to the ting for her evening dminsitration Records (MAR) ing: illigram (mg) 2 capsules by aily, scheduled for 8:00 a.m. tab po at bedtime, scheduled os po at 8:00 pm. tab 5 mg 2 tabs po at bedtime,	F2	242	Resident #48 has had her medicat times adjusted to 7:00 pm to accommodate her medication time preference. Resident #162 has an in place for double portions and is receiving double portioned meals a ordered. Residents requesting medication tinadjustments will be reviewed by the interdisciplinary team to ensure requesting medication tinadjustments will be reviewed by the interdisciplinary team to ensure requested to the interdisciplinary team to ensure requested to the interdisciplinary team to ensure requested to the interdisciplinary team to ensure requested by the resident were and a receiving meals as ordered and receiving the scheduling of medical as requested by the resident within parameters of physician orders and manufacturer recommendation of administration. Staff has been proviet to assure residents are received to assure residents are received to assure medications are administered as ordered and per resident to ensure medications are administered as ordered and per respected to ensure medications are administered as ordered and requested the resident. Results and follow up presented to QAPI committee times months. DON will monitor for compliance.	n order s me uested ble. es for ire quested ation tions the d idet ving s per 2 esident ignee weeks e diets ed by to be	

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		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 242	- morphine sulfate evening, schedule - MAPAP rapid relethree times daily, sp.m. and 8:00 p.m. September 2017 gabapentin 400 rmouth (po) twice dand 8:00 p.m melatonin 3 mg 1 for 8:00 p.m ativan 0.5 mg 2 tales morphine soluble scheduled for 9:00 rmorphine sulfate evening, schedule MAPAP (acetami	ER 15 mg 2 tabs po every d for 8:00 p.m. ease gelcap 500 mg 2 tabs po scheduled for 8:00 a.m., 12:00 milligram (mg) 2 capsules by laily, scheduled for 8:00 a.m. I tab po at bedtime, scheduled abs po at 8:00 pm. e tab 5 mg 2 tabs po at bedtime, p.m. ER 15 mg 2 tabs po every d for 8:00 p.m. Inophen) rapid release gelcap three times daily, scheduled for	F 242			
	registered nurse (I medications were was aware R48 wap.m RN-G stated medication time channed and could not just and was not aware had been community of the c	n 10/3/17, at 2:53 p.m. RN)-G stated R48's evening scheduled for 8:00 p.m. and anted them scheduled for 7:00 R48 had been requesting the nange for the last one to two ted she was a hospice patient change the medication times e if medication time preferences nicated to hospice. In 10/5/17, at 10:14 a.m. of nursing (ADON)-A stated she 8 wanted her evening duled for 7:00 p.m. rather than ADON-A stated medications e daily or at bedtime could be				

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F 242	changed by the nath that are scheduled to be communicated. The facility policy indicated: "The coright to a quality of confidentiality, indicated and decision make and Federal regulated fully informed in a fand of any change may affect your will planning care and and treatment, un	page 19 pursing staff. The medications of for a certain time would need ated to hospice for changes. Resident Rights dated 7/15, enter recognizes the resident's of life that supports privacy, dependent expression, choice, king, consistent with State law lation You have the right to be advance about care, treatment, les in the care or treatment that well-being and to participate in d treatment or changes in care aless you have been adjudged bund to be incapacitated under	F 2	42		
	he was cognitivel appetite or over each care Plan dated regular diet with I R162's Nutrition I Assessment date received regular during observation 12:20 p.m. nursing one brat, 1/2 corrand one ice creat ordered two brats that was it since I portion diet. NA-	MDS dated 08/17/17, indicated y intact and did not have a poor eating. R162's Nutrition Risk 05/17, indicated he received a arge portions. Risk Data Collection And ed 08/16/17, indicated he diet with large portions. On and interview on 10/02/17, at an assistant (NA)-V was a R162 his room tray which had an on cob, a cup of baked beans and two ice cream cups and the is on a high protein large V stated that he did not take his as not on his diet and that is what				

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	what I had on my m I wanted." R162 the had on my Fing came here [the facil In follow up intervie R162 stated he new brat or ice cream as on 10/02/17. During phone intervient, make the her but thought R16 meat diet so he shoportion at lunch on to talk to the facility. During interview on manager (DM)-A stated portion diet are should have checked upset and that he stee two brats and direquested. 483.10(f)(5)(iv)(A)(6)(GRIEVANCE/RECO)(15) The resident in participate in resident in the state of the facility must be supported by the facility of the facility must be supported by the facility of the facility must be supported by the facility of the facility must be supported by the facility of the facility must be supported by the facility of the facility must be supported by the facility of the facility must be supported by the facility of the facili	have. R162 stated, "I know heal ticket and that is not what len stated, "This is not what I ticket and I never should have lity]." w on 10/03/17, at 8:00 a.m. her was offered the second is he requested during lunch where we have a double had received a two meat 10/02/17, and recommended is dietary manager. 10/03/17, at 1:40 p.m. dietary had stated the nursing assistant hed on his diet after he became hould had been able to have ouble ice cream as he B) LISTEN/ACT ON GROUP DMMENDATION has a right to organize and ant groups in the facility.	F 24			11/13/17
	the grievances and	roup and act promptly upon recommendations of such issues of resident care and life				

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F 244	(A) The facility muresponse and ratio (B) This should no facility must implet request of the resist This REQUIREME by: Based on intervier facility failed to ensconcerns presented to the residents. TR10, R11, R12, R43, R44, R50, R8, R106, R116, R127 participated in the Findings include: During interview or resident council reare not getting any stated there have closure of the resident council reare not getting any stated there have closure of the resident council reare not getting any stated there have closure of the resident council reare not getting any stated there have closure of the resident council reare not getting any stated there have closure of the resident council reare not getting any stated period of were incontinent resided on 4/7/17, 4/1 staffing and provising and provising and provising and provising and provising and provising and stated he has	age 21 st be able to demonstrate their onale for such response. It be construed to mean that the ment as recommended every dent or family group. ENT is not met as evidenced we and document review, the sure they had followed up on ed at resident council meetings his affected 24 residents (R6, I3, R14, R21, R31, R34, R39, I8, R65, R66, R73, R79, R96, IR, R135, R179) who have resident council meetings. In 10/1/17, at 10:14 a.m. the presentative, R31 stated, "We where with anything." R31 been concerns regarding dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, understaffing at the inse to call lights, variance of administration in the morning dent store, and the store in the insertion in the morning dent store, and the store in the insertion in the morning dent store, and the store in the insertion in the morning dent store in the insertion in the morning dent store in the insertion in the morning dent store in the inse	F 2	Identified 1) The Resident council minutereviewed from March 2nd to Softh. Identified concerns have documented on a resident grie report. The concerns were dethe appropriate department mandadress. The social service ditrack concerns for follow up reresident council minutes. The service director will encourage to bring up concerns as they of immediate follow up. Like 2) Resident council minutes with by the executive director of social service director of the grievance form for the resiminutes. For continuity of car resolution of the resident councomplaints will be communical residents who expressed the cogrievance. Education 3) The director of social service educated on the resident coungrievance process, and minutes the proper follow through.	eptember been evance livered to anagers to rector will garding the social residents ccur for ill be viewed signee to ervice is form when inpletion of dent council e, cil ted to those concern or e was cil policy,		

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F 244	A review of the refrom 3/2/17 to 9/7 -3/2/17, resident of time it took to have failure to provide answered. The number of the facility for complaint is filled completed. The number of the facility for concerns identified. The meeting was following resident R66, R79, R106. -5/4/17, concerns of the facility for concerns identified were not minutes. The meeting was following resident R21, R31, R34, F R66. -6/1/17, concerns related to the provious concern identified. The meetings previous concern identified. The meetings.	sident council meeting minutes 7/17 identified the following: concerns regarding the length of ve call lights answered, and care when lights were ninutes also identified an update sman of the resident right to allow up with residents if a and an investigation was neeting was noted to have been following resdient's: R6, R21,	F 2	244	4) Resident council minutes will be reviewed by the Executive Director monthly. Trends of resident council minutes will be reviewed by the Quassurance Committee on monthly Executive Director will monitor for compliance. Date of compliance: 11/13/17	r cil uality	

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F 244	R44, R65, R66, R -7/6/17, concerns resumption of the minutes not addreresolution to conce was attended R10 R58, R106, R116, -8/3/17, The Resirequested all nurs routed to the direct through. The minuinquired whether is use the facility to it available. The minumanagement staff line staff (nurses, Resident attendant meeting minutes to the concerns promew business he speaking with statiated care/staff aid attendance was not minutes to reflect. During interview of director of social is been acting as the since July of 2017 there continued to desire to resume to this time there are stated there were regarding grievance.	were identified related to resident store. The meeting ss previous concerns or erns identified. The meeting, R11, R12, R21, R31, R43, R179. dent Council president ing related complaints be tor of nursing for follow tes also reflected the residents egal services were available to mplement nurses/aides being jutes identified concerns should be cut instead of front	F 244			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 244	the executive direct through. The DSS addressed but the staffing concerns, able to file written expressed lack of concerns. During interview of stated the facility of follow through on however, stated the as to how this would grievances which on, however, stated ED approximately been a formalized stated she was aware garding staffing were still working. A policy, effective Council identified four the council with ED and/or resubsequently prepared for the ED and/or resubsequently prepared for	ctor (ED) to review and follow stated staffing was frequently re has been no resolution of and these residents were also grievances and noted R31 had follow through regarding written in 10/5/17, at 2:35 p.m. the ED had identified the need for resident council concerns, here was not a plan formalized had been filed were followed uped prior to her appointment as one month ago, there had not process for follow up. The ED ware of residents concerns and provision of cares and they on these concerns. July 2015, titled, Resident under Procedure: bullet number all report concerns/grievances to ponsible party who will pare a response to any sees from the council. This provided in writing by the facility Resident Concern Report.	F2	44			
F 247 SS=D	resident council m	IT TO NOTICE BEFORE	F 2	47		11/13/17	

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F 247	§483.10(e) Respe a right to be treate including: (e)(6) The right to the reason for the room or roommate This REQUIREME by: Based on intervier facility failed to enswas provided to 2 reviewed for facilit discharge practice. Findings include: R130's quarterly M08/15/17, identified with no behaviors. During interview of stated, "I will never moved in, I was wroommate by the findings includes and the was never roommate by the findings interview of R130's R130 was notified. R48's quarterly MI she was cognitivel. During interview of R48's quarterly MI she was cognitivel.	ct and Dignity. The resident has d with respect and dignity, receive written notice, including change, before the resident's in the facility is changed. ENT is not met as evidenced w and document review, the sure notice of a new roommate of 3 residents (R130, R48) y admission, transfer and s. Minimum Data Set (MDS) dated d R130 was cognitively intact in 10/02/17, at 2:22 p.m. R130 r forget the day my roommate atching television and he ht in by the paramedics." R130 etime this year in May, and er notified that he was getting a acility. Medical record did not indicate of a new roommate. DS dated 06/17/17, identified y intact with no behaviors. In 10/01/17, at 3:59 p.m. R48 d at least five new roommates ed of any new roommates prior	F 247	Identified 1) Resident Grievance Reports comfor R48 and R130 for lack of notification new roommates. Resident 48 and Resident 130 have notification of roommate or room chalke 2) Residents affected by all pending changes have been notified of new roommate. Residents with room changes and/or roommate changes have been revie and documentation of notices compediated documentation of notices compediated and Roommate Changes policy and procedure. Facility will monitor documentation of roommate and/or changes during the facility's meeting process as it occurs. Monitoring 4) Room change notification forms or reviewed every morning Mon-Fri in morning meeting to ensure notification be reviewed daily until results are reviewed with QAPI for 3 months.	e had hange. If room	

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F 247	Continued From pa	ge 26	F 247			
	R48 was notified of			Executive Director will monitor compliance.		
	director of social se a room change the The DSS stated the residents know if th not always let them indicated they do n	10/05/17, at 11:41 a.m. the ervices (DSS) stated if they do by give them seven days notice. The facility tries to let the large get a new roommate but do large. The DSS further out document in the medical or had not been informed the boommate.				
	Change effective Jathe attending physi room and/or room receiving the room indicated to monito the change in room adjustment issues. 483.20(g)-(j) ASSE	cedure Room and Roommate anuary 2017, indicated: "notify cian, all departments of the nate change, and resident(s) mate." The Procedure further reach resident's adjustment to and/roommate to account for SSMENT	F 278			11/13/17
		sessments. The assessment lect the resident's status.				
	(h) Coordination A registered nurse each assessment v participation of hea					
	(i) Certification (1) A registered nur the assessment is	rse must sign and certify that completed.				
	(2) Each individual	who completes a portion of the				

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F 278	(j) Penalty for Falsi (1) Under Medicare who willfully and kr (i) Certifies a mate resident assessme penalty of not more assessment; or (ii) Causes another and false statemer subject to a civil m \$5,000 for each as (2) Clinical disagre material and false This REQUIREME by: Based on observa review, the facility of Minimum Data Set residents (R134, R urinary continence, of care behavior.	sign and certify the accuracy of assessment. fication e and Medicaid, an individual nowingly- rial and false statement in a ent is subject to a civil money e than \$1,000 for each r individual to certify a material at in a resident assessment is oney penalty or not more than sessment. ement does not constitute a	F 278	R134 Significant Change MDS AR was modified on 10/6/17 to correct catheter coding. R24 Quarterly 5day MDS ARD 9/1 v modified on 10/6/17 to correct reject care coding. Residents with rejection of care and	D 7/13 vas tion of	
	(MDS) dated 07/13 cognitively impaire two with toileting aurine. R134's MDS urinary catheter. F 10/2017, indicated	change Minimum Data Set 6/17, indicated he was severely d, needed extensive assist of nd was always continent of 6 failed to indicate he had an 134's care plan dated he had a history of urinary I had a Foley catheter. R134's		catheters have been reviewed for accuracy and changes made as new The IDT will receive the re-education Tuesday Oct 17th regarding MDS accuracy standards per the RAI man Re-education will be conducted by the Regional Director of Revenue Integration of Revenue Integrity or designee will audit three	n on nual. he rity or	

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F 278	Urinary Incontiner (CAA) dated 7/27/dependence with bowel and bladde incontinence care products. The CAUrinary urgency at toileting. The CAA catheter. R134's hospice caindicated he had a and had a indwellid on 10/03/17, at 8the dinning room below his Broda catheter. During interview 1 director of nursing went to the hospit third floor and trarreturned from the catheter bag should be stated this was not returned from the either had been contained to the orders. During interview 1 coordinator, licens stated when R134 there was no orderstaff did not docur	are Care Area Assessment [17, indicated he needed total toileting and was incontinent of and staff managed all s and used incontinent A assessment indicated he had and needed assistance with a failed to indicate he had a are plan dated 07/07/17, alteration in bladder elimination and urinary catheter. 22 a.m. R134 was observed in to have a catheter bag attached hair (tilt and space positioning 0/05/17, at 8:43 a.m. assistant a (ADON)-B stated R134 had al in July 2017 when he was on asferred to first floor when he hospital. ADON-B stated his all be changed weekly and the e changed monthly. ADON-B at put on his orders when he hospital and she was not sure if completed since they did not 0/05/17, at 10:00 a.m. MDS are turned from the hospital are for a catheter, the nursing ment R134 had a catheter so te he had one on his significant	F 278	MDS's weekly for 2 weeks for 2 months to validate ar coding accuracy. Results of audits will be re facility's QAPI meeting tim RAI coordinator responsib compliance.	nd monitor MDS viewed at the es 3 months.		

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F 278	face sheet, dated sleep apnea. The dated 9/1/17, indice The MDS also indice of cares. During observation R24 was lying in b R24 was dressed without distress without distribution of the Bewith a reference disassessment periodicated R121 has of Care - Presence indicated behavior present during the the MDS dated 9/2 care, was coded a of care occurred distribution of the Bewith distribu	as indicated on the resident 5/29/17, included obstructive equarterly MDS assessment ated R24 had intact cognition. cated R24 had daily rejection on 10//3/17, at 12:05 p.m. ed in her room, awake, alert. for the day, and presented the TV playing. Registered red the room and administered to R24 without any difficulty. The vioral symptoms MDS report ate of 9/27/17, covering the different from 9/21/17 to 9/27/17, di "0" in the section "Rejection ex Frequency." The "0" (the rejection of care) was not assessment period However, 27/17, section E, rejection of si3", which indicated rejection aily.	F 278			
	was based on the code in the "care thad "no rejection of the assessment per LPN-J stated the stocomplete the secare, and maybe histated there was "indicated R24 had	nurse (LPN)-J stated the MDS input the nursing assistants racker." LPN-J stated R121 of care", based on the data for eriods from 9/21/18 to 9/27/17. social worker was responsible action related to rejection of the hit the wrong key. LPN-J nothing documented to "daily" rejection of cares.				

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F 279 SS=D	assessed R24 as I because R24 had to wear it. The DS daily refusal of car incorrect after revir R24's refusal to we choice," and not a refusals should be acknowledged he coded that incorrect A policy regarding resident assessments as provided. 483.20 (d);483.21(I COMPREHENSIV 483.20 (d) Use. A facility assessments commonths in the residence and the code of the assessments of the assessment	ervices (DSS) stated he naving daily refusal of cares, a C-PAP machine, and refuses as stated he coded that as a ses. The DSS stated he was ewing the MDS instructions. For the CPAP was a "resident refusal. The DSS stated R24's in her care plan. The DSS realized the error and stated, "I ctly." completion of the MDS ent was requested, but none	F 2			11/13/17
	comprehensive pe each resident, con set forth at §483.1 includes measural to meet a resident' and psychosocial i	e Care Plans st develop and implement a rson-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that ble objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/	05/2017
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F 279	(i) The services the or maintain the resphysical, mental, a required under §448.1 (ii) Any services the under §483.24, §44 provided due to the under §483.10, incommendations findings of the PAS rationale in the resident's representational entities (iv) In consultation resident's representational entities (b) The resident's future discharge. If whether the resident community was as local contact agenentities, for this put (C) Discharge plant (iii) Any specializer rehabilitative servit provide as a result recommendations findings of the PAS rationale in the resident's representational entities and the resident's future discharge. If whether the resident community was as local contact agenentities, for this put (C) Discharge plant	at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and nat would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse 483.10(c)(6). If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the ntative (s)- goals for admission and preference and potential for facilities must document ent's desire to return to the seessed and any referrals to cies and/or other appropriate	F 279			
	section.	orth in paragraph (c) of this ENT is not met as evidenced				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
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F 279	Continued From pa	age 32 ation, interview and document	F 279	R7's Plan of Care and Care Plan	ans	
		re plan for 1 of 1 resident (R7) lure, and 1 of 3 residents		have been updated to reflect appro goals and interventions related to h respiratory diagnosis. R108's Care and Plan of care have been review updated to reflect appropriate beha	er Plan ed and	
	Findings include:	1.1.10/44/47:11 1/5		monitoring with interventions related individual behavioral health needs.	d to the	
	diagnoses of morb hypoventilation (a roxygenate adequal chronic obstructive chronic respiratory admission Minimula indicted intact cognoxygen both prior to facility. The MDS a BIPAP/CPAP (a deboth prior to admission to the facility	•		2. Residents that reside at GVRH respiratory diagnosis requiring addi monitoring and skilled care have the potential to be effected by this prace Policies and procedures have been reviewed and are current. Resident have a diagnosis related to respirate concerns have received chart revieupdates made as appropriate. Updainclude CPAP/BiPAP settings per Morders with monitoring settings regularized respiratory monitoring indially lung sounds, oxygen saturation levels, liters of oxygen per physician	tional e tice. s that ory ws with ates to ID ularly. cluding n	
	was noted to have cannula with liquid R7 stated she was 8/9/17, however, w related to respirate	on 10/1/17, at 9:57 a.m R7 oxygen in place via a nasal oxygen while up in wheelchair. admitted to the facility on vas hospitalized on 8/19/17, ory problems and sepsis (an ed oxygen therapy and a BIPAP to the facility.		orders with parameters if approprial identified signs and symptoms of which update the physician related to a post-change of condition. Resident's that reside at GVHR with a mental heal diagnosis that require a behavioral care plan for targeted and identified and behavior issues have the poter affected by this practice. Residents	hen to otential t the health I mood ontial be	
	R7 was hospitalized history and physical admitted with resp. The Discharge Sulwas hospitalized with the chronic respiratory.	rsing progress notes identified ed on 8/19/17. The admission al (H&P) identified R7 was iratory failure and septic shock. mmary of 8/26/17, noted R7 with diagnosis of acute on a failure. The document experiencing septic shock.		identified target mood and behavior issues have had a chart review with updates made as appropriate. Updated include individualized interventions staff to practice that are affective for decreasing or de-escalating behavior that have the potential to impact the resident's highest level of practical	ates to for ors	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
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F 279	acute psychosis, travalue indicating liver liver. A review of R7's Me Record (MAR) and Record (TAR) were records initially ider it did not provide ar settings are used omachine for setting cleaning of the mas of the humidifier bo R7's care plan, revipotential for nutrition medical problems, However, the care complete specific noxygen saturation loxygen to use, or widentify any change status. On 10/4/17, at 9:49 nursing (ADON)-B plan and confirmed any respiratory prolinterventions, with thave impacted her had been recently horoblems. The ADO included in the residuave been reviewer return from the hos	edication Adminsitration the Treatment Administration conducted and although the atified the use of CPAP/BIPAP, by specifications as to which r what to monitor on the s. The directions only outlined sk, humidifier bottle, and filling ttle. sed 8/17, listed R7 had a nal problem, due to multiple and respiratory status. plan did not direct staff to nonitoring of R7's lungs, evels, how many liters of that symptoms to monitor to s or decline in respiratory a.m. the assistant director of confirmed R7's current care the care plan did not identify blems or necessary he exception of how it may nutrition. She confirmed R7 nospitalized for respiratory DN-B stated this should be dent's care plan and should d and updated following her	F 2	2279	wellbeing for both the individual and individuals residing at the center. Interventions to be communicated communication tools currently bein utilized with non-affective interventibeing communicated so revisions occur. 3. Clinical leadership and License Nurses have been educated on clir monitoring and required Care Plantit relates to respiratory monitoring a interventions. Staff in all disciplines been re-educated on the Target Mc Behavior program as it relates to individualized interventions. 4. DON/Designee will audit the ch 3 residents with a respiratory diagnensure appropriate monitoring and documentation 3 times a week for weeks then monthly times 2 month DOSS/Designee will audit Target M and behavior Program and observe interventions for effectiveness for 3 residents weekly x 4 weeks, then 3 residents monthly x 2 months. Rese be brought to QAPI committee mor 3 months for continued opportunities quality improvements. DON will monitor for compliance	through g ons can ed nical ning as and have pod and narts of osis to 4 s. lood e s ults will nthly x	

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F 279	psychotic disorder schizoaffective are quarterly MDS date intact cognition, controlled a litercations and responsible activities of daily. Assessment (CA. identified residentiallucinations who problems. During observation R108 was yelling home at (R71 and yourself in the midefinition of ugly, Service (SS)-B wrong was all the times leaves the area. It confrontation, lood R108 about his youn minutes later, R7 administration off (ED), and assistated AED-B and directly yelling, he was "ticalling him "an In You have not don tired of it. All you nothing gets done no idea what I or we get called those the image of the ED, and AED kept telling admiricing admiricing a mad at he (R108) goes off of the ID,	page 34 or, paraplegia disorder, and bipolar disorder. R108's sted 7/24/17, identified he had lisorganized thinking, verbal needed staff assistance for living. The behavior Care Area (A) worksheet dated 2/24/17, at displayed delusions and ich could cause behavior on on 10/3/17, at 10:12 a.m. in the entry way of the nursing d R201) stating, "Look at error and you will see the delusion at the area talks to supset yelling (R108) calls us and nothing happens, R71 R108 remained in area after the king around, no one talked with delling at R71. At 10:16 a.m., four of the was outside of the sice yelling at executive director (AED)-A, for of quality. R71 very upset and dian", and (R201) a "Nigger". The anything about this, and I am tell (R108) to do is calm down, and I am sick of it. You have (R201) have gone through when se's names. "I am sick of it!" O-A tried to calm R71 down. R71 distration (R108) "bums R192) all the time. I have heard er, she doesn't like it when an people, so she gives into him sigarettes a day from her. While	F 2	79			

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F 279	sitting in his wheel away, smiling and watching R71 yellistaff. R108's Mood and Plan review on 8/8 disorder, and used and antianxiety maincluded, monitor altered perception speech, lethargy, hallucinations and staff interventions to deal with R108's using profanity and residents to help of During interview of ADON-A and SS-A verbal behaviors of with very "colorful" regular basis but a well, his main focut behaviors. Associated us to develop cigarettes so his in would stop him from the started to sell the complained they would not like the taste, sprogram at the enimplemented any plan for R108, we	definition and the facility administration. R108 was administration. R108 was alchair approximately 15 feet grinning with enjoyment while ng at the facility administration. Behavior Assessment Care 8/17, identified bipolar affective d antipsychotic medications, edications. The interventions for side effects, periods of or awareness, disorganized changed in cognitive level, constipation. There were no idenfied to assist staff on how is behavior of being demanding, d name calling of other decrease these behaviors. In 10/4/17, at 9:23 a.m. with A both stated, R108 has lots of of yelling at staff and residents words. He sees ACP on a also refused to see them as us is cigarettes with his ated Clinic Psychology (ACP) a cigarette plan, and roll his money lasted longer and this on bothering other residents, then he were not packed right and did so he (R108) stopped this d of June 2017. We have not other behavior plan, or care	F2	279			

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F 279	with issues and/or of to provide for a rest of well being." The bullet one: "Initate the according to the RA instrument) process change in condition 483.10(c)(2)(i-ii,iv,v)	conditions can be addressed ident's highest practible level procedure identified under the appropriate Care Plan AI (resident assessment is and as needed with resident in. c)(3),483.21(b)(2) RIGHT TO	F 27			11/13/17
SS=D	483.10 (c)(2) The right to pand implementation plan of care, includ (i) The right to particulating the right to be included in the prequest meetings a revisions to the per (ii) The right to particulate pand of care. (iv) The right to recincluded in the plan (v) The right to see right to sign after si of care. (c)(3) The facility stright to participate in the participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(3) The facility stright to participate in the plan (c)(4) The pl	the care plan, including the gnificant changes to the plan nall inform the resident of the n his or her treatment and sident in this right. The				

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F 280	Continued From pa	ge 37	F 28	30		
	(i) Facilitate the incresident representa	lusion of the resident and/or ative.				
	(ii) Include an assestrengths and need	ssment of the resident's ls.				
		resident's personal and s in developing goals of care.				
	483.21 (b) Comprehensive	Care Plans				
	(2) A comprehensiv	e care plan must be-				
	(i) Developed within the comprehensive	n 7 days after completion of assessment.				
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to				
	(A) The attending p	hysician.				
	(B) A registered nur resident.	rse with responsibility for the				
	(C) A nurse aide wi resident.	th responsibility for the				
	(D) A member of fo	od and nutrition services staff.				
	the resident and the An explanation must medical record if the and their resident re	racticable, the participation of e resident's representative(s). It be included in a resident's e participation of the resident epresentative is determined the development of the in.				

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F 280	(F) Other appropridisciplines as deteor as requested by (iii) Reviewed and team after each a comprehensive ar assessments. This REQUIREME by: Based on intervie facility failed to respecific feeding in (R19) identified wireceived safe and eating. In addition care plan to include 2 residents (R48) for a catheter. Findings include: R19's Admission In he had dementia a Data Set (MDS) daneeded extensive had no swallowing Assessment (CAA he required assist	iate staff or professionals in ermined by the resident's needs by the resident. revised by the interdisciplinary ssessment, including both the nd quarterly review ENT is not met as evidenced ew and document review, the vise the care plan to include estructions for 1 of 1 residents ith swallowing difficulties appropriate assistance with n, the facility failed to revise the de an indwelling catheter for 1 of reviewed for justification of use Record, undated, indicated that and dysphagia. R19's Minimum ated 09/08/17, indicated he assist of one with eating and g disorder. R19's Care Area A) dated 09/08/17, indicated that with feeding at meals and	F 2	1. R19's Care plan has and updated to reflect die R48's catheter has been justification and Care Plan updated to reflect change 2. Residents that reside altered diets have the pot affected by this practice. I procedures related to altered planning have been review current. Residents with al received a chart review we made as appropriate to redietary orders. Policies ar related to catheter care planed to catheter shave received and updates have appropriate.	been reviewed tary orders. reviewed for has been s. at GVHR with ential to be Policies and ered diets care wed and are tered diets have ith updates effect current had procedures lanning have urrent. Resident wed chart e been made as	
	A Discharge Sumindicated R19 had x-ray with bilatera R19's speech theindicated PT (pati	mary Note dated 11/30/16, If aspiration pneumonia, and I infiltrates. Trapist note dated 08/02/17, Tra		 3. Clinical leadership an nursing staff have been reupdating resident care platoccur so it reflects curren plans of care. 4. DON/designee will auweek for 4 weeks then memonths to ensure appropidate care planning for both 	e-educated on ans as changes t and active dit 3 charts per onthly times 2 riate and up to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 280	complete final sest documentation. The special region of strategies at patier meals." The speech therapthe following: * Bite sizes should to spoon size) *Allow patient to cligiving another bite to not put more still chewing * If he begins couguntil coughing discontinus indicated to catheter CAA date occasionally incoman indwelling urina to complete the coughing and the coughing and the coughing discontinus indicated to catheter CAA date occasionally incoman indwelling urinating the complete the coughing and the coughing discontinus indicated the coughing discontinui	sion to receive discharge herapist followed up with ding use of printed allowing strategies to reduce 4-hour log updated for services due to inability to ementia and inability to follow ff to implement use of allowing strategies and monitor and symptoms of aspiration. Report dated 08/02/17, secontinue] from ST today ney thick liquid diet. Printed ants table to follow during by instruction sheet indicated be 1/2 spoonful of puree e honey thickened fluids (1/2) ear mouth completely before food in patient's mouth if he is thing, do not give more food ontinues. cked the specific feeding and by the speech language A. Intinence and Indwelling and 3/27/17, indicated R48 was tinent of urine and did not have	F 280	altered diets and resident with of Results will be brought to the Quantities monthly x 3 months continued opportunities for qualimprovements. DON will monitor for compliance.	API for lity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280	catheter and was to R48's quarterly ME R48 had an indwel On 10/3/17, at 9:37 her room to have a leg draining yellow R48's urinary contindicated R48 was urine. The care plane Foley catheter. During interview or assistant director of R48's care planesh reflect the use of a interventions for standard the comprehensive calculation of the Resident of t	spice nurse inserted a Foley of be maintained by hospice. OS dated 6/17/17, indicated ling catheter. Of a.m. R48 was observed in a catheter attached to her right urine. In ence care plan dated 8/7/17, occasionally incontinent of an did not indicated R48 had a not 10/5/17, at 10:14 a.m. of nursing (ADON)- A stated ould have been revised to Foley catheter, and list aff to maintain the catheter. Care Plans dated 7/15, after follows the CMS RAI ocess on care planning. The replan should be an ammunication tool that must objectives with time frames and ces to be provided to attain or ent's highest practicable and psychosocial wellbeing. The reviewed and revised AI process, and services and must be consistent with tten care plan."	F 2			44/40/47	
	PERSONS/PER C. (b)(3) Comprehens		F 2	02		11/13/17	

PRINTED: 11/01/2017 FORM APPROVED OMB NO. 0938-0391

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F 282	as outlined by the must- (ii) Be provided by accordance with accordance was of 3 residents (R1 assistance for repersonal (R121) whom requival activities of daily I completed for 3 or dependent upon accordance with accorda	rided or arranged by the facility, comprehensive care plan, y qualified persons in each resident's written plan of ENT is not met as evidenced ration, interview and document failed to ensure care plan implemented as directed for 2 34, R121) who required staff rositioning; 1 of 1 resident uired range of motion. In nitoring not completed for 1 of 2 a current pressure ulcer and iving (ADL's) were not f 5 residents (R183, R55, R2) staff for ADL's. Staff for ADL's.	F 2	1. R134, R121, R6, R183, R have had their medical record reviewed and updated as appropriate Services related to repositioni motion, skin monitoring, and A being completed per care plar interventions. A PUSH tool has completed for R6. 2. Residents that reside at C care planned interventions related repositioning, range of motion skin monitoring, and ADL assist the potential to be affected by practice. Policies and procedubeen reviewed and are current requiring assistance with above have received a medical record and interventions have been unappropriate. Skin monitoring woverseen by clinical leadership completion of all required asset and effectiveness. Dependent who require ADLS services with timely and appropriate care the	s and ropriate. ng, range of ADLs are ns been WHR with ated to services, stance have this ares have t. Resident's we services rd review apdated as will be to to ensure essments a residents all receive at includes		
	indicated he requ be repositioned e pressure relief su indicated he was	irred frequent turning, and was to very two hours and to provide a rface. In addition the care plan incontinent of bowel and actual/Potential For Infection		but is not limited to; scheduled bathing per resident choice, not weekly and as needed, daily a grooming of hair and facial hat incontinent care per residents when visible soiled, clothing we	ail care and PRN ir, POC and		

Facility ID: 00112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 282	of urinary tract inference of urinary tract inference of uring continuous 8:35 a.m. to 11:07 R134 was observed chair (tilt and reclir being repositioned At 8:35 a.m. R134 nurses station on twas moved across hall, at 9:12 a.m. Find chair, at 9:30 a.m. hospice nurse moved inning room. At moved R134 back nurses station. At the hall in his Brook was still in hallway he was still asleep informed nursing a findings. During interview 10 stated that he had for bowel incontine around 8:30 a.m. During interview 11 stated she had assisted that he had assisted that he had for bowel incontine around 8:30 a.m. During interview 12 stated she had assisted that he had for bowel incontine around 8:30 a.m.	observation 10/03/17, from a.m. (2 hours and 32 minutes) ed to be sitting in his Broda ne positioning chair), without //toileted or checked/changed. was observed across from the che first floor, at 9:00 a.m. R134 from the nurses station in the R134 was asleep in the Broda registered nurse (RN)-K wed R134 from the hall to the 10:02 a.m. R134 was asleep in the 10:22 a.m. R134 was asleep in la chair. At 10:42 a.m. R134 in chair asleep. At 11:00 a.m. At 11:07 a.m. surveyor assistant (NA)-M and NA-J of 10:03/17 at 11:01 a.m. NA-N repositioned and checked him ence right after breakfast 10:03/17, at 11:12 a.m. NA-M sisted NA-N right after breakfast 10:03/17, at 11:12 a.m. NA-M sisted NA-N right after breakfast 10:03/17, at 11:12 a.m. NA-M sisted NA-N right after breakfast 10:04 a.m. this indicated chance to reposition him again not have enough staff and that of two so she could not	F 28	and neat and free of holes/r residents will be monitored odor and offered hygiene see 3. Licensed and unlicense been re-educated on following resident's plan of care related repositioning, ROM services monitoring, and ADL services. 4. DON/Designee will auding weekly for 4 weeks then monitoring, and comples services. Results will be broughed committee monthly and continued opportunities for a simprovements. DON will monitor for compliance will make the complete services.	for increased ervices. Indicate staff have ing the ed to es, skin es. It 5 residents onthly times 2 OM services, etion of ADL ought to the 3 months for quality		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10	/05/2017		
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 282	R134's skin was in redness of the skin redness of the skin Although R134's caturned and repositi facility failed to impwent approximately repositioned. R121's diagnoses, orders dated 9/28/Alzheimer's demer Minimum Data Set indicated R121 warequired the physic bed mobility, eating personal hygiene. a stage 4 pressure involving bone, mu R121's "Skin Integrand Treatment Carpressure ulcer to creposition program (every) two hours. During observation R121 was lying in the gown and covered call light was clipped mattress was on the "4". R121 was laying side of bed, with a cover, slightly lifting covers, the shape of the skin was covered to the skin was covered to the skin was laying	acatheter for urine. In addition tact with no open areas or an area plan indicted he was to be oned every two hours the plement his care plan and R134 of three hours without being as identified on physician's 17, included early onset intia. A significant change (MDS) dated 8/18/17, is totally dependent upon and ital assistance of two staff for ital graphs and ital assistance of two staff for ital graphs, toileting and ital ital ital ital ital ital ital ital	F 28	32				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10	0/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	During continuous 1:58 p.m. (2 hours positioning in bed p.m., nursing assisentered R121's rothem, and announ "check you" and "reach side of R121 the bed to a workicares, talking with R121's brief was on NA-B removed the side, and NA-D to legs. Together NA bed, then refitted the and now placed R with a pillow under pillow between R1 adjusted, then R12 sheet. Before NA they removed glow During an interview nursing assistant (R121 was "done" and now it was two busy down there, and now it was two busy down there, and the wound can down more. RN-Estage 4 pressure to acceptable" that R supposed to be.	observation from 11:32 a.m. to and 26 minutes), R121's remained unchanged. At 1:58 stants (NA)-D and NA-B om, closed the door behind ced to R121 they were going to reposition you." Working on 's bed, NA-D and NA-B raised in height, and began their R121 as they preceded. Shecked and was not wet. It is pillow from under R121's left ok out the pillow between his in he pillows between his legs, 121 slightly facing the window, at R121 right back side. The 21 legs was replaced, and legs 21 was covered with the bed in he he he had she had and NA-D exited the room, we and washed their hands. In on 10/3/17 at 2:06 p.m., (NA)-D stated the last time (repositioned) was at 11:30, to o'clock. NA-D stated we got and that (R121) should be each every two hours. NA-D	F 28	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/	05/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	EET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	more aware of the When interviewed of assistant director of "would expect" R12	residents' care needs. on 10/4/17 at 8:52 a.m., the f nursing (ADON)-C stated she	F 2	82				
	printed 10/4/17, ind program goal to be current range of mo PROM to bilateral of reps each time. The Explain procedure; lower extremities a complaints of pain,	Program History report, licated R121's passive ROM: Resident will maintain otion with assistance of doing extremities twice a day for 15 ne program directed: 1. 2. Perform PROM to bilateral and; Report to nurse any refusals. R121's mobility care entified contractures and						
	was lying in his bed window, a pillow un were at his side, ell 45 degree angle fro upon his stomach. bilaterally, on his fe observation from 8 remained lying on h a.m., nursing assis nurse (RN)-B repos RN-B, NA-D and N dressing change ar R121 was again re R121 was not offer	on 10/3/17 at 8:18 a.m., R121 If in his room, facing the older his left side. R121's arms bows folded and forearms at om his elbow, and situated R121 wore heel boots, et. During continuous 8:18 am to 11:32 a.m., R121 his bed in his room. At 9:29 tant (NA)-D and registered sitioned R121. At 11:32 a.m., A-B assisted with R121 with a nd repositioning. At 1:58 p.m., positioned by NA-B and NA-D. ed nor was provided any range by of the visits by nursing staff.						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY MPLETED
		245186	B. WING _		10/	05/2017
	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	During interview of stated she assisted did not do any kind stated she "did not motion or exercised." When interviewed stated R121 did not restorative nursing from a ROM programs and hands." During observation 10/4/17 at 9:42 a. R121 with morning and oral cares. To complete range of morning routine. We give a same, NA-C stange of motion point with that. NA worked with resimanyone work with she did not perforn During an interview NA-A stated she corange of motion point have had "someout odo. NA-A stated any exercise or rate when interviewed assistant director R121 had a restor aides should be occares or when rep questioned how R program because	on 10/3/17 at 2:06 p.m. NA-D and R121 only to reposition and d of ROM exercises. NA-D at think" R121 has any range of a program. I on 10/3/17 at 4:38 p.m., RN-B ot have any orders for g, however, R121 could benefit ram, so (R121) could keep his more limber." In of the morning routine on m., NA-A and NA-C assisted g cares, including repositioning here was no provision or offer to f motion for R121 during the When interviewed on 10/4/17 at stated R121 did not have a rogram, and has not assisted -C stated often therapy often a their rooms, but has not seen R121 in his room. NA-C stated m ROM for R121. W on 10/4/17 at 9:59 a.m., did not think R121 had any rogram, and if he did, we would ne from therapy" show us what d she did not help R121 with	F 28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 282	stated the instruction the care tracker we she "expected" R1 services as identification as identificat	s each time. ADON-C also ons for restorative program in ere part of the care plan, and 21 to receive range of motion ed. ONITORING: mum Data Set (MDS) dated R6 had intact cognition, assistance with activities of had unhealed pressure ulcers sk for further pressure ulcer Assessment: Prevention and an dated 8/7/17, identified R6 sk of pressure ulcer had a history of past pressure lan listed several interventions his skin clean and moist, or reposition every two hours lish [Pressure Ulcer Scale for	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/0	5/2017
	PROVIDER OR SUPPLIEF	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	When interviewed interim director of plan was used to, resident needs an abreast of the interest the DON stated the part of a compreh could help determ needed for a presson dentified multiple heart failure, diabenty failure and urinary R183's admission completed on 8/3/cognitively intact videpression. R183 of one to two staff dressing, groomin mobility. A review of R183's 7/28/17 identified assistance with pen hygiene/grooming During observation 3:44 p.m., R183 wonly with a sheet. On staff for provisi my light on, but I completed to come." R183 wonly with a come."	on 10/4/17, at 1:37 p.m. the nursing (DON) stated a care "keep all staff informed," of d staff were expected to keep rventions listed on it. Further, e PUSH tool was considered ensive skin assessment and ine if new interventions were sure ulcer. //IDED: Record, dated 10/5/17, medical diagnosis including etes, morbid obesity, ohedema, chronic respiratory retention. Minimum Data Set (MDS) 17 identified resident was with moderate symptoms of required extensive assistance to complete ADL's including g, bathing, toileting and	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 282	commode for 45 responded within R183 stated his but had not yet refacility which was R183 stated to reto be transported shower while on received a "A who to wash up with a a strong, foul oddodors. During observation 12:23 p.m. R183 dressed today but last bed bath was was dressed in a was noted to hav perspiration and had been noted on The personal oddoroom, and lingered he chose note to it took too long to uncomfortable arrulcers. Following schedule was positioned in the personal oddoroom, and lingered he chose note to it took too long to uncomfortable arrulcers. Following schedule was positioned R183 refevenings. During interview of stated he had received to the personal oddoroom, and lingered he chose note to it took too long to uncomfortable arrulcers. Following schedule was positioned R183 refevenings. During interview of stated he had received to the personal oddoroom, and lingered he had received to the personal oddoroom, and lingered he chose note to it took too long to uncomfortable arrulcers. Following schedule was positioned R183 refevenings.	minutes. He stated the staff five minutes after he called 911. both is scheduled for Mondays, eceived since admission to the more than two months ago. In a gurney and assisted to the cart. R183 stated he has bore bath", when he was assisted to basin. R183 was noted to have or of perspiration and other body on and interview on 10/2/17, at stated he was going to get at didn't feel real clean and his about two weeks ago. R183 hospital gown at this time and the a increased personal odor of other more personal odors than during observation on 10/1/17. For was very prominent in the read into the hallway. R183 stated get up for lunch today because a get back to bed, he was and has had a history of pressure this interaction, the facility bath asted at the nurses station and received his bath on Tuesday.	F 2	282			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10/05/2017		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉT		
F 282	During interview of assistant (NA)-S is assistance to provide plan. R183 could restated when provide bedbath, it is imposed bedbath it is imposed bedbath it is imposed bedbath it is imposed bedbath in one digotten two in a day	n 10/4/17, at 2:19 p.m. nursing tated he had provided ide a bedbath for R183 and ed care according to the care request what he wanted. NA-S ding routine cares, and not a ortant to provide catheter care, reter, and performing hygiene to expect the progress notes of R183 did not wish to pursue noting "I can't even get nelp me shit. I won't be	F 28				

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			TE SURVEY MPLETED				
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)			245186	B. WING		10	/05/2017
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					7505 COUNTRY CLUB DRIVE	ZIP CODE	
E 202 Continued From 1975 54	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
task would be passed on to the oncoming shift to complete. The ADON-B state it would be appropriate for him to be washed up and receive a bath at the time the odor was noted. R55's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voidingly incontinent of urine. Diagnoses included dementia and depression. R55's ADL/Mobility care plan last dated 4/10/17, included a goal for R55 to be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene and dressing. On 10/1/17, 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substances was noted to be under her long fingernalls on her right hand. During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair in the wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap. On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand. During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated	F 282	task would be pass complete. The AD appropriate for him a bath at the time to R55's quarterly Mir 9/1/17, indicated R impairment and ned dressing and persoidentified R55 was episodes of urinary episode of contined Diagnoses include R55's ADL/Mobility included a goal for groomed daily. The assist with personal On 10/1/17, 9:50 a wheelchair in the dbrown substances long fingernails on During observation was seated in her and nursing desk, and was noted to be lap. On 10/4/17, at 6:48 wheelchair near the R55 stated she had dark brown substa fingernails on her roughly designed to be lap.	sed on to the oncoming shift to ON-B state it would be to be washed up and receive the odor was noted. Inimum Data Set (MDS) dated 155 had moderate cognitive reded extensive assistance with onal hygiene. The MDS frequently (seven or more requently (seven or more requently incontinent of urine. It dementia and depression. If care plan last dated 4/10/17, R55 to be neat, clean and well recare plan directed staff to all hygiene and dressing. In. R55 was seated in her doorway to her room. A dark was noted to be under her her right hand. If on 10/1/17, at 11:10 a.m. R55 wheelchair by the elevators R55 smelled strongly of urine be saturated in the area of her relevator and nursing desk. It is a shower the night before. A nice remained under her right hand.	F 2	282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/0	05/2017
	VIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
di Al ur pl Ri in ar ar wi as so ar ca ar ca ar ca ar so wi st sa as wi st Ri	DON-A stated response soiled clothing an should have be a significant chart dicated R2 had made needed extensed personal hygie as frequently inconstant of the sist with personal dicated R2 would be a sist with personal dicated R2 would be a sist with personal dicated R2 would be a sist with personal dicated R3 would be a sist with personal dicated and ADL's and at the are plan lacked appropriate the plan lacked appropriate standing at the area of the right lower significant was uncompared to the plan lacked around aff members offer a hair was uncompared to the plan was uncompared to the plan lacked around aff members offer a hair was uncompared to the plan was uncompared to the plan lacked around aff members offer a plan was uncompared to the plan was uncompared to t	ekly with their showers. idents should not be sitting in g. ADON-A stated R55's care	F 28				
sa of ha	aturated with urine urine present tha allway. n 10/3/17, at 10:1	e back of his pants were e. R2's room had a strong odor at could be smelled in the 2 a.m. R2 was walking in the he nursing desk, his shoes					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	were untied, his had up in multiple place the back of the color the other. ADON-Atie his shoes. R2 as shoes; however Alback to his room a comb his hair. On 10/4/17, at 6:5 dining room watch uncombed and walling ray t-shirt had front. R2 was in the when he walked dand laid in bed. St offer to change his this time. During interview of stated R2 frequentiand would soil his stated R2 needed and assisted with refusals were to be aware when R2 was interested R2 was interested R2 was interested R2 meeded and assisted with refusals were to be aware when R2 was interested R2 was intereste	air was uncombed and sticking es, his gray t-shirt had a tear in or from one side of the neck to approached R2 and offered to allowed ADON-A to tie his DON-A did not offer to take him and help him change his shirt or a 1 a.m. R2 was sitting in the ing television. His hair was as sticking up in multiple places. It is a quarter sized hole in the e dining room until 9:06 a.m. own the hall towards his room aff did not approach R2 and a shirt or comb his hair, during a shirt or comb his hair, during a shirt or comb his hair, during to be checked every two hours to be charted. Further, staff are as soiled, and needed res but were unable to assist of staffing. NA-G stated on her group this morning she with cares, and wasn't sure	F 28	2		
	be looked at for re follow the current ADON-A stated R	2's current care plan needed to visions; however staff did not care plan and should have. 2's care plan directed staff to ith personal hygiene, grooming				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245186	B. WING _		10	/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282			F 28	32		
F 309 SS=J	indicated "The cen philosophy and pro comprehensive car interdisciplinary communication too objectives with time services to be prov resident 's highest and psychosocial who reviewed and reprocess, and service be consistent with cresident 's written of in distinct functional gaining knowledge status." 483.24, 483.25(k)(I FOR HIGHEST WE 483.24 Quality of life is a functional gaining knowledge status." 483.24 Quality of life is a functional care as residents. Each refacility must provide services to attain of practicable physical well-being, consisted comprehensive assessment of a rethat residents received.	care planViews the resident I areas for the purpose of about the resident 's function PROVIDE CARE/SERVICES ELL BEING The second principle that and services provided to facility sident must receive and the experimental the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.	F 30)9		11/13/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	care plan, and the but not limited to the comprehensive and the residents with protested the comprehensive and the residents. The far residents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREMED by: Based on observative, the facility of (R19) identified with received safe and an ursing staff when concern while feed constituted an immore for R19, with the proof death. The immediate jeon 8:12 a.m. when the have on-going issues Staff were not followestablished by the due to dysphagia (executive director)	rehensive person-centered residents' choices, including te following:	F 3	R108 will have a behavior plant developed with assistance from psychiatrist and ombudsman. care will assist and guide the smanage resident's behaviors. Interventions specific to R108' with others have been created other residents are protected a affected by resident's target m behaviors. Plan of care will be reevaluated quarterly and as not changes in condition or as behaviors are protected as affected by resident's target must be a change or escalate. R48 is having pain medication administered when scheduled upon request. Pain assessme completed to ensure adequate management.	n Plan of Plan of Staff to Sta	
	assistant ED-A and	I ED-B were informed of the youngley on 10/04/17, at 4:15 p.m		R134 had catheter replaced ar received from the MD for ongo		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/0	05/2017
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GOLDEN	VALLEY REHABIL	ITATION AND CARE CENTER		GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309		page 56 yed 10/05/2017, at 2:54 p.m., ce remained at the lower scope	F 3	care. Facility will coordinate to deliver care and commun		
	and severity of (D) isolated, with potential for al harm that is not Immediate		resident's needs. R48 will have care coordina and hospice agency. Facilit meeting with hospice to ens	ted with facility by will have sure proper	
	plan was in place bullying behaviors	cilty failed to ensure a behavior for 1 of 1 residents (R108) with s which contributed to verbal the facility failed to		communication and care co R19 will be assisted with ea manner by licensed nurses, speech therapists. R19 care	ting in a safe NARs, and	
	pain medications who had complain	assess for pain, and provide timely for 1 of 3 residents (R48) ats of pain. The facility also the hospice services for 2 of 2		nursing assistant care delive updated with speech therap recommendations. Meal tic was updated to alert staff to	y ket for R19	
		R48) reviewed for hospice.		feeding instructions. Treatn updated to have licensed sta monitor through visual obse	aff (nurses)	
	EATING:			feeding recommendations a followed at breakfast, lunch, Specific education for R19 v	, and dinner.	
	he had dementia swallowing). R19 (MDS) dated 09/0 extensive assista	Record undated indicated that and dysphagia (difficulty 's annual Minimum Data Set 18/17, indicated he needed noe of one with eating and had		to nurses and NARs regardinstructions. Feeding instruprovide alternating ½ spoon and ½ spoonful of thickened waiting for mouth to clear.	ctions include ful of puree d liquids and Respiratory	
	Care Area Assess indicated he requ meals and had a	orders. R19's Nutritional Status sment (CAA) dated 09/13/17, ired assistance with feeding at need for special diet or altered		therapist completed a respir assessment on R19 on 10/4 Physician was updated on 1 regarding increased coughir	1/17. 0/4/17	
		n might not appeal to resident. ndicated he received sufficient		new orders were received. Immediate verbal education to Employee 1 (LJ) that was with feeding and instructed	assisting R19	
	North Memorial M hospitalized from Discharge Summ	mary Note dated 12/02/16, from ledical Center, indicated he was 11/30/16 to 12/02/16. The ary note identified he had onia, and x-ray with bilateral		licensed nurses and NARs a assist residents with eating. was suspended pending the the investigation.	Employee	
		ings (something that has gotten		Residents with behaviors the	at can	

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F 309	Continued From p	age 57	F 3	809		
1 303	in to the lungs fror density will show ulungs. Usually the or some sort of infis in the lung). R19's Speech The indicated PT (patie to address dysphate to receive discharge followed up with normal printed compensareduce aspiration discontinuation of progress due to decues. Nursing star compensatory swafer ongoing signs. A 24 Hour Status of for nursing staff of for nursing staff of [discontinue] from thick liquid diet. Putable to follow during the speech therap staff to do the follow the speech therap staff to do the follow spoon size) * Allow patient to congiving another bite to not put more still chewing	in the outside. Any abnormal up in the otherwise air filled infiltrate will mean pneumonia, fection with edema/swelling that erapist note dated 08/02/17, ent) seen for skilled ST services ugia and complete final session ge documentation. Therapist tursing staff regarding use of tory swallowing strategies to risk. A 24-hour log updated for services due to inability to ementia and inability to follow ff to implement use of allowing strategies and monitor and symptoms of aspiration. Report (communication report ated 08/02/17, indicated: "D/C ST today continue puree/honey rinted strategies at patients ng meals." by instruction sheet directed owing swallowing strategies: I be 1/2 spoonful of puree re honey thickened fluids (1/2 lear mouth completely before food in patient's mouth if he is ghing, do not give more food	F3	potentially affect others have re-assessed for target model behaviors and care plans developed and communicate Plan of care to include intrecommendations to deed behaviors and protect otheresident that could be affeored occurring at the center with and reviewed daily based reports and followed up on Residents will receive pain physician orders. Reside will have care coordinated agencies. ADONs will attracted at the center will be monitated agencies with catheters reviewed to include order management of catheter. At the center will be monitated at the center will be monitated agencies. Residents with catheters reviewed daily based off the and followed up on as application, DON, and ED report in the center will be monitated agencies. Residents in faciliated for potential difficultified for potential difficultified for potential difficultified for potential difficultified for have like contained assessed by speech there occupational therapy for for technique on 10/4/17. Residents in small pieces as the court in small pieces.	cood and have been cated with staff. derventions and scalate her potential ected. Behaviors ll be monitored off triage on as appropriate. In medication per ents on hospice d with hospice tend hospice tend hospice tend hospice to communicate linate care. have been es for Pain occurring tored and triage reports propriate. nagers, speech or, registered eviewed all becial feeding ity were iculties with essment during onts were ocerns. R97 was apy and feeding of requires food	
		n on 10/01/17, at 12:12 p.m. (NA)-B was observed to give		on left side. Resident me plan and NAR care delive updated with recommend	ery guide were	

F 309 Continued From page 58 R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon full of his mashed potatoes and he coughed again. NA-B stated to R19 'It's ok' and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the dining room. NA-B stated to heat her and saked NA-M instructed her that he should only receive		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		\ , ,	(X3) DATE SURVEY COMPLETED	
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GOLDEN VALLEY REHABILITATION AND CARE CENTER 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 58 R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon of his pureed roast beef and he coughed again. NA-B stated to R19 'It's ok' and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive	NAME OF I	PROVIDER OR SLIPPLIE					05/2017	
F 309 Continued From page 58 R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon full of his potatoes, and then a level teaspoon full of his mashed potatoes and he coughed again. NA-B stated to R19 'It's ok'' and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive					7505 COUNTRY CLUB DRIVE	-		
R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon full of his pureed roast beef and he coughed again. At 12:19 p.m. NA-B fed him a level teaspoon full of his mashed potatoes and he coughed again. NA-B stated to R19 'It's ok" and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE	
then took the teaspoon at the table and placed in his honey thickened juice and proceeded to feed him 1/2 teaspoons of his food and beverages and his coughing had decreased. During observation 10/04/17, at 8:12 a.m. HR-A was observed in the first floor dining room assisting R19 with eating. R19 had scrambled eggs, pureed sausage, oatmeal and honey thickened cranberry juice. At the same table directly across from HR-A, sat assistant director of nursing (ADON)-B whom was assisting R134 with eating. HR-A gave R19 a level teaspoon full of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first waiting for R19 to swallow the spoonful of pureed sausage before immediately giving a heaping	F 309	R19 a drink of his thickened liquids drink it instead of proceeded to hav started to cough with NA-B stopped white the stop and then of teaspoon full of hite teaspoon of his proceeded again. A level teaspoon full coughed again. A level teaspoon full coughed again. A gave him a drink of 12:20 p.m. the su NA-B if she was a recommendation pathologist (SLP) instructions that will dining room. NA-NA-M instructed him 1/2 teaspoons of then took the teash his honey thicken him 1/2 teaspoon his coughing had During observation was observed in the teast his honey thicken him 1/2 teaspoon his coughing had During observation was observed in the teast his honey thicken him 1/2 teaspoon his coughing had During observation was observed in the teast his honey thicken him 1/2 teaspoon his coughing had During observation was observed in the teast his honey thicken him 1/2 teaspoon his coughing had During observation was observed in the teast his honey thicken him 1/2 teaspoon his coughing had	juice bringing his cup of honey to his mouth and having him using a spoon as required. She e him take three drinks and R19 while drinking from the cup. en he coughed waited from him continued to give him a is potatoes, and then a ureed roast beef and he at 12:19 p.m. NA-B fed him a I of his mashed potatoes and he NA-B stated to R19 'It's ok" and of his juice from his cup. At reveryor intervened and asked aware of R19's specific feeding is from the speech language. A and showed her the vere on the window sill of the B stated she was not aware and her that he should only receive food and liquids at a time. NA-B spoon at the table and placed in ed juice and proceeded to feed in ed juice and proceeded to feed so of his food and beverages and decreased. In 10/04/17, at 8:12 a.m. HR-A he first floor dining room a eating. R19 had scrambled sage, oatmeal and honey rry juice. At the same table of HR-A, sat assistant director I)-B whom was assisting R134 gave R19 a level teaspoon full e and then immediately gave a afful of his oatmeal, without first swallow the spoonful of pureed	F3	B is going to be treated by spe for ongoing treatment. Resider identified orders on 10/5/17 that is NPO. MD will be present ne evaluation. Care plan and NAI delivery guide updated with new Education will be provided to such behavior management plans a interventions for resident's exhibehaviors that affect others an information is located. Licensed be educated on pain management delivering pain medication per order. Licensed staff will also educated on hospice role in the and coordination of care. Education was provided to staff leadership team, nurses, NAR service, dietary, maintenance, resources regarding only nurse current license, nursing assistate currently on the registry or spetherapists may assist residents 10/4/17 and 10/5/17. Education provided to nurses and nursing to include: residents with specinstructions will be indicated on ticket to refer to the nutrition sebinder which will be located on cart in the dining room, and/or card placed at the table. Staff feeding and report to nurse impany excessive coughing, swalled issues, or holding food in mout Education will be provided to a present in building on 10/4/17 and 10	at B has at resident ext week for a care worders. Itaff on a continuity of the cont		

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F 309	started to cough, lo from HR-A to the righim and rubbed his stop coughing. HR-honey thickened crachin and began spospoonfuls of thicken without first waiting HR-A fed R19 a full not a half teaspoon swallowing strateging R19 a heaping spose and R19 immediate stopped again and and HR-A then brouthickened cranberry began feeding R19 juice, and a level tedid not wait for R19 she gave him anoth covered his mouth while he coughed. A attempts to stop HF though HR-A was not strategies and R19 being fed. R19 had eggs, pureed sausa and 3/4 of his hone ADON-B left the sa R19 and NA-M ther across the same ta approximately 8:25 room, and surveyor observation. HR-A protector and SLP-the table and instru	ge 59 udly turning his head away ght. HR-A stopped feeding back and waited for him to A then brought R19's glass of anberry juice just below his on feeding R19 three ned juice, one after another for R19 to swallow each bite. teaspoon of thickened juice, as identified by the ST es. HR-A proceeded to give onful of his pureed sausage by began to cough. HR-A let him cough without waiting ught R19's glass of honey y juice to his chin and quickly three level teaspoonfuls of aspoon full of oatmeal. HR-A to swallow each bite, before her bite to eat. R19 began to s face turned red while HR-A with his clothing protector ADON-B whom was directly while she fed R19, made no R-A from feeding R19 even not following the ST swallowing continued to cough while deaten 100% of his scrambled age, and half of his oatmeal y thickened cranberry juice. me table HR-A was assisting a sat down to assist R134 ble R19 was sitting at. At a.m. SLP-A entered the dining informed her of the above was removing R19's clothing A immediately walked up to cted HR-A she should have recommendations of bite sizes	F3	809	provided to all employees before the able to work. Notification will be possible to the work. Notification will be possible to the work of the ceive mandatory education price working. This education will be producing orientation and annually to all staff. Feeding instructions will be reviewed nurse manager and dietician quarter with significant changes in condition Nurse managers will verify that feed instructions are available in binders laminated cards are available at mediuarterly and with any changes. Social Service will complete weekly of 3 residents for 4 weeks then most times 2 months for compliance with behavior management plan of care Audits to consist of ensuring behave interventions being applied appropriand that they are effective based of resident response. DON or designed complete assessment of pain management of 10 residents a week weeks then monthly times 2 month include completion of pain assessment administration of pain meds as ordered and/or requested, and follow-up completed if plan of care for pain management ineffective. DON or Designee will audit 1 resident with a catheter weekly for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 4 weeks then monthly times 2 months for appropriate diagrand orders for care. DON or designed will audit 1 resident's plan of care we for 2 weeks then monthly times 2 months for appropriate diagrand orders for care.	ested anager or to evided ed by erly and eals – ed audits eals – ed audits et als enough enou	

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F 309	which is 1/2 spoon then stated that NA the SLP instruction R19. R19's Nutrition Ris indicated he receive thickened liquids at the dining room and The care plan did recommendations. Review of R19's dineeded total assist honey thickened liquids at the dining room and the care plan did recommendations. Review of R19's dineeded total assist honey thickened liquids at the dining room and the recommendations. Review of R19's dineeded total assist honey thickened liquids addition, R19's nurundated, indicated consistency and he eating with a note, instruction." During interview or licensed practical recommendations. During interview or SLP-A stated she had a stat	ful of liquids and food. HR-A A-M had just informed her of as and she had stopped feeding k Care Plan dated 09/08/17, yed a pureed diet with honey nd needed total assistance to d reminded of meal times. not list specific speech therapy	F 309	,	ection will be idits of all sual with feeding th placement of n binder in cards placed aff assisting completed by ors for every 3 times a week ensure reviewed embers to lits after review		
	trained staff that as SLP indicated she the table where he disappear and she cards and leave the stated she also told	for R19 on 7/24/17, and ssisted with feeding him. The left the feeding instructions at ate and the instructions would would have to make new em again at his table. SLP-Ad the interim nurse manager at she no longer works at the					

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F 309	these recommend communication be SLP-A further stat and she recommendations awhile ago, but did through on her recommendations for aspiration and with SLP's recommendations when she feed R1	age 61, the SLP-A stated she wrote lations on the 24 hour pard for all staff to see. The led R19 will cough while eating landed a swallow evaluation do not think the facility followed commendation. She relied if to follow through with her since he was at such high risk it was vital to follow through mendations. The SLP-A stated 9 1/2 teaspoons of his food and much less and it reduced his	F 30	9		
	stated, "I don't know evaluation" and the floor at the facility "before me and I was recommendation" guardian. In addit out about R19's rewhen she overhead how to feed him. gets pureed food a	0/04/17, at 1:01 p.m. ADON-B ow anything about a swallow at she had been working on the for six weeks. This happened wasn't aware of the and reported she could call his ion, ADON-B stated she found ecommendations last Friday and a NA instruct another NA ADON-B further stated R19 and you have to give it to him is not aware of any portion size in slowly.				
	stated R19 had co slow to eat, receiv pureed liquids. NA ounce glass to as coughing while us spoon for the thick teaspoon of fluid.	n 10/4/17, at 3:32 p.m. NA-O bughed a lot while eating, was ed thickened liquids and NA-O stated they use a four sist R19 to drink. If R19 had ing the glass, he would use a kened liquids and give a full Previously (approximately 3 e were written directions on the				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 309	table that directed but these direction NA-O added staff previously, either womitor his responseded to give R1 not use a glass. During interview of stated an educator on R19's SLP-A restated, "I told her awon't remember wanything and had reducated." NA-L t since he was on his During interview of stated she receive needed to check the feeding instruction the black book wor cart. A nurse need prior to staff serving started coughing on nurse. Specific insimeal ticket. During interview of stated she had been process regarding diet. The ticket on instructions and if the black book which beverage cart Nurse room prior to serving assist if there were assist if there were all the staff she had been process regarding diet. The ticket on instructions and if the black book which beverage cart Nurse room prior to serving assist if there were	staff to use a spoon for fluids is were removed from the table. It is sesumed to feed R19 as did with a glass or spoon, and se. NA-O was unaware he is half teaspoon of fluids and in 10/04/17, at 3:42 p.m. NA-Let from the facility instructed her commendations but she is soon as you walk away I hat you told me. She didn't say me sign a paper saying I was hen stated, "I had not fed him is new diet." In 10/5/17, at 2:15 p.m. NA-Q in the meal ticket for any special and directions that referred to hald be located on the beverage ed to be in the dining room in gresident and if anyone in choking they were to alert the tructions were added to R19's in 10/5/17, at 2:17 p.m. LPN-Fen educated on the new residents who have special table would have the needed would indicate to check	F 30	9			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	pneumonia, and withe facility failed to instructions to preinon-trained staff a ADON-B and NA-I while HR-A was femade no attempts occurred. A policy was requerecommendations The immediate jet at 8:12 a.m. and rep.m. when it was with document review, could and could not needed to be in the were eating, where guidelines were lowed what guidelines to facility checked off guidelines to ensure followed and updato other residents where the state of the state o	a history of aspiration as at high risk for aspirating, of follow the specific SLP-A went aspiration, and had ssisting R19 to eat his meal. Were directly across the table eding R19 incorrectly, and to stop or intervene while this ested for following SLP but none was provided. Opardy that began on 10/4/17, emoved on 10/5/17, at 2:54 verified by observation, and staff interview of whom of feed residents, that a nurse edining room when residents individual resident swallowing cated in the dining room, and follow to assist R19 to eat. The ner resident with swallowing re their programs were being ted R19 careplan's along with no were at risk. Sheet, undated, identified es of intracranial injury, paraplegia disorder, d bipolar disorder. R108's ed 7/24/17 identified he had sorganized thinking, verbal hysical staff assistance for ving. The behavior CAA et/24/17, identified resident as and hallucinations which	F 30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		1	0/05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	R108 was yelling home at (R71 and yourself in the min definition of ugly,' (SS)-B whom was very upset yelling time and nothing R201 who was in agreement to what remained in area around, no one tat R71. At 10:16 a was outside of the executive director (AED)-A, R71 very upset ye [R108] yelling'' ar (R201) a "Nigger' about this, and I at to do is calm dow sick of it. You have gone through whe "I am sick of it!" R71 down. R71 bums cigarettes' heard him get mat (R108) goes off oand he gets 3-4 ce R71 was yelling a sitting in his wheel away, smiling and watching R71 yell staff.	on on 10/3/17 at 10:12 a.m. in the entry way of the nursing d R201) stating, "Look at rror and you will see the R71 yells back. Social Service in the area talks to R71 who is (R108) calls us names all the happens, R71 leaves the area. the same area, stated, "yeah" in at R71 was saying. R108 after the confrontation, looking alked with R108 about his yelling at r. (ED), and assistant executive AED-B and director of quality. elling, he was "tired of him and calling him "an Indian", and r. You have not done anything am tired of it. All you tell (R108) in, nothing gets done and I am we no idea what I or (R201) have en we get called those's names. The ED, and AED-A tried to calm sept telling administration (R108) from (R192) all the time. I have and at her, she doesn't like it when in people, so she gives into him igarettes a day from her. While it administration. R108 was elchair approximately 15 feet a grinning with enjoyment while ling at the facility administration.	F 3	09		
		and needed minimal staff ctivities of daily living. R201 was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245186	B. WING			10/0	05/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	no MDS data availa in her assessment During interview or coordinator (HUC)-compliant, and he 'this to staff and oth demanding to othe wants cigarette. He he will pay you tom say no to him, he s which occurs sever curses at everyone not do what he war During observation was sitting in the diffront of him. He stapractical nurse (LP approximately 50 ft LPN-H, "Why did y dilaudid [narcotic p someone else "has continues to yell at During interview or stated R108 was yedoesn't get his coff cigarettes right awa explosive and dem names like, "fat floin to others. During interview or and NA-C both staft the "F word", and reserved.	e facility on 10/2/17. There was able as a result of R201 being period. 10/4/17 6:53 a.m. health unit ab stated R108 was none l'instigates riots here", he does her residents. He is very residents and staff, and a tells resident's and staff that orrow. HUC-B indicated if they wears at them using profanity ral times a day. He yells, and bully's them when they do	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	very mean, and ha especially yells who reposition or toilet we try to calm him be nice, I can yell we that we can get him morning when he we cigarette. We tell he you can get up and gets what he wants he knows a resident until he get both were unawaredeal with R108's betterning and reposit screaming, and cu and staff, "Niger, Ir bitches." He is very pay for you to work he wants something everything and do indicated she attenmake a plan with he times not. He alwas sooner than sched due at 3:00 p.m., athem, but you have him not until 3:00 pyou need to make pain medications, the with you, as long a you told him. This time. If you break There is no behavi	s a lot of behaviors. He en we want to do cares for him, him. He tells us no, and when down he says. "I don't have to when I want." The only time in to do anything is in the early wants to get up and have a im, after we change you then I he agrees to this. When he is, then he starts yelling again. If int smokes he will bug that ets a cigarette. NA-A and NA-C et of any behavior plan to help	F 30			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	During interview or stated R108 calls rass, and good for reverything but a "cursed at and mak not. He hurts my feme. He tries to "bu "no", then he goes this was not right thand he makes me anything. When he sweet until he gets to himself. Staff tachanges. During interview or stated he was comother day trying to yelled at him, "Hey you not on the resettime that I am a, "frignore him, and tel but nothing works. member FM-A) on found out about this sorry and was good I was in the dining about the shooting to me and asked for He tells me, I just sknow you have one then tells me, "I wo I turned around and and left the dining hallway entrance yadministration. Not nothing about this,	in 10/4/17 at 7:47 a.m. R201 ine a, "Niger, bitches, hoes, fat nothing person." He calls me hild of god." I hate being ing me something that I am beling when R108 talks bad to im a cigarette", and I tell him off, yelling at me. R201 stated that they have to put up with this feel that I am not worth wants something he can be all what he wants, and then back lk with him, but nothing in 10/4/17 at 7:57 a.m. R71 ing out of the dining room the get coffee, and R108 just in, you fucking Indian, why are ervation." He tells me all the fucking dirty Indian." I try to l him "come on dude let it go," l just lost a (significant family 9/11/17, unexpectedly. He s, and at first he said he was d. Then on Tuesday (10/3/17), room watching the television in Las Vegas. R108 come up or a cigarette, I told him "No". saw you smoking one, and I e, so I just ignored him. R108 ander how you dead [FM-A] is." d told him why is he like that room, then when he was in the	F 30			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		OATE SURVEY COMPLETED	
		245186	B. WING		10/	05/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETION DATE	
F 309	maintenance direct behavior varies, hot of coffee. He word", and has but treat him with respalong. If you do litt respect he is bette by his facial exprea frown, has a glainto space this is rroll him cigarettes that. R108 smoke the month, his behad ran out of check, his mood is money. During interview of stated R108's behad ran out of check, his mood is money. During interview of stated R108's behad ran out of check, his mood is money. R108's hot a be cigaretter for him get more cigaretter residents. The mocigarettes he dem last. As long as the cigarettes, he gets residents he will produced to have a be cigarettes, he gets residents he will produced to have a be cigarettes he dem last. As long as the cigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes, he gets residents he will produced to have a becigarettes he dem last. As long as the cigarettes, he gets residents he will produced to have a becigarettes he dem last. As long as the cigarettes he dem last. As long as he cigarettes he dem last. As long as he cigarettes he dem last	rage 68 In 10/4/17, 8:42 a.m. Interpretation of (M)-A stated R108's It is asks for coffee so I get him a calls the kitchen staff the "C read his bridges with them. I beet, talk with him and we get the things for him and get his er, but sometimes not. I can tell ssion his mood. When he has say eyed look and staring out not a good day. SS-A used to a good day. SS-A used to a lot, and by the third week of haviors get really bad because money. When he gets his is better, until he spends his in 10/4/17, at 9:12 a.m. HUC-A laviors are bad, he yells at emeaning and not nice. He havior plan and SS-A rolled R108 would come back and its rolled, then sell them to other fore SS-A rolled, the more anded so that program did not ey (residents) give him is along with them. He tell ay them back, but he never bid him. There is no behavior. Behavior Assessment Care of Risperdal, Xanax and Vistaril. included, monitor for side altered perception or ganized speech, lethargy, live level, hallucinations and	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245186	B. WING _		10	/05/2017	
			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
constipation. Ther idenfied to assist a behavior of being name calling of oth help decrease the Review of the Ass (ACP) notes from R108 had areas owhich included: cowound care, fluid therapies, medical control, activity levanote identified R10 The ACP recommate th	e are no staff interventions staff of how to deal with R108's demanding, using profanity and her residents in the facility to se behaviors. ociated Clinic of Psychology 3/31/17 to 9/29/17 identify for concern that increased his risk ompliance with medical advice, restrictions, participation in tion compliance, impulse rel and social isolation. The 08 main focus was cigarettes, endations were as identified: k to make sure he is his medicaiton, needs to follow endations, and compliant with 08 can be successful in his is agreed not to empty his eside; FM-B is helping R108 is cigarettes so he has more enthe cigarettes, to help reduce wants his motorized wheelchair R108 was unsafe using the lity was working on getting parts his is difficult since the chair is continued. A 3/31/2017 ACP it using the word "boundaries" is 08 knows and responds to, reminding him of the peers and staff may be helpful no further mention of using 21/17, and 7/28/17, note r provided R108 with validation		09			
	PROVIDER OR SUPPLIES I VALLEY REHABILI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p constipation. Ther idenfied to assist s behavior of being name calling of oth help decrease the Review of the Ass (ACP) notes from R108 had areas o which included: co wound care, fluid in therapies, medical control, activity lev note identified R10 The ACP recommistaff need to chec consistently taking physician recomm all his cares so R1 recovery; R108 ha colostomy bag out with the cost of his money to purchas his behaviors. He back even though power chair. R108 parts, and the faci for this chair, but t model has been d note indicated that something that R1 redirecting him by boundaries of his at times. There is "boundaries." A 7/2 identified the write of his feelings and	245186 PROVIDER OR SUPPLIER I VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 constipation. There are no staff interventions idenfied to assist staff of how to deal with R108's behavior of being demanding, using profanity and name calling of other residents in the facility to help decrease these behaviors. Review of the Associated Clinic of Psychology (ACP) notes from 3/31/17 to 9/29/17 identify R108 had areas of concern that increased his risk which included: compliance with medical advice, wound care, fluid restrictions, participation in therapies, medication compliance, impulse control, activity level and social isolation. The note identified R108 main focus was cigarettes. The ACP recommendations were as identified: staff need to check to make sure he is consistently taking his medicaiton, needs to follow physician recommendations, and compliant with all his cares so R108 can be successful in his recovery; R108 has agreed not to empty his colostomy bag outside; FM-B is helping R108 with the cost of his cigarettes so he has more money to purchase the cigarettes, to help reduce his behaviors. He wants his motorized wheelchair back even though R108 was unsafe using the power chair. R108's power chair has broken	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 constipation. There are no staff interventions idenfied to assist staff of how to deal with R108's behavior of being demanding, using profanity and name calling of other residents in the facility to help decrease these behaviors. Review of the Associated Clinic of Psychology (ACP) notes from 3/31/17 to 9/29/17 identify R108 had areas of concern that increased his risk which included: compliance with medical advice, wound care, fluid restrictions, participation in therapies, medication compliance, impulse control, activity level and social isolation. The note identified R108 main focus was cigarettes. The ACP recommendations were as identified: staff need to check to make sure he is consistently taking his medicaiton, needs to follow physician recommendations, and compliant with all his cares so R108 can be successful in his recovery; R108 has agreed not to empty his colostomy bag outside; FM-B is helping R108 with the cost of his cigarettes so he has more money to purchase the cigarettes, to help reduce his behaviors. He wants his motorized wheelchair back even though R108 was unsafe using the power chair. R108's power chair has broken parts, and the facility was working on getting parts for this chair, but this is difficult since the chair model has been discontinued. A 3/31/2017 ACP note indicated that using the word "boundaries" is something that R108 knows and responds to, redirecting him by reminding him of the boundaries of his peers and staff may be helpful at times. There is no further mention of using "boundaries." A 7/21/17, and 7/28/17, note identified the writer provided R108 with validation of his feelings and emotional support as effective	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIVATE ACTION SHAPE DEFICIENCY)	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER SITE TADDRESS, CITY, STATE, ZIP CODE 10	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	oriented therapy, ereinforcement for printerventions. During interview of ADON-A and SS-Abehaviors of yelling "colorful" words are wanted to get out orefuses all cares a sees ACP on a regisee them as well, four visits. He has physical, cigarettes behaviors. ACP to plan, and roll his colonger and this woother residents. The then he wanted mostarted to sell them complained they wanted like the taste, sprogram. This produce 2017, and we other behavior plan uses profanity to ghim why, he says the attention. He is a wanted for behaviors have go on 2nd floor. They	emotional support and positive behaviors as effective on 10/4/17 at 9:23 a.m. with a both stated, R108 has lots of g at staff and resident with very at has called 911 when he of bed and was very sick. He also and is a difficult person. He gular basis but also refused to the does this about once every only verbal behaviors and not as are his main focus with his and us to develop a cigarette grattes so his money lasted uld stop him from bothering his program initially worked, but once and more cigarettes. He in to other residents, then he were not packed right and did so he (R108) stopped this agram stopped at the end of the have not implemented any in since, we do our best. He et your attention, and if you ask that he does this to get their work in progress, we try to need to do but we do not have his behaviors and his tten worse since he was placed try to keep him occupied but arm over it has been tough to be	F3	309			
	facility has consist	, there was no indication the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED	
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	245186 OF PROVIDER OR SUPPLIER DEN VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 71 handle or divert R108 behaviors of using profanity, yelling at residents, staff and refusing his cares. Pain R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact. The MDS identified diagnoses of anxiety, depression and fracture and received hospice care. The MDS identified R48 was receiving scheduled and as needed pair medication, however, did not receive any non-pharmalogical interventions related to pain. The MDS pain interview indicated R48 had pain occasionally, which made it difficult to sleep at night and limited R48's daily activities. R48 rated her pain a 7 out of 10 at the time of the MDS. R48 did not have a Pain Care Area Assessment. During interview on 10/1/17, at 3:53 p.m. R48 stated she had pain from her belly button all the way around to her back, including her shoulders. She rated her pain 9 out of 10, with 10 being the worse pain. R48 stated she hurt like that all the time, and it went away only when she slept, if she could fall asleep. R48 did not display any signs or		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	handle or divert R profanity, yelling a his cares. Pain R48's quarterly MI R48 was cognitive diagnoses of anxie and received hosp R48 was receiving medication, however pharmalogical interview occasionally, which night and limited February her pain a 7 out of did not have a Pain During interview of stated she had part way around to her She rated her pain worse pain. R48 stime, and it went a could fall asleep. If symptoms of pain R48's physician's the following pain chronically on opia disease, migraines of the metatarsal bor metabolic encepharman.	t residents, staff and refusing t residents, staff and refusing to residents, staff and refusing to residents, staff and refusing to S dated 6/17/17, indicated by intact. The MDS identified by depression and fracture bice care. The MDS identified by scheduled and as needed pain over, did not receive any non-erventions related to pain. The work indicated R48 had pain he made it difficult to sleep at R48's daily activities. R48 rated if 10 at the time of the MDS. R48 in Care Area Assessment. In 10/1/17, at 3:53 p.m. R48 in from her belly button all the back, including her shoulders. In 9 out of 10, with 10 being the tated she hurt like that all the laway only when she slept, if she					
	pain) soluble tab 5 PRN (as need	arcotic for moderate to severe is milligrams (mg) every 4 hours led), started on 7/11/17. Iuble tab 5 mg every hour PRN,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING_		10.	/05/2017
	PROVIDER OR SUPPLIER	A BUILDING 245186 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EQUILATORY OR LSC IDENTIFYING INFORMATION) FRIEDRY FROM 30617. gabapentin (nerve pain) 400 mg 2 caps daily, started 3/6/17. morphine sulfate ER 15 mg 1 tablet every and 2 tablets in the evening every 12 hours, started 7/29/17. MPAP (accetaminophen) 500 mg 2 tabs times daily, the order did not indicate a start date. S Medication Administration Record (MAR) ctober 2017, indicated the following dule: gabapentin 400 mg 2 caps twice daily duled for 8:00 a.m. and 8:00 p.m. morphine sulfate ER 15 mg 1 tablet every and 2 tablets in the evening every 12 hours, started 7/29/17. MPAP (accetaminophen) 500 mg 2 tabs times daily, scheduled for 9:00 a.m. and 9:00 p.m. MPAP (accetaminophen) 500 mg 2 tabs times daily, scheduled for 8:00 a.m., 12:00 and 8:00 p.m. MPAP (accetaminophen) 500 mg 2 tabs times daily, scheduled for 8:00 a.m., 12:00 and 8:00 p.m. S facility medical record lacked a prehensive pain assessment and a care plan				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE
F 309	- nitroglycerin tongue every 5 mir started 3/6/17 gabapentin (Itwice daily, started - morphine sul a.m. and 2 tablets started 7/29/- MPAP (aceta three times daily, to date. R48's Medication Afor October 2017, schedule: - gabapentin 4 scheduled for 8:00 - morphine sul a.m. and 2 tablets scheduled for MPAP (aceta three times daily, sp.m. and 8:00 R48's facility medication Afor October 2017, scheduled for 10/3/17, at 9:30 seated in her whee not display and sighad a flat affect. Repain medication for received her medication for received the pain the floor nurse told on her medication	0.4 mg dissolve 1 tab under the nutes up to 3 doses PRN, nerve pain) 400 mg 2 caps 3/6/17. fate ER 15 mg 1 tablet every in the evening every 12 hours, 17. Iminophen) 500 mg 2 tabs he order did not indicate a start Administration Record (MAR) indicated the following 00 mg 2 caps twice daily a.m. and 8:00 p.m. fate ER 15 mg 1 tablet every in the evening every 12 hours, r 9:00 a.m. and 9:00 p.m. Iminophen) 500 mg 2 tabs scheduled for 8:00 a.m., 12:00 p.m. cal record lacked a in assessment and a care plan ain. 7 a.m. R48 was observed elchair in her bedroom. R48 did ins or symptoms of pain, but 48 stated she had scheduled r 8:00 a.m. and had not	F 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING	·····	10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309 Continued Fro		age 73	F 309				
	it took staff so long	to bring it, she just tries to n. R48 again rated her pain a 9					
		19 a.m. RN-E administered dications by bringing them to					
	stated she had a "I residents' medicatifacility and was just medication. RN-E scheduled for 9:00 have an hour before scheduled medication. At 10:2 RN-E's medication administering R48 included pain med "that's not good." administered R48 the scheduled time gastroesophageal (anti-anxiety) 0.5 m 15 mg, two tablets mg, two capsules of pressure, angina adisorders) 180 mg depressive disorders of gabapentin (treat During interview or stated R48 had ne but if she did NA-C further stated the r	n 10/3/17, at 10:20 a.m. RN-E nectic" morning pre- packaging ons to take on leave from the at administering R48's morning stated the medications were a.m. RN-E stated the staff re and an hour after the tion times to administer 22 a.m. RN-A approached cart. RN-E stated she was just s morning medications, that ications. RN-A then stated, At 10:48 a.m. RN-E stated she the following medications after at omeprazole (treatment of reflux disease) 40 mg, ativaning, morphine sulfate (narcotic) of Tylenol (pain reliever) 500 of diltiazem (treat high blood and certain heart rhythm and duloxetine (treat major er,) 60 mg, and two capsules at nerve pain) 400 mg.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		10/0	05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	p.m. R48 stated he now, and after reclate, it didn't help has going to lie do her pain. On 10/3/17, at 2:3 asked her pain levoccasionally she reand usually rated her and stated going pharmalogical intercomprehensive paradmission, but was assessments were defined by the comprehensive paradmission, but was assessments were defined by the comprehensive paradmission, but was assessments were defined by the comprehensive paradmission and becomes more and when interviewed ADON-A stated should be a comprehensive paradmission by the comprehensive paradmission and becomes more and beco	sterview on 10/3/17, at 2:06 or pain was "pretty bad" right eiving her pain medications her pain much. R48 stated she own and try to sleep to relieve of p.m. RN-E stated R48 was el at least every shift, equested PRN pain medication, her pain a 7 out of 10 or better. Hought the medications helped high to chapel was a non-rivention. RN-E stated a hin assessment was done on a not sure if the pain a completed any other time. In 10/5/17, at 9:12 a.m. was important to receive pain when it gets out of control R48 axious increasing the pain. In 10/5/17, at 10:14 a.m. he was not aware R48 was dichanges to her pain the last few months. ADON-A art and stated there should be pain assessment and care plan	F 309				

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	1 .0.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROPOLICIENCY)) BE	(X5) COMPLETION DATE
F 309		nge 75 eased her pain levels.	F 3	09			
	indicated he was so needed extensive a was always contine failed to indicate he catheter. R134's che had a history of had a Foley cathete Incontinence Care. 7/27/17, indicated hwith toileting and w bladder and staff mand used incontine assessment indicated to the contine assessment in the contine assessment indicated	Area Assessment (CAA) dated ne needed total dependence as incontinent of bowel and tanaged all incontinence cares nt products. The CAA ted he had urinary urgency and with toileting. The CAA failed					
	indicated R134 had elimination and had catheter. Home hed bladder function, hy urinary catheter cal hospice care plan i caregiver will demode on 10/03/17, at 8:2 the dining room to	re plan dated 07/07/17, I alteration in bladder Id an indwelling urinary alth/hospice was to assess ydration and education on re as needed. In addition the indicated patient, family, instrate proper catheter care. In alta and alta ched air (tilt and space positioning					
	During interview 10 nurse-North Memo	1/03/17, at 9:30 a.m. hospice rial (HN)-A stated R134 had ase load on 07/06/17, and he					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	CTION (X3) DATE (COMPL	
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
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F 309		age 76 er ever since he was admitted	F3	809			
	to hospice. In add	ition, HN-A stated hospice had atheter, tubing or bag and that					
	assistant director of R134 had went to he was on third flo	of nursing (ADON)-B stated the hospital in July 2017, when or and transferred to first floor					
	stated his catheter weekly and the cat monthly. ADON-B he returned from to and she was not s	from the hospital. ADON-B bag should be changed theter should be changed stated there no orders when he hospital for catheter care ure if either had been					
		ney had no orders. The efacility should be responsible res.					
	was observed in b observed attached catheter anti-reflux	n 10/05/17, at 8:59 a.m. R134 ed. His indwelling catheter was to the left side of the bed. The valve and tubing inside was mucus gray matter.					
	stated he did not n catheter. He indica hospital and return	n 10/05/17, at 9:00 a.m. NA-J ormally see gray sediment on a ated R134 had been in the ned to the first floor with the ated staff empty the catheter					
	ADON-B stated the when to change the indicated she was R134. ADON-B stated and not changed to	n 10/05/17, at 9:11 a.m. e facility should have orders on e catheter, bag and tubing and unable to locate orders for ated she would assume staff he catheter, tubing and bag from the hospital on 07/05/17,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245186	B. WING _		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 309	noticed the sedim know why he had one before his hos the catheter was p 6/23/17, and the reason for the cation buring interview of had contacted R1 orders to remove not have a reason ADON-B further in signs and his tempsigns of sepsis. Although R134 had hospice or the nurcare to identify what he catheter for R1 A Service Agreem And A Nursing Fadated 05/23/16, in Care means a writh maintained, review collaboration betwoed Facility that including and symptom relieved and related in Family, and (c) defrequency of such delineation of according to the property of the property of the property of the property of such delineation of according to the property of the pro	ns). ADON-B further stated she ent in the catheter and did not a catheter since he never had spitalization. ADON-B stated blaced in the hospital on ecord did not indicate the heter. n 10/05/17, ADON-B stated she 34's physician and received the catheter since the facility did for R134 to have the catheter. Indicated she had taken his vital perature was 98.2 and had no an indwelling catheter, neither using home had coordinated his nom was responsible for care of 134. ent By And Between Hospice collity (North Memorial Hospice), dicated: "Combined Plan of the care plan established, wed, and modified, in the end Hospice and the Nursing es (a) an assessment of each an identification of Hospice granagement of discomfort the fineeded to meet such patient's the test of the Hospice Patient's tails concerning the scope and Hospice Services. (d) countability of services".	F 30	9		
		DS dated 6/17/17, indicated ly intact. The MDS identified				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3		TE SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	diagnoses of anxiethospice care. The receiving schedule medication, however pharmalogical intervence occasionally, which night and limited Repain a 7 out of did not have a Pain R48's facility medicomprehensive paragraph dated 8/end of life care related care plan dated 8/end of life care related care plan dated 8/end of life care related congestive herindicated physical declining status. Heresponsible for dis Interventions incluced consulting physicial needed, liberalized condition, encourar contraindicated an support resident's and see pain managraph and see pain mana	ety, depression and received MDS identified R48 was ed and as needed pain ver, did not receive any non-rventions related to pain. The w indicated R48 had pain in made it difficult to sleep at R48's daily activities. R48 rated 10 at the time of the MDS. R48 in Care Area Assessment. I cal record lacked a sin assessment and care and a towards pain. R48's Palliative 17, indicated R48 was receiving ated to coronary artery disease art failure. The care plan symptoms of pain and ospice and nursing staff were ease management. I ded: support choices and ones and clinical sources as diet according to medical	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505	ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Pain remained a 7, change after collab facility nurse, disco and increased long bedtime. During interview or ADON-A stated she having pain and an the last few months recent hospice care ADON-A stated the with the floor staff, the care in facility v changes in the host coordinate the need communication betwas poor. ADON-A invited to attended and her hospice teath only the facility since and the facility since RN-F stated there we present and only the (SS)-A and R48's state care conference.	8, or 9 out of 10 with little coration with resident and intinued short acting morphine acting MS Contin to 30 mg at a 10/5/17, at 10:14 a.m. e was not aware R48 was y pain medication changes in a ADON-A stated the most e plan was from July 2017. The hospice nurse may check in but the ADON's who managed were not getting notified in pice care plan to effectively ded care. ADON-A stated the tween the facility and hospice a stated she had never been a care conference with R48	F3	09			
	weeks and the comupdated forms whe sure why the facility plan was from July better coordination	npany was to fax over the en completed. RN-F was not y's most recent hospice care 2017, and there needed to be					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IG	COMPLETED
		245186	B. WING _		10/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
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F 312 SS=D	the facility and Ase 11/10/17, indicated hour room and boacare and nursing n coordination with the ensure that the lew would have been p caregiver at home provided before House 483.24(a)(2) ADL ODEPENDENT RES (a)(2) A resident what it is a civities of daily living errors and and oral house to maintain personal and personal personal house to maintain personal house to m	rCare Hospice set to expire on: "The facility shall furnish 24 ord care, meeting the personal eeds of the Hospice Patient in the Hospice representative and the lost of care provided is what rovided by the primary and at the same level of care aspice care was elected." CARE PROVIDED FOR SIDENTS The is unable to carry out ing receives the necessary in good nutrition, grooming, and	F 31		e to e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 312	included a goal for groomed daily. The assist with personal On 10/1/17, at 9:50 wheelchair in the distribution of the province	care plan last dated 4/10/17, R55 to be neat, clean and well a care plan directed staff to all hygiene and dressing. D a.m. R55 was seated in her loorway to her room. A dark was noted to be under her long right hand. To on 10/1/17, at 11:10 a.m. R55 wheelchair by the elevators R55 smelled strongly of urine be saturated in the area of her re R55 was loudly requesting to garette, as staff passed by her, a her. At 11:18 a.m. the social RSD) brought R55 onto the er for a cigarette. SSD did not	F 312	Nurse managers and DON will personal care audits on each oresidents will be audited week weeks then monthly times 2 m. Results of the audits will be for the QAPI committee for opport continued quality improvement months. DON to monitor compliance.	unit. 3 ly for 4 nonths. rwarded to tunities of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	were diabetic, then On 10/4/17, at 6:4 wheelchair near th R55 stated she ha dark brown substat fingernails on her R55's bath list indi Tuesday evening (10/3/17). During observation assistant executive R55 outside to sm her right hand and never offered to ha brought her back u room for breakfas: During observation brought R55 out o room and started o stated her nails we should be cleaned noticed they were morning, however smoke before she NA-H stated nail o and on their bath o scheduled for a sh nail care should ha During interview o assistant director o care should be do dirty, otherwise we	n the nurse did the nail care. 9 a.m. R55 was seated in her re elevator and nursing desk. d a shower the night before. A since remained under her right hand. cated she received showers on which would have been n on 10/4/17, at 7:08 a.m. e director (AED)-B assisted oke. R55 held her cigarette in AED-B lit her cigarette. AED-B ave R55's nails cleaned and upstairs to the 4th floor dining to a cleaning her fingernails. NA-H are "really really dirty" and they every day. NA-H stated she dirty when she got her up this, someone brought her out to had a chance to clean them. are should be done as needed days. NA-H confirmed R55 was nower the evening before and ave been done. In 10/4/17, at 8:37 a.m. of nursing (ADON)-A stated nail ne daily with cares if visibly bekly with their showers. sident should not be sitting in	F 31:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From page	age 83	F 312			
	indicated R2 had rand needed extensional hygicians frequently incompassociated skin daschizophrenia. R2' (CAA) dated 8/19/a functional declinations, physicomplications of mweight loss and debe developed to sl complications and directed to see carand interventions.	ange MDS dated 8/18/17, noderate cognitive impairment sive assistance with dressing ene. The MDS identified R2 ontinent of urine, with moisture image. Diagnosis included was a ADL Care Area Assessment 17, indicated R2 was at risk of e due to psychoactive cal limitations, falls, nobility including incontinence, pression. A care plan was to ow or minimize a decline, avoid minimize risks. The CAA e plans for problems, goals				
	indicated R2 would groomed daily. The assist with persona and undressing wi care plan indicated and ADLs and at ti	ast reviewed on 8/5/17, If be neat, clean and well If care plan directed staff to If hygiene, grooming, dressing If hysical assistance. The If R2 was resistant to therapy If hygiene, grooming, dressing If hygiene, gro				
	was standing at the strong urine smell. saturated with urin as the right lower suncombed and stic Multiple staff were desk and no one or room to assist with	n on 10/2/17, at 2:10 p.m. R2 e nursing desk and had a His sweatpants were e in the front and back, as well side of his shirt. R2's hair was cking up in multiple places. located around the nursing iffered to take him back to his a changing his clothes and At 3:00 p.m. R2 was observed				

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		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER	,	7505 (ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427	1	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	lying on his right swere saturated w strong odor of uri in the hallway. On 10/3/17, at 10 hallway in front of were untied, his hup in multiple place the back of the cother. ADONtie his shoes. R2 shoes, however Aback to his room comb his hair. On 10/4/17, at 6:5 dining room watch uncombed and w His gray t-shirt hafront. R2 was in the walked of and laid in bed. Soffer to change his time. During interview of services assistant.	side in bed, the back of his pants ith urine. R2's room had a ne present that could be smelled an extension of the nursing desk, his shoes the nursing desk, his gray t-shirt had a tear in ollar from one side of the neck to A approached R2 and offered to allowed ADON-A to tie his aDON-A did not offer to take him and help him change his shirt or and help him change his shirt or day a quarter sized hole in the ne dining room until 9:06 a.m. down the hall towards his room taff did not approach R2 and a shirt or comb his hair, during on 10/4/17, at 8:47 a.m. social to (SS)-A stated R2 had a brother	F3	112	DEFICIENCY)		
	new shoes and the pair. SS-A stated R2's clothing and help in obtaining a residents right thowever, R2 wou holes in his clothing.	cted in the past about getting the brother bought him a new the had not noticed the holes in had not notified R2's brother for new clothing. SS-A stated it was to wear what they wanted, and never complain about having an unless they were really large.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 312	and would soil his of stated R2 needed to and assisted with the refusals were to be aware when R2 was assistance with car R2 due to the lack although R2 was ordid not assist him who did. NA-G stat but needed hands ordid allow staff to conchanging his clother staff approached him R2's Behavior Deta 10/4/17, indicated R9/16/17, and staff who During interview on ADON-A stated in this own personal confering assistance be offered toileting hours, staff should changing his clothing refusals needed to nurse so others concares. ADON-A stated holes in there cloth them any. She was holes, however, did communicated R2's assistance. Staff should changing his hair. As combing his hair.	y removed his incontinent pad clothing with urine. NA-G to be checked every two hours bileting needs, and any charted. Further, staff are soiled, and needed tes but were unable to assist of staffing. NA-G stated in her group this morning she with cares, and was not sure ted he was fairly independent on assistance frequently and with his hair and assist with tes, it just depended on how with. It Report from 7/7/17 to R2 resisted care one time on was able to redirect R2. In 10/5/17, at 9:39 a.m. The past R2 had done some of the ares, however, staff should be as needed. Although, R2 is to and assistance every two have assisted him with the soiled with urine. Any be charted and reported to a culd try and assist with needed ted a lot of residents have the sand have no one to buy aware R2 had clothing with	F 3:	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 312	Continued From p	age 86	F 31	2			
	identified multiple heart failure, diabe hypertension, lymp failure and urinary R183's admission R183 had intact co symptoms of deprextensive assistan	Record, dated 10/5/17, medical diagnoses including etes, morbid obesity, ohedema, chronic respiratory retention. MDS dated 8/3/17, identified ognition with moderate ession. R183 required ace to complete all ADL's except welling catheter and did not					
	A review of R183's identified R183 receptsonal hygiene/gR183's care plan of	s care plan dated 7/28/17, quired personal assistance with grooming/dressing/undressing. did not list interventions to use s hygiene and meet his bathing					
	resting on his bed. R183 was noted to of perspiration and urinary drainage bed frame, and tul observed under the dependent on staff can turn my light of will take them to che had called 911 commode for 45 mesponded within franks stated his babut had not yet rect the facility greater	4 p.m. R183 was noted to be covered only with a sheet. In have a strong, pungent odor if other body odors. A straight ag was noted attached to the bing from the bag was e sheet. R183 stated he was if for provision of care stating, "I will be a sheet if the state of the bind the state of the had been left on the sheet. He stated the staff five minutes after he called. In at his scheduled for Mondays, be eved one since admission to than two months ago. R183 a shower he would need to be					

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		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 312	transported on a gwhile on the cart. whore bath," where with a basin. During interview of stated he was go not feel real clean was about two we dressed in a hosp noted to have an inbody odor that has strong, pungent be the room, and also of the R183's room get up for lunch, at to get back to be and had a history interview, the bath posted at nurses areceived his bath. During interview of stated he had record to get up. R183 stated after get up out of bed to get up. R183 stochange linens follohave fresh linens. changed as requesting interview of assistant (NA)-S assistance for a befelt he had provided care plan. NA-S sidentify what they	gurney and assisted to shower R183 stated he has received "An he was assisted to wash up on 10/2/17, at 12:23 p.m. R183 ing to get dressed today but did. R183 stated his last bed bath eks ago. R183 was noted to be ital gown at this time and was ncrease of strong, pungent ad been noted on 10/1/17. The ody odor was very prominent in a notable in the hallway outside m. R183 stated he chose not to and stated it would take too long, would become uncomfortable of pressure ulcers. Following a schedule was noted to be station and identified R183 on Tuesday evenings. In 10/4/17, at 7:05 a.m. R183 eived a bed bath last evening. his bed bath he requested to and was asked why he wished ated he had to instruct staff to owing his bath as he wished to R183 stated his linens were	F3	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505	ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE DEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	A review of R183's 10/2/17, identified catheter removal is someone here to demeaned any fur During interview of ADON-B stated R went on to state if assistance, he will 911. ADON-B state answered immediate within ten minutes summon adequate for transfers. ADC concerns regarding expressed it was the washed up with mincluding washing armpits, and application ADON-B stated rewashed on bath difference R183 had received times. ADON-B stated it she was not award shower, but stated complete the show on to the oncomin ADON-B stated it be washed up and odor was noted.	s physician progress notes of R183 did not wish to pursue noting, "I can't even get help me shit. I won't be ther." n 10/5/17, at 9:59 a.m. the 183 was very impatient and he does not receive immediate attempt to self transfer, or call ed the call light should be ately, with assistance provided, however, it may take longer to e staff to provide assist of two N-B stated she was unaware of g personal odors, and the expectation residents were orning and bedtime cares, of face, hands, pericare, cation of lotion and deodorant.	F3	112			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY MPLETED
		245186	B. WING _		10.	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314 SS=D	also requested and The facility policy A Program dated 7/1 resident has specif ADL assistance. Batechniques and intenot limited to:" Selecting and Putting clothe Fastening but Taking off all i Applying or relimbs Use of adapti Maintaining p Planning the t Gathering sup Combing hair Washing face Brushing teet Shaving if app Applying mak Trimming nail Use of adapti 483.25(b)(1) TREA PREVENT/HEAL F (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure	Inot provided. activities of Daily Living (ADL) 5, included: "Determine if the ic tasks and areas requiring athing, dressing and grooming erventions may include, but are obtaining clothes son tons and snaps items of clothing emoving braces and artificial equipment ersonal hygiene task oplies and hands holicable dorant e-up if applicable so we equipment applicable so w	F 3′			11/13/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 314	ulcers unless the demonstrates that (ii) A resident with necessary treatmy professional standhealing, prevent in from developing. This REQUIREM by: Based on observation of the second o	individual's clinical condition to they were unavoidable; and a pressure ulcers receives ent and services, consistent with dards of practice, to promote infection and prevent new ulcers. ENT is not met as evidenced ration, interview and document of failed to provide timely 2 of 4 residents (R121, R134) in identified at risk for pressure int. In addition the facilty did not thensive assessment for 1 of 2 the sample with a stage three	F3	R121, R134, and R6 will recessary care and monithealing and prevent new understand will be updated assessed to not be healing getting worse. Identified recepositioned per plan of case will be completed weekly pressure ulcers to monitor wound. R6 had a reasses risk factors, PUSH tool up of care reviewed for accurance will be completed for accurance will be residents that reside in the pressure ulcer or those who pressure ulcers have the paffected. Residents with coulcers will have a comprehassessment completed; Prompleted as applicable; a updated with new assessment completed; Prompleted as applicable; and the prevention and treater nurses will be re-educated monitoring pressure ulcers use of the PUSH tool.	oring to promote ulcers. if wounds are g or wound is esidents will be are. PUSH tools per policy for status of sament of skin dated, and plantacy. The facility with a no are at risk for potential to be current pressure mensive skin tuSH tool and care plansment. The will be arding pressure ment. Licensed to on policy for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	indicated R121 had was seen by a wood During observation 10/2/17, at 12:34 pobserved. R121's coccyx area, and recentimeters (cm) be come. The wound be surrounding skin where of maceration without odor, and houring continuous 11:32 a.m. to 1:58 R121's positioning unchanged. At 1:58 (NA)-D and NA-B at the door behind the they were going to you." Working on and NA-B raised the pillow from unchook out the pillow from unchook out the pillow NA-B and NA-D purefitted the pillows placed R121 slight pillow under R121 between R121 legal adjusted, then R12 sheet. Before NA-they removed glow During an interview nursing assistant (R121 was "done" (R121 was "done")	d a stage 4 area to coccyx, and	F 314	DON or designee will complete and repositioning audits on eace Each unit will audit 3 residents of 4 weeks then monthly times 2 monthly of presence of PUSH tools in provided weeks then monthly times 2 monthly times 2 monthly times 2 monthly of the QAPI committee for opportute continued quality improvement months. DON to monitor compliance.	h unit. weekly for nonths. nd book blace. ekly for 4 onths. varded to unities of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 314	busy, and that (R turned every two late." The "Skin Integrit Treatment Care Fidentified R 121's directed a turn ar frequency of "Q2" plan also directed and PRN (as need Review of Wound-Initial Evaluation has wound on co (length, by width measurable cm (tissue. At requestage 3 pressure day duration. The There is no indicate condition. Wound and Plan of Care pressure ulcer wo Discontinue hous skin Prep once dimattress (pressure twice daily, zinc stays, off load words."	121) should be checked and hours. NA-D stated "it was by Assessment: Prevention and Plan" for R121, dated 4/17, pressure ulcer to coccyx, and and reposition program with a ' (every) two hours. The care it staff to monitor wound weekly	F3	14		
	wound,;stage 4; c wound size 6.5 cl ser-sanguinous e devitalized necrol granulation (new	d 5/24/17: Pressure duration greater than 27 days; m x 7 x 0.3 cm; light exudate; 15% thick adherent tic (dead, scar) tissue; 40% growth) tissue; 45% skin; deteriorated. Assessment and				

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		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		750	REET ADDRESS, CITY, STATE, ZIP CODE D5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	excisional debrident daily; foam once daily; foam and Paurgical excisional prep, foam and Sailere, foam once daily; foa	mendations: surgical ment; continue skin prep once aily; Santyl once daily. 6/14/17: Pressure wound reater than 26 days; wound cm; light sero-sanguinous of adherent devitalized necrotic ress: deteriorated. It an of care recommendations: debridement; continue skin antyl once daily. 6/21/17: pressure wound, an 53 days; wound size 4.5 x 3 sanguinous exudate; 75% trailized necrotic tissue; 25% wound progress improved. It an of Care: surgical excisional ontinue skin prep once daily; antyl once daily; add negative exper week, skin prep to perime per week. 7: pressure wound stage 4, and (area around wound): odor eep tissue injury) acceration; moderate Sero te; wound progress ssment and Plan of Care: surgical excisional nue negative pressure three in prep to periwound area	F3	14			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		245186	B. WING _		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 314	5.2 x 4.8 x 2.4 cm; undermining (tunno o'clock (position or Sero-sanguinous edevitalized necrotic tissue; wound pro and Plan of Care Fexcisional debrider times per week; sk three times per we on 7/5/17 evaluation 8/9/17 greater than 99 dacm; light Sero sanguranulation tissue; Assessment and FRecommendations decreased surface continue: protection moist, twice daily. Review of recent V for R121 indicated9/27/16 stage 4 p 4.1 cm (centimeter width, x 1.3 cm in wound; red in colo areas under the wound); no blotouch9/20/17: stage 4 drainage, necrotic odor; undermining doctor, d/t (due to) deeper and mild of wrong setting, edu9/11/17stage 4	periwound radius odor; eling under skin) 4 cm at 3 n wound); moderate exudate; 60% thick adherent citissue; 40% granulation gress improved. Assessment Recommendations: surgical ment; negative pressure three in prep to periwound area, ek. Prealbumin recommended: "Expressure wound stage 4, ys; wound size 4.4 x 4 x 3.8 guinous exudate; 100% wound progress improved. Plan of Care improved as evidences by area, increased granulation, we dressing, twice daily, wet to		4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY IPLETED
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		00,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	sero-sanguineous and tunneling 3 to8/30/17 No wee8/23/17 No skin8/17/17 stage 4 sanguineous pink tunneling/undermi8/9/17 no week8/2/17 no week7/26/16 no weel7/19/17 no stag serosanguinous d tissue 40%; no od o'clock with depth7/5/17 no stage serosanguinous d mild odor; tunnelir with depth of 4 cm6/28/17 no stage serosanguinous d no undermining/tu6/21/17 no stage serosanguinous d tunneling/undermi6/14/17 no stage serosanguinous d tunneling/undermi5/31/17 no stage serosanguinous d tunneling/undermi5/31/17 no stage serosanguinous d odor; no tunneling5/24//17 no PU serosanguinous d odor; no undermin5/17/17 no PU serosanguinous d odor; no undermin5/17/17 no PU serosanguinous d serosanguinous d	clock. PU; 3.8 x 3.0 x 1.3 cm; drainage, red in color, no odor, 8 o ' clock. kly skin grid assessment found grid assessment found PU, 3.8 x 3.6 x 2.5; sero drainage; no odor and ning 3.8 cm depth at 12 o'clock ly skin grid assessment y skin grid assessment kly skin grid assessment e PU listed; 5.0 x 4.0 x 3.0; rainage with necrotic/slough or; tunnel/undermining at 2 4.5 cm. PU listed; 5.2 x 4.8 x 2.5 cm; rainage; necrotic/slough 60%; glyundermining at 4 o ' clock e PU listed; 4.0 x 4.0 x 1.8 cm; rainage; red in color; foul odor; nneling identified e listed; 4.5 x 3.0 x 2.3 cm; rainage; no odor; no ning identified e PU listed; 6.2 x 3.0 x 0.3; rainage; 100% necrotic tissue; ing/undermining identified ge PU listed; 6.5 x 2.5 x 1.2 cm; rainage; necrotic tissue; no /undermining identified stage listed; 6.5 x 7 x 3.0 cm; rainage; necrotic tissue; no	F 314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	RECTION (X5 SHOULD BE COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	serosanguinous dodor; no tunneling5/3/17 no PU st drainage; pink tiss or undermining4/26/17 no PU st depth, no drainage undermining/tunne4/19/17 no PU depth; no color; no tunneling /undermining/under	stage listed; 2.1 x 0.6 x 0.1; rainage; pink tissue noted; no or undermining age listed; 2.3 x 0.6 x 0.1; no sue noted; no odor; no tunneling stage listed; 2.0 x 0.5 x 0 cm; no e, no color; no odor; no eling stage listed; 3.5 x 4 cm no o drainage; no odor; no	F 314	4		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	· /	TE SURVEY MPLETED
		245186	B. WING	<u>.</u>	10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Continued From p	age 97	F 314			
	acceptable" that R supposed to be. If the aides needed more aware of the During interview of medical doctor (M stated the pressure not deteriorating, I MD-B stated "98% improvement and nursing, and the and repositioned to orders included two wound, and wet to	ssure ulcer, and also it was "not tal21 was not turned as he was RN-B stated he thought some of more training and needed to be residents' care needs. In 10/4/17, at 11:22 a.m., In 10/4/17, at 11:22 a.m., In 10/4/17, at 11:22 a.m., In 10/4/17 at 11:22				
	assistant director of R121 had a currer also skin and wou completed by licer would expect the a least weekly. ADO R121 to be turned as care planned. R134's significant (MDS) dated 07/13 cognitively impaired two with bed mobil MDS further indicated he was of the significant of t	on 10/4/17, at 8:52 a.m., the of nursing (ADON)-C stated at stage 4 pressure ulcer, and assessments were to be used staff at least weekly, and assessments be documented at DN-C stated she exoected and repositioned every 2 hours change Minimum Data Set 3/17, indicated he was severely ed, needed extensive assist of lity, transfers and toileting. The ated he was at risk for pressure pressure ulcers. R134's Care (CAA) dated 07/27/17, dependent on staff for activities as) and is repositioned per staff				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		30.20
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	and transfers with lift. The CAA futher wheelchair with a cincontinent of bown in addition, the CA pressure and required regularity to relieve and required regularity. Skin Integrated And nutrition, friction further indicated he two hours and to pressure relief surfiction further indicated he was a movement (BM) with incontinence by a constitution of the pressure relief surfiction of the pressure relief surfict	assist of two and mechanical or indicated he used a cushioned seat and was all and had an urinary catheter. A indicated he was at risk for ired staff assistance to move by pressure over any one site ar schedule of turning. Ity Assessment: Prevention on and shear. The care plan on and shear. The care plan or was to be repositioned every rovide Treatment Plan Of Care dicated he required frequent els and manage moisture, a face. In addition, the care plan always incontinent of bowel ill have decreased episodes of established elimination be cooperative with assisted es) R134 was observed to be chair (tilt and recline	F 314			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER VALLEY REHABILITA	ATION AND CARE CENTER		750	REET ADDRESS, CITY, STATE, ZIP CODE D5 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	stated that he had refor incontinence riginal a.m During interview 10 stated she had assist breakfast with reported in the needed assist of reposition him time. During observation (almost 3 hours with NA-N were observed R134. R134 was consistence with no open A Procedure Turnin July 2015 indicated assistance with turn Residents will be turn to their co-morbidition. The center strives the and fatigue and reduced residents with the unit of the center strives the turning and repositions and impositions and impositions are successive ulcers and residents with the unit of the center strives the turning and repositions and impositions and impositions are successive ulcers and residents with the unit of the center strives the turning and repositions and impositions and impositions are successive ulcers and stripes are successive ulcers are successive ulcers.	nd NA-J of findings. //03/17, at 11:01 a.m. NA-N epositioned and checked him ht after breakfast around 8:30 //03/17, at 11:12 a.m. NA-M sted NA-N right after sitioning R134. She indicated not be reposition him again thave enough staff and that f two so she could not y. 10/03/17, at 11:30 a.m. hout repositioning) NA-J and d to reposition and check continent of bowel and had a haddition, R134's skin was areas or redness of the skin. If and Positioning, effective the center provides hing and positioning. If and positioning and positioned according es and individual abilities. In avoid musculoskeletal injury uce the risk of injury of se of positioning techniques. In operating and event pooling of lung rove circulation." It assessed to be at risk for It was care planned to be	F 3	14			
	turned and reposition went almost three h	oned every two hours, R134 nours without being					

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	repositioned to hel pressure ulcers. A facility policy, Pre Prevention/Treatm all residents would and at regular interidentified interventi including the use of also directed to revintegrity assessmenteal pressure ulceremove underlying LACK OF ASSESS R6's quarterly Mini 8/11/17, identified I required extensive daily living (ADLs), and remained at ris development. Furtive rejection of care(s) than daily." R6's Didentified R6 had disease (PVD), schidisorder, and bipol R6's progress note identified R6 to have pisodes of wound change refusals, in when staff remove "[approximately] 30 R6 was further docurrent or rest of tx	essure Ulcer ent, dated July 2015, indicated be assessed upon admission rvals. Further, the policy ons to manage pressure, if turning and repositioning, and view and revise the skin nt to reflect interventions to rs and stabilize, reduce or risk factors. BMENT: mum Data Set (MDS) dated R6 had intact cognition, assistance with activities of had unhealed pressure ulcers sk for further pressure ulcers ther, the MDS identified R6 had on a regular basis, "but less biagnosis Report dated 7/25/16, iabetes, peripheral vascular nizophrenia, personality ar disorder. e(s) dated 9/1/17 to 10/3/17, we numerous, documented and pressure ulcer dressing icluding an entry on 9/13/17, d R6's sock and, o maggots fell on to the floor," cumented to, "would not have	F 314	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 314	pressure ulcer dev R6's Skin Integrity Treatment Care PI was at moderate ridevelopment and I ulcers. The care pincluding keeping encouraging him to and, "Complete Pt Healing] Tool Wee During observation was laying in bed i mattress in place, catheter drainage stated he had pain my tail bone," which the wheelchair." Fand try to reposition want them to. During interview or registered nurse (Ficurrent pressure under the woundstating, R6's Skin Grid - Pr Ulcer/Other tracking identified R6 had a coccyx with an, "In 9/16/17, measuring cm by 3.0 cm in size	relopment and skin breakdown. Assessment: Prevention and an dated 8/7/17, identified R6 sk of pressure ulcer and a history of past pressure plan listed several interventions his skin clean and moist, or reposition every two hours ash [Pressure Ulcer Scale for kly." In on 10/2/17, at 1:10 p.m. R6 in his room. The bed had an air and R6 had a visible urinary bag sitting on the floor. R6 due to a, "severe wound on the he obtained, "from sitting in urther, R6 stated staff come in in, however, added he doesn't in 10/2/17, at 1:42 p.m. RN)-A stated R6 had several licers including a stage 3 or 4 the dermis exposing fatty ue) on his coccyx. Si p.m. RN-A was going to no g change to R6's pressure it to have the surveyor observe	F 314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	drainage or odor pridentified R6 refuse on 9/20/17. The neidentified the ulcer measuring 2 cm by however, now had (thin and watery, of odor with 5.4 cm of R6's medical recordany completed PUS care plan, nor a cor R6's skin risk factor efusals, and subse R6's coccyx pressure ulcer(s) waskin grid tracking costated R6 does not dressings to be chapressure ulcer(s) waskin grid tracking costated R6's coccyx worse," and staff wound physician to address it. RN-As coccyx ulcer to be RN-A stated she was comprehensive skin of, and added she cone, if one had beer record. Further, RI was completing the R6's care plan, nor the medical record.	resent. The tracking chart and to have his ulcer assessed ext recorded entry on 9/26/17, remained a stage III of 1 cm by 3 cm in size, serosanguineous drainage at the pink in color) and mild at tunneling. If was reviewed and lacked the serosanguineous drainage at the pink in color) and mild at tunneling. If was reviewed and lacked the serosanguineous drainage at the serosanguin	F3	14			
		und was, "getting bigger,					

1	FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
245186	B. WING		10/0	5/2017
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 314 Continued From page 103 getting worse or stalled." RN-A stated the PUSH tools were not being completed, "at this moment," but would be completed on a weekly basis going forward. When interviewed on 10/4/17, at 1:37 p.m. the interim director of nursing (DON) stated a comprehensive skin assessment would include completion of the PUSH tool to help determine if the current treatment was effective or if something different needed to be done. An undated, uncompleted Pressure Ulcer Scale for Healing (PUSH) tool identified directions to observe and measure each ulcer and total the resulted scores adding, "A comparison of total scores measured over time provides an indication of the improvement or deterioration in pressure ulcer healing." The tool listed a, "Pressure Ulcer Healing Graph," section which ranged in number(s) from 17 (worst possible) to 0 (healed) and allowed staff to identify the pressure ulcer progress. F 315 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315			11/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/05/20)17
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) PLETION DATE
F 315	(i) A resident who eindwelling catheter resident's clinical catheterization was (ii) A resident who indwelling catheter is assessed for renas possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary traccontinence to the expectation on the resident's continence to the expectation of the service of acility must ensure incontinent of bower treatment and service to the expectation of the service of the expectation of the expectation of the service of the expectation of the expectatio	enters the facility without an is not catheterized unless the ondition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder the treatment and services to be infections and to restore extent possible. with fecal incontinence, based comprehensive assessment, the exthat a resident who is eli receives appropriate ices to restore as much normal	F 315			
	review, the facility to justification for use of 3 residents (R48 indwelling catheter to comprehensively and put into place)	tion, interview and document failed to provide medical of an indwelling catheter for 2 s, R134) reviewed for . In addition, the facility failed y assess the bladder function interventions to minimize of 4 residents (R55, R2) y incontinence.		R48 and R134 have been re-assessed for catheter care and justifications have been made to suindwelling Foley catheters. R48 and have been re-assessed for bladder function and care plans have been updated to reflect changes with interventions in place to minimize incontinence. Resident that reside at GVHR Catheter have the potential to be a by this practice. Residents currently Catheters have been re-assessed medical justification for needing a continuation.	with a ffected y with for the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	R48's quarterly Min 6/17/17, indicated In had an indwelling use included anxiety, down MDS did not indicated an eurogenic bladder. On 10/3/17, at 9:37 her room to have a leg draining yellow placed a Foley cather urinate every two has sleep. R48 did not of pain. R48's Bladder Data dated 8/15/16, and R48 was continent not identify any form R48's nursing progport. The program indicated R48 Foley catheter and hospice. The program R48 had a Foley catheter and hospice. The program R48 had a Foley catheter and hospice. The program R48 had a Foley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had a roley catheter and hospice. The program R48 had an indwell direction for hospic order lacked a diagonal R48's physician's order lacked a diagonal R48's ph	inimum Data Set (MDS) dated R48 was cognitively intact and urinary catheter. Diagnoses expression and a fracture. The te R48 had diagnoses of or obstructive uropathy. If a.m. R48 was observed in catheter attached to her right urine. R48 stated hospice neter as R48 was having to ours and was not getting any display any signs or symptoms If Collection and Assessment reviewed 1/10/17, indicated of urine. The assessment did not incontinence or nocturia. If the assessment did not indicate why atheter placed and lacked a R48's medical record did not comprehensive bladder eted when the Foley catheter If the dated 8/31/17, indicated ing Foley catheter with the to place and maintain. The mosis for the Foley catheter. If the dated 10/2/17, included a inence and nocturia for use of the contraction of the c	F3	and changes have been made to care as appropriate. In addition with catheters have documentary size and changing protocols for of the catheter and communicate care plans and treatments record Resident with urinary incontiner resides at GVHR has the potent affected by this practice. Reside assessed for urinary incontinent been re-assessed and appropriate idleting programs have been caplanned as appropriate. 3. Clinical leadership, licensed unlicensed staff have been educenteer implication related to rijustifications. Education has als provided on bladder assessmer formulating an appropriate plan related to care for incontinent rethat improve continence and miincontinence. 4. DON/Designee will audit 1 with a catheter and 3 residents urinary incontinence weekly for then monthly times 2 months. DON/Designee will review all aurelated catheters and urinary incontinence. Results will be brothe QAPI committee monthly x for continued opportunities for comprovements. DON to monitor compliance.	residents ion on frequency ed on the ds. ce that ial to be nts be have atte are and cated on nedical to been ts and of care sidents nimize esident with 4 weeks dits anoths anoths and to be a sident with 4 weeks dits		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		7505	EET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	On 10/2/17, at 2:40 nursing (ADON)-A: Foley catheter for in During interview on ADON-C stated she nocturia was not a catheter. During interview on ADON-A stated the 10/2/17, was obtain R48's record lacked Foley catheter whe ADON-A stated hos prior to her start of however, she felt egiven to hospice princontinence and noreasons to place a stated if R48 was hurination a comprel should have been of to use of the cathetic considered such as briefs, medication in sleeping patterns. During telephone in a.m. hospice registic catheter was placed having to get up ou urinate. RN-F state managed by her curresident who enters	ge 106 p.m. assistant director of stated R48 had an indwelling acontinence and nocturia. 10/5/17, at 9:12 a.m. efelt incontinence and reason to place a Foley 10/5/17, at 10:14 a.m. physician diagnosis on ned at that time because dia diagnosis for the use of a nirequested by the surveyor. Spice placed the Foley catheter employment at the facility, ducation should have been for to placing the catheter, as potturia were not acceptable. Foley catheter. ADON- A aving issues with frequency of nensive bladder assessment completed. She indicated prior for alternatives should of been a offering a bed pan, overnight eview, and review of R48's ered nurse (RN)-F stated the dias R48 had complaints of the offering a diagram of the dias R48 had complaints of the dias R48 had complaints of the dias R48 did have pain, but it was the restrict of the diagram of the	F3	15			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	clinical condition of catheterization was an indwelling cath justification for the for catheter use. A includes underlying justification, determined be reversed and cappropriate indication indwelling catheter. R134's significant indicated he was sneeded extensive was always continguished to indicate he plan dated 10/17, urinary tract infect R134's Urinary Inc. Assessment (CAA needed total depoint on the continent of bow managed all incontinent production indicated he had a assistance with to indicate he had a R134's hospice caindicated he had a and had an indwer on 10/03/17, at 8 the dining room to below his Broda ochair).	demonstrates that as necessary. All residents with eter require a medical initiation and continuing need a comprehensive assessment ag factors supporting medical mination of which factors can development of a plan for tions for continuing use of an respond 14 days." change MDS dated 07/13/17, severely cognitively impaired, assist of two with toileting and tent of urine. R134's MDS are had a catheter. R134's care indicated he had a history of tions and had a Foley catheter. Continence Care Area (A) dated 7/27/17, indicated he endence with toileting and was well and bladder and staff intinence cares and used cts. The CAA assessment urinary urgency and needed ileting. The CAA failed to	F 315			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, 7505 COUNTRY C GOLDEN VALLE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	DER'S PLAN OF CORRECTI ORRECTIVE ACTION SHOUI FERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 315	R134 had went to the was on third floor when he returned frequency and the cather weekly and the cather weekly and the cather weekly and the cather was not sure if since they had no on the cather and the cather anti-reflux covered in a thick, or the cather and	ne hospital in July 2017 when or and transferred to first floor from the hospital. ADON-B bag should be changed stated this was not put on his urned from the hospital and either had been completed orders. 10/05/17, at 8:59 a.m. R134 d. His indwelling catheter was to the left side of the bed. The valve and tubing inside was mucus grey matter. 10/05/17, at 9:00 a.m. IA)-J stated he did not dediment on a catheter. He been in the hospital and for with the catheter. NA-J he catheter bag each shift. 10/05/17, at 9:11 a.m. facility should have orders on a catheter, bag and tubing and unable to locate orders for the she would assume staff the catheter, tubing and bag from the hospital on 07/05/17 s). ADON-B further stated she in the catheter and did not catheter since he never had bitalization. ADON-B stated acced in the hospital on cord did not indicate the	F 3	15			

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245186	B. WING_		10/	05/2017
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F 315	had contacted R13 orders to remove the not have a reason ADON-B further incisigns and his temp signs of sepsis. Although R134 had facility failed to have catheter and orders. A facility Procedure effective July 2015 team of plan, educinterventions as incompleted and the sepsion of the sep	4's physician and received ne catheter since the facility did for R134 to have the catheter. dicated she had taken his vital erature was 98.2 and had no a indwelling catheter the remedical justification for the set to maintain the catheter. Indwelling Urinary Catheter, included to inform care giving attention on techniques and dicated.	F 3 ⁻			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245186	B. WING		10	/05/2017		
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
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F 315	The facility was unacomprehensive blas for R55. R55's Urinary Cont 7/17/17, indicated I incontinence and ir prompted voiding umeals, at bedtime a care plan did not id The care plan also adult pull up and for needed. R55's undated nursindicated R55 had [incontinence] upon and at bedtime. " T sheet did not direct assistance R55 new During observation was seated in her wand nursing desk. I and was noted to blap. During this tim to go outside for a her, not interacting social services direct the elevator to bring not address R55's During interview or unit coordinator (H the nursing desk for R55 was soiled wit times a week.	able to provide a adder assessment completed cinence care plan, revised on R55 had functional acluded interventions of upon rising, before and after and individualized times. The lentify the individualized times. Indicated R55 was to use an or staff to change the pull up as sing assistant care sheet "functional incont. In rising, before and after meals the nursing assistant care at staff on what type of	F 318					

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		UCTION	(X3) DATE SURVEY COMPLETED			
		245186	B. WING			10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 COUN	DRESS, CITY, STATE, ZIP CODE ITRY CLUB DRIVE VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	was seated in her vand nursing desk. go out for a cigaret assistant executive outside to smoke, a R55 back to the 4th dining room for breakfast, NA-H broleaned her nails. If at this time following nails were cleaned area near the eleval a.m. NA-I brought with removal of her nails. NA-I did not of At 9:05 a.m. R55 who by NA-I. At 9:08 a.m. wheeled R55 to the television at 9:08 a.m. wheeled R55 to the televisio	wheelchair near the elevators R55 stated she was waiting to the at 9:00 a.m At 7:08 a.m. at director (AED)-B took R55 after smoking AED-B brought in floor and brought her to the eakfast. At 8:07 a.m. after rought R55 to her room and NA-H did not offer to toilet R55 at breakfast and after R55's in she moved R55 back to the eator and nursing desk. At 8:56 R55 to her room and assisted for chin hair and clipped her coffer to toilet R55 at this time. Was assisted outside to smoke in., after smoking, NA-I did not offer	F3	15			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 315	brought R55 back there were no sher probably wet them she would like to go check and change R55 to transfer fro With gloved hands incontinent brief, w NA-H stated R55's urine in it. Further, linens that morning with urine. She ind R55's linens in the were wet. During interview of ADON-A stated R5 bladder assessme plan, R55's inconting related to inability stated a bladder as hours of bladder modetermine R55's to subsequent sched stated R55 was to and changed. ADO be reassessed for never seen R55 to R55 was not being current care plan of meals and at HS. R2's significant chandicated R2 had mand needed extens The MDS identified.	age 112 n on 10/4/17, at 9:55 a.m. NA-H to her room. R55 indicated ets on the bed because, "I last night." R55 further stated o on the toilet, but the staff just her brief. NA-H then assisted m her wheelchair to her bed. NA-H changed R55's which was saturated with urine. It brief had a large amount of she had to remove R55's bed g because the linens were wet icated it was usual to change morning because the linens n 10/5/17, at 10:01 a.m. 55 did not have a current ence was functional and to transfer herself. ADON-A assessment should include 72 nonitoring to effectively bileting patterns and uling needs. ADON-A further be toileted and not checked DN-A indicated R55 needed to her toileting needs as she had ileted. ADON-A also stated to toileted according to her of upon rising, before and after ange MDS dated 8/18/17, noderate cognitive impairment sive assistance for toileting. diagnoses of benign prostatic and schizophrenia. The MDS	F 315				

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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 05 COUNTRY CLUB DRIVE DLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	also identified R2 wepisodes of urinary episode of continer The MDS indicated been attempted wit R2 was on a currer Urinary Incontinent indicated R2 trigge to extensive assistate frequently incontine moisture associate factors contributing psychological or psychological or psyrestricted mobility. urinary urgency and toileting. A care pla improve R2's curre avoid complications R2's Bladder Data dated 4/4/16, and r R2 was always incoincluded: "clothes we pads." The assessi excessive intake of bladder irritants. The had urge and funct treatment program no scheduled times prompted voiding prompted voiding prompted voiding processionally soiled behavior which indiurinate, soiling hims to be changed was	vas frequently (seven or more incontinence, but at least one it voiding) incontinent of urine. It voiding) incontinent of urine. It a trial toileting program had in no improvement noted and it toileting program. R2's see CAA dated 8/19/17, and for further assessment due ance with toileting and was ent of urine, as well as it diskin damage. Modifiable it o incontinence included: ychiatric problems and Other factors listed were in mass to be developed to intilevel of functioning and it level of functioning and it. Collection and Assessment eviewed on 5/11/17, indicated ontinent. Signs and symptoms wet, bedwetting, and wears ment also indicated R2 had it caffeine beverages and / or the assessment identified R2 ional incontinence with a of prompted voiding, however, is were provided for the	F3	115			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 554	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 315	behavior, other than his clothing. The or R2 with incontiner offer prompted voi offering every two plan also directed at individualized time listed conflicting in and change. R2's undated nursidirected staff to "rathours", chart both [continent]." During observation was standing at the strong urine smell the front and back of his shirt. Multipl nursing desk and assist him with toil observed lying on of his pants were strong odor of uring smelled in the hall. During interview of stated R2 was soil four times a week had to direct R2 to urine soiled clothir did not have the times directed R2 to change out of his strong out of his stro	an to encourage him to change hare plan indicated to provide at briefs and directed staff to ding at individualized times of hours and as needed. The care staff to check and change R2 mes as resident refuses to toilet plan did not include as for toileting needs for R2 and formation of toileting and check ding assistant care sheet emind to toilet q2h [every two inc [incontinent] and cont. In on 10/2/17, at 2:10 p.m. R2 are nursing desk and had a and the hard the staff were located around the no staff members offered to eting. At 3:00 p.m. R2 was his right side in bed, the back staturated. R2's room had a needed.	F3	15		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	During interview of stated R2 frequer and would soil his stated R2 needed and assisted with refusals were to be aware when R2 wassist R2 due to the aware when R2 wassist R2 due to the aware when R2 wassist R2 due to the aware when R2 walking around woon 10/2/17, howe him. ADON-A stated and the new try and assist R2 R2 removed and not sure if adult previewing R2's black 5/11/17, ADON-A the assessment as re-assessed and was not sure why times set for toile R2's Behavior De 10/4/17, indicated 9/16/17, and staff report did not included in the resisting care. The facility policy 7/15, indicated: "Tresidents who are appropriate treatmuch normal black."	on 10/4/17, at 9:12 a.m. NA-G antly removed his incontinent pad as clothing with urine. NA-G at to be checked every two hours toileting needs, and any be charted. Further, staff were was soiled, but were unable to the lack of staffing. On 10/5/17, at 9:39 a.m. he did not recall seeing R2 with clothing saturated with urine ever, staff should have assisted ated R2 should have been and any refusals should be aurse alerted, so other staff could ADON-A stated she was aware refused to wear briefs, but was ull ups had been tried. After adder assessment dated a stated she did not agree with and felt R2 needed to be interventions looked at as she of there were no individualized	F3	115		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		SURVEY PLETED
		245186	B. WING _		10/0	05/2017
	PROVIDER OR SUPPLIER VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 315	Continued From pa	_	F 31	5		
F 318 SS=D	implementation and with evaluation of the effinterventions and reappropriately mana Recording and eval (such as frequency toileting and responsimportant for determ decline. Various con aggravate the seve incontinence. Steps these conditions/sit 483.25(c)(2)(3) INC DECREASE IN RA	evision, as appropriate) to ge urinary incontinence. luating specific information and times of incontinence and use to specific interventions) is mining progress, changes, or notitions or situations may rity of urinary a should be taken to alter uations whenever possible." CREASE/PREVENT NGE OF MOTION	F 31	8		11/13/17
	receives appropriatincrease range of n decrease in range of (3) A resident with I appropriate service to maintain or impropracticable independent in the company of the com	imited mobility receives s, equipment, and assistance ove mobility with the maximum idence unless a reduction in rably unavoidable. NT is not met as evidenced			DOM	
	review, the facility frange of motion (Roresidents (R121) re	tion, interview and document ailed to consistently provide OM) services for 1 of 2 viewed whom had a limited d restorative nursing.		 R121 has been re-assessed for services and plan of care has been updated as appropriate. Resident is currently receiving ROM services prof Care. Residents requiring Range of Machine Services for maintenance and or 	s er Plan	
	i muniga molude.			30, vices for maintenance and 0		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY
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	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	orders dated 9/28 Alzheimer's deme Minimum Data Se indicated R121 w required the phys bed mobility, eatir personal hygiene. Recommendation R121, dated 4/6/1 Active Range of M Program History in R121's passive R Resident will main with assistance or extremities twice. The program dire Perform PROM to Report to nurse a R121's mobility or contractures and problem. During interview or member (FM)-C stated when ROM for R121, and towels and places hand to keep ther tight. FM-C state ROM program was	s, as identified on physician's 1/17, included early onset entia. A significant change et (MDS) dated 8/18/17, as totally dependent upon and ical assistance of two staff for ing, dressing, toileting and a A facility document, Therapy is for Restorative Program for 1/27, indicated "Passive and/or Motion." R121's Restorative report, printed 10/4/17, indicated OM program goal to be: Intain current range of motion of doing PROM to bilateral a day for 15 reps each time. In a day for 15 reps each time. It is complaints of pain, refusals. It is a target in 10/2/17 at 6:22 p.m., family stated she had "a concern" rograms getting completed. In she visits, she completed the indicated of late had been rolling is rolled up hand towels in R121's in from rolling up and getting dishe "questioned" if (R121's) its getting done. FM-C stated ROM twice daily, but stated "I'm	F 31	prevention have the potential affected. Residents requiring motion services have had mappropriate. 3. Licensed nurses and Nabeen re-educated on restoral Facility has added a Restoral champion to manage the property of the	g Range of nedical record nade as ARs have ative services ative ogram. 3 residents to eing provided ce weekly for 2 months. ie QAPI other than the control of the control	
	was lying in his be	on on 10/3/17 at 8:18 a.m., R121 ed in his room, facing the under his left side. R121's arms				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/	05/2017
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F 318	were at his side, education of the variance of	elbows folded and forearms at rom his elbow, and situated. R121 wore heel boots, feet. During continuous 8:18 am to 11:32 a.m., R121 his bed in his room. At 9:29 stant (NA)-D and registered ositioned R121. At 11:32 a.m., NA-B assisted with R121 with a rand repositioning. At 1:58 p.m., repositioned by NA-B and NA-D. red nor was provided any range any of the visits by nursing staff frames. In 10/3/17 at 2:06 p.m. NA-D and R121 only to reposition and d of ROM exercises. NA-D at think" R121 has any range of the program. I on 10/3/17 at 4:38 p.m., RN-B ot have any orders for g. RN-B stated if there was a rapy, "licensed staff would be a stated there were no orders in ord for range of motion for ed, however, R121 could benefit ram, so (R121) could keep his	F3	18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10	/05/2017	
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F 318	stated R121 did no program, and has in NA-C stated often in resident in their rook work with R121 in in not perform ROM in During an interview NA-A stated she distrange of motion prohave had "someon to do. NA-A stated any exercise or ran A review of the RO report from 7/8/17 following number of R121; number of resill: July 20x (time: August 34x I September 15 October (throus refusals; 0x ill) During interview or director of therapy therapy case load a return from hospital restorative program. The DT stated she conference about the discussion that RO for R121. She was program was being The DT stated R12.	thave a range of motion not assisted him with that. therapy often worked with oms, but has not seen anyone nis room. NA-C stated she did for R121. You on 10/4/17 at 9:59 a.m., d not think R121 had any ogram, and if he did, we would be from therapy" show us what she did not help R121 with	F 31	8			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY MPLETED
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F 318	When interviewed of physical therapist (I evaluated last April that time R121 was in range of motion aremained unchanged definitely "would be described the plan knees, ankles, bilat (repetitions) each, a twice daily. When interviewed of assistant director of R121 had a restoral aides should be concares or when report questioned how R1 program because of stated the ROM protection of R121 had a restoral aides should be concares or when report twice daily, 15 repostated even though the care plan, the interprogram in care trained she "expected motion services. A facilty policy, Consulty 2015, indicated improve joint mobili maintaining or achipreventing or reduction preventing or reduction ange of motion) as goal.	on 10/4/17 at 8:16 a.m., PT)-A stated R121 was, following hospitalization. At a unable to actively participate and his condition has ed. PT-A stated R121 enefit" from ROM and to include PROM to legs, terally, and usually 10 reps and the exercises be done on 10/4/17 at 8:43 a.m. the finursing (ADON)-C stated ative program and futher the impleting that task, during esitioning. The ADON 21 could be 'refusing' the of his current disposition and orgam was to be completed each time. ADON-C also this was not "spelled out" in instructions for restorative cker was part of the care plan, 'R121 was to receive range of a sit purpose "To maintain or ity to assist resident in eving independent function, or sing contracture or deformity. It providing PROM (passive an intervention to achieve the	F 31			
F 323 SS=D		1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 32	23		11/13/17

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F 323	(d) Accidents. The facility must er (1) The resident en from accident haza (2) Each resident rand assistance dev (n) - Bed Rails. The appropriate alternated rail. If a bed of must ensure correct maintenance of betto the following electothe following electothe following electothe resident or resignation (2) Review the risk the resident or resignation formed consent propriate for the This REQUIREME by: Based on observation review, the facility framework that the appropriate for the This REQUIREME by: Based on observation review, the facility framework that the appropriate for the This REQUIREME by: Based on observation review, the facility framework that the facili	nsure that - avironment remains as free ands as is possible; and ecceives adequate supervision vices to prevent accidents. the facility must attempt to use tives prior to installing a side or r side rail is used, the facility ct installation, use, and d rails, including but not limited ments. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain prior to installation. bed's dimensions are resident's size and weight. NT is not met as evidenced tion, interview and document failed to comprehensively smoking for 2 of 4 residents and for smoking.	F 323	1. R20 no longer resides at GVRH has been re-assessed for smoking care plan has been updated to reflechanges. 2. Residents that reside at GVRH choose to smoke have the potential affected by this practice. Residents choose to smoke have had their more cords reviewed and new smoking assessments completed with plans care updated as appropriate. Smoke that are not deemed safe to smoke	and ect C that I to be that edical of ers

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		245186	B. WING		10/0	05/2017
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F 323	A Resident Smoke provided upon entr The listing identifie which included R2 On 10/1/17, at 3:37 room in her wheeld waiting to go outsid on my own," after so During subsequent 12:50 p.m. R21 was main entrance with R96, smoking with No staff were prese R21, and she had R21 was able to brand ash without dror her clothing. R2 take me," outside to cigarettes for her. (AA)-A approached and conversed with bingo stating he wowhen you're done inside. Afterwards another resident, Ficigarette. R21 har who used it to light p.m. registered nur resident outside to smoking. RN-A as a cigarette?" R21 already," after throher wheelchair.	rs listing dated 9/29/17, was rance to the facility on 10/1/17. d all current smoking residents	F 323	independently have had interventic into place and care plans have been updated. 3. Department heads, licensed sunlicensed staff have been educate following the resident plan of care relation to smoking. Clinical leader and operations have been educate appropriate assessments and form safe plans of care for residents who smoke. 4. ED/Designee to perform audit compliance of smoking policy 3 times and policy 3 times and policy 3 times a week for 4 weeks monthly times 2 months for accurate smoking assessments and plans of for safety. Results will be brought QAPI committee monthly x 3 month continued opportunities for quality improvements. ED to monitor compliance.	taff and ted on in reship ted on hulating to wish the son the tete to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 323	unable to commure smoking standards demonstrate approability to appropria was identified to be directed to refer to supervision require signed on 10/2/17 (ADON)-A (the sar R21 smoking outs R21's progress no identified an entry smoking. Smoking Resident is deemed Smoking materials put in med room." When interviewed nursing assistant (smoke but, "does"	age 123 nicate understanding of the s and procedures, did not opriate use of an ashtray, nor tely extinguish a cigarette. R21 e a "dependent smoker," and the facility smoking policy for ements. The assessment was by assistant director of nursing me day the surveyor observed ide without staff supervision). It dated 10/2/17, at 1:25 p.m. of, "[R21] was outside g assessment completed. Ed a dependent smoker. Is removed from resident & [and] on 10/3/17, at 9:28 a.m. NA)-F stated R21 used to not anymore." NA-F stated g outside to smoke to her	F 32	3		
	ADON-A stated R2 yesterday when st room. ADON-A st complete a smokin because R21 wen ADON-A stated sh been included on tupon entrance, ho to assess safety w prevent injury or b	n 10/3/17, at 9:51 a.m. 21 was not a smoker until aff found cigarettes in her ated she was directed to a assessment yesterday to outside and was smoking. We was not sure why R21 had the list of smokers presented wever, added it was important with smoking for residents to urns.				
	had intact cognitio	n. When interviewed on m. R96 stated staff bring R21				

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F 323	outside to smoke, a in the past. When interviewed assistant executive Resident Smokers was created by ask social services staf smoking. AED-B supon the survey tea	and had done so several times on 10/3/17, at 3:06 p.m. director (AED)-B stated the listing provided on entrance ting the nurse managers and f on each floor who is currently tated the listing was current am entrance as, "that's who e," as current smokers.	F 3	23			
	identified resident hadiagnoses, in addithypertension, and or R20's quarterly MD moderate cognitive episodes of attentive thinking, as well as depression. R20 wassistance with trail locomotion on the uR20's tobacco use During interview on hospice nurse (HN smoke." HN-A stat while outside smoknight shift, and shoout unsupervised.	diabetes. S dated 7/9/17, identified impairment with fluctuating veness and disorganized moderate symptoms of vas noted to receive extensive asfers and supervision for unit. The MDS failed to identify					

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		245186	B. WING		_	10/0	5/2017
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F 323	8/22/17, at 3:50 a.m. on the floor in front R20 was noted to have and was sent evaluation and trea at 5:15 a.m A substitute of supervised smoking initiated. A review of identify any addition minutes checks or note of 9/1/17. identified in the parking lo further stated R20 I continued to go out smoke, a wanderguher lack of physical facility and potentia was obtained on 9/ and this was placed. A review of R20's conforming and sessing assessing 10/26/16, and identified in the parking and would smoking and would smoking. The care change in status, in supervision. The care changes made to concare plan did not rewanderguard for sale.	of the facility at 2:45 a.m have a cut on bridge of the to the emergency room for treatment, returning to the facility sequent note of 8/23/17, at R20 was non-compliant with g and a 15 minute check was of progress notes did not hal information regarding 15 smoking activities. A progress tified R20 had been noted to to to two occasions. The note had been advised if she side without supervision to hard would be placed due to capacity to get back into the large for injury with traffic. An order 1/17, for use of a wanderguard don R20. The care plan noted R20 was at risk smoking. The care plan noted hent had been completed on diffied R20 met the criteria to the ty. A subsequent smoking 2/13/17, identified R20 was sent smoker (requiring cigarette burn holes noted in require supervision with plan did not reflect any	F 3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	1 10	00/2011
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETION DATE
F 323	health unit coording require supervision weeks prior to her was unsure of the direction of upper were kept in the management of the supervision was resupervision was resupervision was resupervision was resupervision was resupervision was approximately two was unaware of the During interview of stated R20 had be until the last month supervised smoking During interview of director of social separates, stating R20 would pick upground. The DSS aware of this behar placement of the wheehad not observe posing a risk for being previously been in however, as her her to get in and out of wanderguard was ADON-D stated the	nator (HUC)-A stated R20 did n with smoking for the last two death on 9/23/17, however, rationale as this was under the management. R20's cigarettes redication room once equired. In 10/03/2017, at 2:53 p.m. had been independent with aware this had changed to three months ago, although re reason. In 10/3/17, at 2:57 p.m. NA-T reen independent with smoking h, when she required high due to weakened health. In 10/5/17, at 10:57 a.m. the revices (DSS) stated R20's high action availability of that when her supply was gone or cigarette butts off of the stated staff members were avior and this contributed to wanderguard. The DSS stated ed R20 ashing on herself,	F 32	3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
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	ADDITION OF CORRECTION 245186			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIME DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	alerted staff of resic supervision. A revie completed by ADOI to be an independe not been make follo 2/13/17. ADON-A stated was been a dependent sassessment had ar smoking the care pupdated. ADON-A scomprehensive cardone. A facility MN (Minne 4/2017, identified thresidents, "who hindependent smoke plan in place." Fur to evaluate smoking quarterly and with a condition. 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used	dent attempts to exit without aw of the care plan was N-D and noted R20 was noted and smoker, and a revision had owing the assessment of s unaware R20 was to have smoker, further stating if an any indication for dependent lan should have been stated due to staff turnover, a see plan review had not been ersor have a safe smoking for ave been assessed to be ers or have a safe smoking ther, the policy directed staff grabilities upon admission, any significant change in DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General. gregimen must be free from and the first form of the control of	F 323			11/13/17

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F 329	(4) Without adequal (5) In the presence which indicate the discontinued; or (6) Any combination paragraphs (d)(1) 483.45(e) Psychot Based on a compresident, the facilit (1) Residents who drugs are not give medication is necessional to a diagnoral clinical record; (2) Residents who gradual dose reduinterventions, unlean effort to discontinuity failed to reconditity failed to reconded (PRN) and appropriate monitor reviewed for unnessed for unnessed (PRN) and appropriate monitor reviewed for unnessed (PRN) and appropriate monitor rev	ate indications for its use; or e of adverse consequences dose should be reduced or ons of the reasons stated in through (5) of this section. ropic Drugs. The hensive assessment of a many must ensure that have not used psychotropic many these drugs unless the messary to treat a specific mosed and documented in the use psychotropic drugs receive ctions, and behavioral ss clinically contraindicated, in	F 329	1. R6 has received a medication regimen review and updates were mas appropriate. R6 received a record review with target mood and behavior program updates to include individuation-pharmaceutical interventions to used prior to drug therapy. 2. Resident that reside at GVRH the currently receive PRN psychoactive medications have the potential to be affected by this practice. Resident the receive PRN psychoactive medications.	d or alized be at

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245186	B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	and verbal sympton R6's most recent is 9/6/17, listed R6's order(s) for: - Zoloft (an antider (milligrams) by modepression; - Risperdal (an antimouth every bedtin "anxiety" and; - Risperdal 0.5 mg needed for depressisted start date of R6's medication as were reviewed. In any of the PRN Ris R6 received the Pl twice on 9/17/17, for a total back side of the M labeled, "Commer provided directions medications are gimedications are gimedications are gimedication was left black side of the M labeled, "Commer provided directions medications are gimedication was left black side of the M labeled, "Commer provided directions medications are gimedication was left black section was left black section was left black section was left black section was left black was documented as keeping positive," however, listed an "There have been nursing staff." Fur	signed physician orders dated current medications including pressant medication) 200 mg buth every bedtime for tipsychotic medication) 3 mg by me for a listed diagnosis of, "by mouth twice daily as sion." The PRN dosing had a	F 329	have received a medication regime review with updates made to plans as appropriate. Non-pharmaceutical interventions have also been created based off an individual assessment care approach. Non-pharmaceutical interventions to be attempted and documented prior to medication administration. 3. Clinical leadership, licensed states Social service have been educated Target Mood and Behavior programmedications and on approaching in with a non pharmaceutical approach. DON/Designee to audit 2 resident receiving PRN antipsychotics for tabehavior programs and monitoring for 4 weeks then monthly times 2 mesults will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. DON to monitor compliance.	of care al ed t and al aff, and l on ns for nitially ch. ents arget weekly nonths.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG			SURVEY PLETED
		245186	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55	.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD E TO THE APPROPRI	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 130	F 3	29			
	his Risperdal p.r.n. provider reminded	on a few occasions since this him that this is available to him depression, anxiety, or unclear					
	10/3/17, identified F on the dates the PF Further, R6's progre 10/3/17, lacked any	t Detail Report dated 8/5/17 to R6 had no recorded behaviors RN Risperdal was provided. ess note(s) dated 8/5/17 to recorded indications or RN Risperdal being provided.					
	rationale for the PRN Risperdal being provided. When interviewed on 10/4/17, at 9:32 a.m. nursing assistant (NA)-G stated R6 was particular in how staff cared for him and, "very non-compliant," at times with thinking staff didn't have equipment to help him, so he would refuse cares. NA-G stated she was unaware of R6 having any hallucinations or other delusional thinking, and further stated any behaviors R6 displayed would be reported to the nurses and charted.						
	practical nurse (LPI PRN Risperdal for would ask for it who staff. LPN-F stated for R6's progress n MAR, to have docu PRN Risperdal had However; after reviews	10/5/17, at 8:10 a.m. licensed N)-F stated R6 received the depression and sometimes en screaming or yelling at the I the usual facility practice was otes, or the back side of the mentation to support why the been given in September. ewing R6's record with the vas not and, "its supposed to					
	and assistant directinterviewed. ADON	a.m. registered nurse (RN)-A tor of nursing (ADON)-A were I-A stated staff should be indication," for giving as					

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER C(X4) ID PREFIX TAG	TED
Although R6 had orders for PRN Risperdal, the staff failed to document the reasoning and indication when they administered it to allow periodic assessment and evaluation to determine if the medication was being effective and/or still	2017
F 329 Continued From page 131 needed medication on the back side of the MAR or in the progress notes. ADON-A stated it was important to document rationale for giving as needed medication, "so you can determine the effectiveness of the medication," and to ensure, "it was necessary." Although R6 had orders for PRN Risperdal, the staff failed to document the reasoning and indication when they administered it to allow periodic assessment and evaluation to determine if the medication was being effective and/or still	
needed medication on the back side of the MAR or in the progress notes. ADON-A stated it was important to document rationale for giving as needed medication, "so you can determine the effectiveness of the medication," and to ensure, "it was necessary." Although R6 had orders for PRN Risperdal, the staff failed to document the reasoning and indication when they administered it to allow periodic assessment and evaluation to determine if the medication was being effective and/or still	(X5) DMPLETION DATE
A facility Psychoactive Medication policy dated 1/2016, directed staff to document, "PRN medication use as applicable," on the care plan and CareTracker system, and staff would completed a review of psychoactive medication use when applicable and during the RAI (Resident Assessment Instrument) process. F 353	/13/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		10/05/2017		
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	10.00.20.11		
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F 353	be implemented be (Phase 2)] (a) Sufficient Staff. (a)(1) The facility is sufficient numbers of personnel on a 2 nursing care to all resident care plans. (i) Except when was this section, licensed. (ii) Other nursing plimited to nurse aid. (a)(2) Except when this section, the facility in nurse to serve as a duty. (a)(3) The facility in nurses have the spects necessary to didentified through in described in the plans of the pl	eginning November 28, 2017 nust provide services by of each of the following types 24-hour basis to provide residents in accordance with s: aived under paragraph (e) of ed nurses; and ersonnel, including but not les. a waived under paragraph (e) of cility must designate a licensed a charge nurse on each tour of must ensure that licensed pecific competencies and skill care for residents' needs, as resident assessments, and	F 353	Correction/s as it relates to the res R55, R2, R183, R134, R121, R19, R48, R28, R196, R180, R162, R47, R31, R24, R82, R130, R192, R43,	R97, 7, R6,		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	₹	· I	STREET ADDRESS, CITY, STATE, ZIP C		
				7505 COUNTRY CLUB DRIVE		
GOLDEI	N VALLEY REHABILI	TATION AND CARE CENTER		GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 353	ulcers, for 1 of 2 rerange of motion, 2 reviewed for paid residents (R48, R2, R6, R31, R24, R8, R183) and 14 staf NA-C, RN-E, RN-E, NA-E,	esidents (R121) reviewed for c of 2 residents (R19, R97) feeding assistant, and 16 28, R196, R180, R162, R47, 2, R130, R192, R43, R31, R66, f members (RN-C, HUC-A, G, ADON-A, HN-A, LPN-E, G, NA-H, ADON-C, AS) whom with the lack of sufficient nursing. This had the potential to affect the facility. d on 10/1/17, at 11:10 a.m. R55 wheelchair with a strong smell a saturated wet area of her lap. questing to go outside for a passed by her, not interacting a.m. the social services director 5 onto the elevator and brought te. SSD did not address R55's	F3	level was increased on 1st an additional NAR and TMA nurse on AM and PM shift a NAR was added on 4th flood PM. Actions/s taken to protect resimilar situations: Staffing reviewed daily by the Executensure appropriate quantity composition of staff to meeneds. Caring Partner progwill be conducted by the ID feedback from residents/resparties related to staffing concerns regarding concerns regarding availability/accessibility of sinclude linens and routine on Rounds will be completed and nurse managers at a madily to observe care and seprovided to meet resident numbers and routine concerns taken or systems ensure that solutions are sure that solutions.	A or licensed and additional or on AM and esidents in will be utive Director to a quality and tresident ram interviews T to gather sponsible encerns. erviewed and staffing and upplies to eare supplies. by DON/ED animum of 2x ervices leeds. Is altered to ustained: Committee ent and monitor el. Acuity e conducted by any committee and monitor el. Acuity en long term CU to do staff of care. ED, ator have been ed staffing ive Director of and staffing	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION		SURVEY PLETED
		245186	B. WING			10/0	05/2017
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F 353	R183's admission MR183 had intact cogassistance to compon 10/1/17, at 3:44 had a strong, pungother body odors. Freceived one bath a greater than two markets of the policy	MDS dated 8/3/17, identified gnition and required extensive plete all ADL's except eating. p.m. R183 while laying in bed ent odor of perspiration and le stated he had not yet since admission to the facility onths ago. RS ty Assessment: Prevention of Care dated 10/03/17, rosition R134 every two hours. Observation 10/03/17, from a.m. (2 hours and 32 minutes) do to be sitting in his Broda e positioning chair), without toileted or check and change. Eyor informed nursing assistant that R134 had not been er 2 hours and 30 minutes. And assisted NA-N and they do aff to reposition resident ata Set (MDS) dated 8/18/17, as totally dependent and all assistance of two staff for oileting and had a current ing continuous observation on a.m. to 1:58 p.m. (2 hours 121's positioning in bed which ed. During an interview on and R121 should be checked	F3	53	basis to determine need for adjusting related to the acuity of the residents input from the floor staff working the assigned units. Plans to monitor performance to ensolutions are sustained and persong responsible: Caring Partners will interview residents related to staffing fineeds are being met by staff wee Any negative responses will be forwed any negative responses will be reviewed min the Center's QA meeting and act taken as needed. Executive Direct Director of Nursing will conduct roum. When the construction of Staffing and adequate amounts of supplies and Rounds will be completed by the Monof the Day on Saturdays and Sunda Director of Operations and Director Clinical Services will evaluate staffing patterns during weekly visits to ensuadequate staffing to meet resident Evaluations will also include staff and resident interviews. Caring Partner interviews/audit results and other at will be tracked and trended by the Executive Director and reported monomatics. By the resident interview of the Executive Director and reported monomatics.	s with e Insure Insu	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10/	05/2017	
	GOLDEN VALLEY REHABILITATION AND CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 135 R121's Restorative Program History report, printed 10/4/17, identified R121 was to receive passive range of motion (ROM). During intervion 10/2/17 at 6:22 p.m., family member (FM)-C stated R121 was not getting his ROM program exercises. When she visits, she completes the ROM for R121, and has been rolling towels and placing them in his hand to keep them from rolling up and getting tight. When interviewed of 10/4/17 at 9:48 a.m., NA-C stated R121 did no have a range of motion program, and has not assisted him with that. ASSISTANCE WITH EATING During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005, her NA			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 353	R121's Restorative printed 10/4/17, idepassive range of non 10/2/17 at 6:22 stated R121 was rexercises. When see ROM for R121, an placing them in his rolling up and getti 10/4/17 at 9:48 a.r. have a range of massisted him with the ASSISTANCE WITDuring interview 10 stated she had beconstructed by the certificate had exprenewed her certifica	e Program History report, entified R121 was to receive notion (ROM). During interview p.m., family member (FM)-C not getting his ROM program she visits, she completes the d has been rolling towels and shand to keep them from ng tight. When interviewed on m., NA-C stated R121 did not otion program, and has not that. TH EATING 0/04/17, at 9:22 a.m. HR-A en working at the facility since ame a NA in 2005, her NA ired in 2008, and she had not icate. HR-A stated she assists they are short staffed and has R97.	F 35	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		10/05/2017		
	GOLDEN VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 136 R28 was cognitively intact and required extensi to total dependence with ADL's. On 10/1/17, at 4:10 p.m. R28 stated he was unable to get in ar out of bed when he liked. Four days out of the week it was common to wait over 30 minutes to get assistance. R196's admission MDS dated 9/16/17, indicate R196 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 12:19 p.m. R196 stated she had to wait an bour while being on the			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE C	(X5) OMPLETION DATE	
F 353	R28 was cognitive to total dependence 4:10 p.m. R28 sta out of bed when h week it was comminger assistance. R196's admission R196 was cognitive extensive assistantinterviewed on 10 stated she had to bed pan and it was the staff put her or you to put the call light R180's quarterly R180 was cognitive for ADL's and recepain medications, stated staff often of and hour or two, at the light he often was at the staff often of and hour or two, at the light he often was a solution was a sister interviewed on 10 fine was a 20 per be answered time say they need to go the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at told by a nursing at the staff walk out at the	ely intact and required extensive be with ADL's. On 10/1/17, at ted he was unable to get in and e liked. Four days out of the non to wait over 30 minutes to MDS dated 9/16/17, indicated rely intact and required note with ADL's. When 1/2/17, at 12:19 p.m. R196 wait an hour while being on the se uncomfortable. R196 stated in the bed pan, leave and tell light on and then don't return	F 353				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10	/05/2017
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F 353	were so understaff answer call lights of he was not always staff. R47's admission MR47 was cognitive to total dependence interview on 10/2/3 staff were so rushed under his foreskin. R6's quarterly MDS was cognitively intrassistance with AE 10/2/17, at 1:19 p. enough staff, and and a half to have added staff someticall light. R31's annual MDS was cognitively introtal dependence of at 1:19 p.m. R31 with the total dependence of the following means of the residers staff members to a When staff take the or two staff members assistance to toiled.	fed there was not anyone to during lunch. R162 also stated getting bathed do to the lack of MDS dated 9/18/17, indicated ly intact and required extensive be from staff for ADL's. During 17, at 12:37 p.m. R47 stated ed there were not cleaning by the stated ed there were not cleaning by the stated ed there were not cleaning by the stated there was not has waited an hour to an hour his call light answered. R6 imes didn't even answer the by the staff for ADL's. On 10/2/17, who resided on 1st floor stated to to three nursing assistants floor, and it was not enough, as the onto that floor required two easist with cares and transfers. We here so not the floor. There is a lack altimes and you can't get the during meal times. He is three times a week, do to the	F 35	3		
	was cognitively int	OS dated 9/1/17, indicated R24 act and required extensive to of staff for ADL's. When				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
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F 353	interviewed on 10 there were not enhad to wait a half answered. Also at answered and she back and don't co happened while b "made me very arbeen incontinent of don't feel they have more people to ta are leaving becaused. R82's annual MD3 was cognitively intotal dependence interview on 10/2/facility was always management said they couldn't scheneeded to wait ovincontinent product happened at least worse on the day bathroom during thave to wait." R130's quarterly R130 was cognitive extensive assistant and wait and the said was cognitive extensive assistant and the said was cognitive extensive extensive assistant and the said was cognitive extensive assistant and the said was cognitive extensive e	page 138 /2/17, at 1:28 p.m. R24 stated ough nursing assistants and hour or more to have call lights times the call light would be ut off, staff say they would be me back for two hours. This has eing on the bed pan and it agry." R24 also stated they have waiting for staff assistance. I we enough staff, and they need ke care of the residents. Staff se of the heavy workload. S dated 6/27/17, indicated R82 tact and required extensive to of staff for ADL's. During 17, at 1:30 p.m. R82 stated the short staffed. The I there was a low census, so adule more staff. R82 stated she er an hour at times to have her ct changed. R82 stated that a four times a week and it was shift. "I hate even going to the he day, because I know I will MDS dated 8/15/17, indicated wely intact and required nee with ADL's. During interview 17 R130 stated he had been	F 35	3		
	at the facility for a don't like the staff the staff, they are them forever to a to an hour for help for help that make brief but would like	bout a year. I hate it here I I, I don't like the food. I don't like always understaffed. I takes nswer the call light I wait 45-min I have had a accident waiting s me feel horrible. I wear a to use a urinal I have to put on them to bring the urinal.				

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		245186	B. WING			10/	05/2017
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F 353	When interviewed of stated he did not fee the facility and at ting of I want my urinal have wet myself and good. R192's admission of R192's was cognitive extensive assistant 2:28 p.m. R192 states on and no one answer R43's quarterly MD R43 had intact cognassistance with act and had, "total deput transfers. During of a.m. R43 was seater room with her call life (seven minutes lated wheelchair outside R43 and stated, "Allay you down?" R4 "they [staff] just was she would tell staff interviewed immed just want to lay downer right leg, hower R43 stated she has assistance with lay anxiety attacks." Rewheelchair in the haminutes later) wher approached her with and assisted her to R31's annual MDS	on 10/2/17, at 2:19 p.m. R130 are there was enough staff in mes waited 30 to 45 minutes, and when they don't come I and it doesn't make me feel MDS dated 9/6/17, indicated wely intact and required be with ADL's. On 10/2/17, at ted she has put her call light wers it for 25 minutes or more. S dated 8/17/17, identified nition, required extensive ivities of daily living (ADLs) are and a wheelchair outside her ight turned on. At 8:54 a.m. are) R43 remained in the her room. RN-E approached are you waiting for someone to 3 responded she was but, lik right on by." RN-C stated and walked away. When intelly following, R43 stated, "I who," as she was having pain in wer, "I don't get help." Further, as waited so long before to get ing down, "I have one of my 43 remained seated in her allway until 9:04 a.m. (17 an unidentified NA th the mechanical lift machine	F3	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 7505 Country Club Drive Golden Valley, MN 55427			
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F 353	assistance of one including transferri grooming and bath 10/2/17 at 12:52 p. chance to get a bath when they are should do everydabeen, "Three week a bath." R31 stated only two staff on the complete a shower when you have you gets missed. R66's quarterly ME indicated R66 exhi and required total the activities of daid dressing, grooming During interview or expressed concern assistance with bath R66 stated if they areceive a bath." R6 received assistance occasions in the laplacing the call light is not a guarantee turn off the call light back, but often dorextended period of R183 stated on 10 the facility was undincontinent of bows staff to assist him.	noted to require extensive to two staff to complete ADL's ng, position, dressing, ing. During interview on m. R31 stated "You get a th once a week or a shower. Out staffed, they give a bed a wash down which they give a bed as wash down which they give a staffed at times it had as in a row that I didn't receive do it is difficult when there are de floor and it takes two staff to gr. If there is not enough staffeur scheduled shower day, it are scheduled shower day, it so extensive assistance with lay living (ADL's), including gr, bathing and mobility. In 10/1/17, at 4:10 p.m. R66 in regarding staffing, stating thing occurred infrequently. The short staffed "You don't go went on to say he had ge to wash his hair on only three st year and a half. When the onto summon assistance, it you will get help. Staff will often that and say that they will come on't return, or return after an	F 35	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STA 7505 COUNTRY CLUB DRI GOLDEN VALLEY, MN	IVE		-
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F 353	commode for 45 m Further, he needed to be put to bed and buttocks and need staff. R183 stated of couple of weeks ag on the floor all day short staff us, we a getting the care we STAFF CONCERN CONCERNS Registered nurse (I 10:01 a.m. due to to facility, nurses tried passes completed, consistently being of stated the four nurs working the cart wa resident needs on to Health unit coordina 10/3/17, at 11:02 a. was "horrible." Sor were not being met residents that need HUC-A added wher assisting other resid there call lights on y yelling. There used 4th floor, but now m scheduling four nur added R6 frequentl did not answer the urine about three to R2. She stated she and changed his ur	inutes and it "pissed" him off. to wait long amounts of time d had a pressure ulcer on his to lay down and not wait for on 10/05/2017 9:24 a.m a lo, there were only two aides and the evenings. "When you ll suffer," and we are not need. S REGARDING STAFFING RN)-C stated on 10/1/17, at he allowed staffing in the lard to get there medication however, treatments were not done as ordered. RN-C further sing assistants and two nurses as not enough staff to meet the	F3	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 353	NA-C stated on 10 frequently take 30 because we are as care and there isn' stated "that's a lonbathroom. NA-C stincontinent becaus Maybe if they could wouldn't be incontischedule four aids asked for more status and think we do purpose. RN-E stated on 10 difficult to get all tafloor there are a lopeople to assist wipeople are assistin wait. RN-E stated at two person transchange their inconwith toileting. RN-G stated on 10 two nursing assistations with gesistants. RN-G stated on 10 two nursing assistations of the 4th floor assistants. RN-G stated on 10 two nursing assistations out of 26 people for transfer had a lot higher act with management brought up staffing not in the budget to The management level of care these residents are leaving the state of the state	/3/17, at 11:46 a.m. call lights to 45 minutes to be answered esisting other residents with the enough staff. NA-C further gitme" to wait to go to the cated resident are frequently be there are not toileted timely. If the toileted timely they nent. The facility will only on the 4th floor and have eff. The residents are angry with the toileted timely. On 4th the forested timely. On 4th the forested timely. On 4th the forested timely on the and the total	F 35	3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/	05/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	the lack of staff. Assistant Director of 10/3/17, at 3:15 p. scheduled in the far call in and the ADO doing cares and participate we get behind on the plans. ADON-A star complaints from resistaff, but we do the schedules by amouneeds. She stated falls and incontinents staffing levels. Hospice Nurse (HN Hospice stated on fourth floor does not stated there is a lot and one evening the had 52 residents we trained medical assimeet all of there ne pain medications in physician orders not be being the control of th	of Nursing (ADON)-A stated on m. there are not enough aids cility to begin with. Then they on's need to fill in on the floor, assing medications and then he assessments and care ted there are a lot of sidents regarding not enough best we can. The facility ant of resident not there care there have been an increase in the increase in	F3	53			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	EET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	,	
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F 353	have enough staff of because so many or residents (bariatric' specializes in treati and require assist of bad for the nursing helping them and the patients ge "sometimes I feel maddition LPN-I state charting done. NA-E stated on 10/days that staff are in their assignments, completed and shahelping in the dining lights. NA-E added calls in and until a into work short. NA-G stated on 10/basis a residents of hours to be answer people. The residents of hours to be answer people. The residents of the frequently inconting floor. There used to 4th floor, which was needs, but now the nursing assistants. entered the facility her helping, and we timely. Sometimes assistants on the 4 hard" and it has be The residents deserbasic needs met. Sevening residents as evening residents as	on first floor especially of the residents are bariatric is is the field of medicine that ing morbid or extreme obesity) of two. LPN-I stated she feels assistance and end up nen drowning in her own work it mad waiting. LPN-I stated my job is impossible". In ed the aides can't get there 4/17, at 12:36 p.m. here were not always able to complete such as toileting, getting baths wing done. They are late in groom while having to answer it is difficult when someone replacement is found they have all light can take up to two red because we are with other ints get upset and are ent. It happens more on the 4th or be five aids scheduled on the is difficult to meet the residents y are only scheduling four. Since the health department there are way more people up the still can't get things done there are only three nursing the floor and its "really really enthis way last two months. Ever more time to have their Staffing is so bad here in the are screaming and fighting. Us were are staffed according	F3	53			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245186	B. WING _		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 353	to our census. NA are neglecting the purpose. NA-H stated on 10 whom are a check they only get chan afternoon, becaus do. There are not resident needs. ADON-C stated or assessments requis a change in concare plan, that are stated she was ne of staff scheduled and care plans ne not enough time. Anonymous staff i 10/5/17, 2:20 p.m. have to be delayed there are not enout the dining rooms, resident in eating. busy with other cat they are short. Review of the faci the facility identified customer services.	G stated it feels like neglect we residents, but it isn't on 0/4/17, at 9:55 a.m. residents and change for incontinence ged in the morning and e that is all the staff had time to enough staff to meet the 10/5/17, at 8:58 a.m. aired quarterly and when there dition, along with updates to the not getting done. ADON-C reded on the floor do to the lack. We know they assessments ed to be updated, but there is 130 minutes or more because updated to bring residents into help pass the meals or assist AS stated the floor staff are res, answering call lights and 150 lity grievance log provided by ed the following staffing and	F 35	,			
	for medications - 8/21/17 cond for cares - 8/30/17 cond	cerns regarding long wait times cerns regarding long wait times cerns regarding staff attitude.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		750	EET ADDRESS, CITY, STATE, ZIP CODE 5 COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	wait times and res - 9/4/17 custo - 9/8/17 custo - 9/11/17 cond put to bed - 9/15/17 cond pain medication - 9/19/17 cond products and care - 9/19/17 cond - 9/28/17 cond - 9/28/17 cond - 9/29/17 cond In an interview on scheduling coordin based, for the most floor. SC-A stated and nursing meet are made depend SC-A stated that se formula or how it i stated the facility i assist in replacem Review of the faci schedule, from Oc identified the follow > 1st Floor: AM S assistants, PM Sh assistants, Night S Monday due to tra and Wednesday a (10/1/17 there were	sidents wandering mer service concerns mer service concerns erns related to cares and time terns regarding wait times for terns related to incontinent erns related to call light time terns regarding care concerns terns regarding care concerns terns regarding cares. 10/4/17, at 10:03 a.m. that or (SC)-A stated staffing is set part, on the census of each each morning administration to review staffing, and changes ing on the needs of each floor. The is not sure if there is a set determined. SA-A further hired an additional scheduler, to	F3	553			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,	
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F 353	this floor) > 3rd Floor: AM SI assistant, PM Shif assistant, Night SI assistant on Sund nursing assistant I night. (10/1/17 the floor) > 4th Floor: AM SI Monday, and 3 nu and 5 nursing assistants Wednesday, PM Sassistants (one at assistants on Mon Tuesday, Night SI assistants. (10/1/1 this floor) During an interview executive director staffing was not opschedule extra if the always possible. We been attempting to issues. ED stated additional schedul with call-in replaces stated that the schweekends. The El director of nursing call, and have staffill weekend call-in morning (Monday management revisatiff, so shortages)	nift 1 nurse and 1 nursing to 1 nurse and 1 nursing nift 1 nurse with no nursing ay night, however only had 1 Monday through Wednesday re were 5 residents on this nift 4 nurses Sunday and reses Tuesday and Wednesday istants on Sunday, but only 4 on Monday through Shift 3 nurses and 6 nursing trainee), with only 4 nursing day and Wednesday, and 5 on nift: 1 nurse and 3 nursing 7 there were 48 residents on w on 10/4/17, at 2:10 p.m. the (ED) stated she was aware that otimal, and attempted to here is a call in, which is not when asked how the facility had of correct the facility has hired an er, who's shifts over lap to help ements throughout the day, but needulers do not work on the D stated that the assistant is (four in total) take weekend if scheduling information with to so. The ED stated each Friday) during "standup," ew the "allocation" of facility and cares concerns can be atted that they try to schedule	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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	"no-shows" so not is stated through qual the facility is working recruitment. ED states things as employed up theme days, mobirthday cake and general time off in the control of the contr	y so that "call-ins" and to impact resident care. ED lity assurance and staff input, ag on employee retention and ated that they are trying such a snack cart, employee dress onthly staff recognition, monthly getting a better system in requests of staff.	F 35			10/5/17	
	may use a paid fee 488.301 of this cha (i) The feeding assi completed a Statemeets the requirem feeding residents; a (ii) The use of feed with State law. (h)(2) Supervision. (i) A feeding assistate supervision of a reconstruction of a reconstruction of the supervision of a reconstruction of the supervision of a reconstruction of a reconstruction of the supervision	ed training course. A facility ding assistant, as defined in § pter, if- stant has successfully approved training course that nents of §483.160 before and ing assistants is consistent ant must work under the gistered nurse (RN) or licensed N). y, a feeding assistant must call					

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F 373	Continued From pa	age 149	F 3	73		
	(h)(3) Resident se	lection criteria.				
	provides dining as	nsure that a feeding assistant sistance who have no complicated				
	not limited to, diffic	eding problems include, but are culty swallowing, recurrent lung be or parenteral/IV feedings.				
	the interdisciplinar resident's latest as Appropriateness for	st base resident selection on y team's assessment and the ssessment and plan of care. or this program should be mprehensive care plan.				
	facility must not us facility as a paid fe individual has succ State-approved tra assistants, as spec	ng of feeding assistants. A see any individual working in the seding assistant unless that cessfully completed a sining program for feeding cified in §483.60				
	Based on observative review, the facility (R19) identified with received safe and eating. A non-train member, Human F with feeding a resinaspiration pneumon problem. R19 was fed by HR-A. Even directly across the	ation, interview and document failed to ensure 1 of 1 residents th swallowing difficulties appropriate assistance with ned paid feeding assistant/staff Resources (HR)-A, assisted dent who had a history of onia and a complicated feeding observed coughing while being a though nursing staff were table while this occurred, they lacing R19 at risk. The findings		1) R19 will be assisted with a safe manner by licensed nurs and speech therapists. R19 cand nursing assistant care de were updated with speech the recommendations. Meal ticked was updated to alert staff to refeeding instructions. Treatment updated to have licensed staff monitor through visual observations feeding recommendations are followed at breakfast, lunch, a	es, NARs, care plan divery guide erapy et for R19 efer to ent record f (nurses) vation that	

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		245186	B. WING		10/	05/2017	
NAME OF F	PROVIDER OR SUPPLIEF	₹	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
				7505 COUNTRY CLUB DRIVE			
GOLDEN	I VALLEY REHABILI	TATION AND CARE CENTER		GOLDEN VALLEY, MN 55427			
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F 373	· •	age 150 nediate jeopardy (IJ) situation	F3	73 Specific education for R19 w	as provided		
	for R19, with the por death.	ootential for serious harm, injury		to nurses and NARs regarding instructions. Feeding instructions provide alternating ½ spoonfits.	ig feeding tions include ul of puree		
	were fed by a paid appropriately asse	iled to ensure residents who I feeding assistants (PFA) were essed to be fed by a PFA, and		and ½ spoonful of thickened waiting for mouth to clear. R therapist completed a respira	espiratory itory		
	program for 2 of 2 observed to be fee	rough a state approved (R19, R97) residents who were d by a PFA. R97 did not have ms but needed staff assistance		assessment on R19 on 10/4/ Physician was updated on 10 regarding increased coughing new orders were received. Immediate verbal education	0/4/17 g at meal no		
	The immediate jed 8:12 a.m. when H	opardy began on 10/04/17, at R-A was observed to assist R19		to Employee 1 (LJ) that was a with feeding and instructed the licensed nurses and NARs at	assisting R19 nat only re able to		
	problem and was executive director	ad a complicated feeding having difficulty swallowing. The (ED), interim director of nursing		assist residents with eating. was suspended pending the the investigation.	outcome of		
	assistant ED-A an immediate jeopard	clinical services (DOCS), d ED-B were informed of the dy on 10/04/17, at 4:15 p.m		 Team including nurse management therapy, dietary management registered dietician, DON, and the control of the con	ager, d ED		
	but non-compliand and severity of (D)	ed on 10/05/17, at 2:54 p.m., be remained at the lower scope) isolated, with potential for		reviewed all residents that respecial feeding needs. Residentified for potential to the resident facility were identified facilities.	dents in ential		
	Jeopardy.	ll harm that is not Immediate		difficulties with eating through assessment during meals. T residents were identified to h	wo other ave like		
	Findings include:			concerns. R97 was assesse therapy and occupational the			
	p.m. with the adm of nursing (DON)	nterview on 10/01/17, at 12:16 instrator and the interim director both stated they did not have a tance program (PFA) to assist ng.		feeding technique on 10/4/17 requires food to be cut in small food placed on left side. Resticket, Care plan and NAR can guide were updated with recommendations. Resident	all pieces and sident meal are delivery		
	he had dementia a swallowing). R19	Record undated indicated that and dysphagia (difficulty s Minimum Data Set (MDS) dicated he needed extensive		be treated by speech therapy treatment. Resident B has ide orders on 10/5/17 that reside MD will be present next week	r for ongoing entified nt is NPO.		

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F 373	assistance of one swallowing disord Care Area Assess indicated he requi meals and had a consistency which The CAA further in eating assistance. A Discharge Sum North Memorial Mospitalized from Discharge Summa aspiration pneumon infiltrates (someth lungs from the our show up in the oth the infiltrate will mof infection with ending from the our show up in the oth the infiltrate will mof infection with ending. R19's Nutrition Right indicated he receing thickened liquids at the dining room and The care plan did recommendations. Review of R19's conceded total assist honey thickened I addition, R19's not undated, indicated consistency and heating with a note instruction."	with eating and had no ers. R19's Nutritional Status ament (CAA) dated 09/13/17, red assistance with feeding at need for special diet or altered a might not appeal to resident. Indicated he received sufficient and the received sufficient of the received sufficient	F3	evaluation. Care plansed delivery guide updated 3) Education was proincluding leadership teasocial service, dietary, human resources regal with a current license, currently on the registry therapists may assist reasolated to nurses and to include: residents with instructions will be indicticket to refer to the nurbinder which will be locart in the dining room, card placed at the table feeding and report to nany excessive coughing issues, or holding food Education will be provided to all employed able to work. Notificating by timeclock to check was to receive mandatory expecial feeding instructions with significant change working. This education orientation and annuall feeding instructions with significant change with significant change instructions are available laminated cards are available laminated cards are available and compliance of planse and displanse and with any expectation and with any expectation and with any expectations are available laminated cards are available lami	with new orders ovided to staff am, nurses, NAF maintenance, and inding only nurse nursing assistantly or speech residents to eat of Education was dinursing assistantly or special feeding cated on the metrition services cated on the juice, and/or laminate e. Staff is to stopurse immediately, swallowing in mouth. In ded to all staff 10/4/17 and ducation regarding to will be posted with nurse manaleducation prior to will be provided by the staff. In condition, erify that feeding ole in binders and vailable at meals changes.	Rs, and states on on the state of the state	

CLIVIL	TO I OIL MILDICAIL	A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	-	
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F 373	to address dysphage to receive discharge followed up with nu printed compensator reduce aspiration ridiscontinuation of sprogress due to decues. Nursing staff compensatory swalf for ongoing signs at A 24 Hour Status R "D/C [discontinue] of puree/honey thick lipatient's table to following: * Bite sizes should * Use spoon to give spoon size) *Allow patient to clegiving another bite * Do not put more of still chewing the begins cough until coughing discontinuation of the still chewing and the begins cough until coughing discontinuation of the started to cough when the stop and then contifull of his potatoes,	gia and complete final session e documentation. Therapist raing staff regarding use of ory swallowing strategies to sk. A 24-hour log updated for ervices due to inability to mentia and inability to follow to implement use of lowing strategies and monitor and symptoms of aspiration. The symptoms of aspiration approximately and diet. Printed strategies at low during meals." The symptoms of puree to honey thickened fluids (1/2 to honey thickened fluids (1/2 to honey thickened fluids (1/2 to honey do not give more food)	F3	373	be completed through meal audits meals. Audits to include visual observation of compliance with fee instructions, compliance with place feeding recommendations in binded dining room and laminated cards pat table, and appropriate staff assis with feeding. Audits will be comple DON or designee on all floors for emeal for 2 weeks and then 3 times for a period of 3 months to ensure compliance. Audits will be reviewed monthly at QAPI. QAPI members determine frequency of audits after of findings. DON and ED responsitions compliance.	ding ment of r in laced sting sted by every a week ed to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 373	12:19 p.m. she fed mashed potatoes NA-B stated to R1 of his juice from his intervened and as R19's specific feed speech language showed her the inswindow sill of the dwas not aware and should only receiv liquids at a time. If the table and place and proceeded to food and beverage decreased. During observation was observed in the assisting R19 with eggs, pureed saus thickened cranber directly across from	d him a level teaspoon full of his and he coughed again, then 9 'It's ok" and gave him a drink is cup. At 12:20 p.m. surveyor ked NA-B if she was aware of ding recommendations from the pathologist (SLP)-A and structions that were on the dining room. NA-B stated she dining room. NA-B stated she dining room of food and NA-B then took the teaspoon at led in his honey thickened juice feed him 1/2 teaspoons of his les and his coughing had an 10/04/17, at 8:12 a.m. HR-A he first floor dining room eating. R19 had scrambled lage, oatmeal and honey ry juice. At the same table in HR-A, sat assistant director	F 37	73			
	with eating. HR-A of pureed sausage heaping teaspoon waiting for R19 to sausage before im spoonful of oatme started to cough, I from HR-A to the rhim and rubbed hi stop coughing. HR honey thickened ochin and began spoonfuls of thickers.	p-B whom was assisting R134 gave R19 a level teaspoon full and then immediately gave a ful of his oatmeal, without first swallow the spoonful of pureed mediately giving a heaping al to R19. R19 immediately oudly turning his head away ight. HR-A stopped feeding s back and waited for him to R-A then brought R19's glass of ranberry juice just below his boon feeding R19 three ened juice, one after another g for R19 to swallow each bite.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING_		10)/05/2017	
	PROVIDER OR SUPPLIE	ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	700,2011	
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F 373	not a half teaspood swallowing strate R19 a heaping spand R19 immedia stopped again and HR-A then brown thickened cranbe began feeding R1 juice, and a level did not wait for R1 she gave him and covered his mout while he coughed across from HR-A attempts to stop I though HR-A was strategies and R1 being fed. R19 heggs, pureed sau and 3/4 of his hor ADON-B left the R19 and NA-M thacross the same approximately 8:2 room, and survey observation. HR-protector and SLI the table and institute the SLP instruction R19.	on as identified by the ST gies. HR-A proceeded to give conful of his pureed sausage ately began to cough. HR-A d let him cough without waiting rought R19's glass of honey rry juice to his chin and quickly 19 three level teaspoonfuls of teaspoon full of oatmeal. HR-A 19 to swallow each bite, before other bite to eat. R19 began to his face turned red while HR-A h with his clothing protector 1. ADON-B whom was directly A while she fed R19, made no HR-A from feeding R19 even anot following the ST swallowing 19 continued to cough while ad eaten 100% of his scrambled isage, and half of his oatmeal ney thickened cranberry juice. Same table HR-A was assisting ten sat down to assist R134 table R19 was sitting at. At 25 a.m. SLP-A entered the dining for informed her of the above A was removing R19's clothing P-A immediately walked up to ructed HR-A she should have the recommendations of bite sizes inful of liquids and food. HR-A IA-M had just informed her of ons and she had stopped feeding	F 3'	73			
	stated she had be	10/04/17, at 9:22 a.m. HR-A een working at the facility since came a NA in 2005, her NA pired in 2008, and she had not					

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F 373	renewed her certifice with feeding when the also assisted another floor. HR-A stated is resident on fourth floors not spill her for herself. During interview on stated she knows the give small amount liquids to make the she does not know of the food or liquid cough while being from says instructions or should also be on her does not work to give small amount floor floo	cate. HR-A stated she assists they are short staffed and had her resident (R97) on the fourth she does not need to feed the door but just makes sure she had while she is feeding 10/04/17, at 12:20 p.m. NA-K that when feeding R19 they are food go down. NA-K stated if there was any size amounts and he had a tendency to fed. She indicated his ticket in how he should be fed and it	F3	73			
	SLP-A stated she h with his plan of care recommendations of trained staff that as SLP indicated she I the table where R1 would disappear, so and leave them agashe also told the inthis time, but she n In addition, the SLF recommendations of board for all staff to	10/04/17, at 12:42 p.m. ad written up the instructions e, and had made these for R19 on 7/24/17, and sisted with feeding him. The eft the feeding instructions at 9 ate and the instructions o she would make new cards ain at his table. SLP-A stated terim nurse manager during o longer works at the facility. P-A stated she wrote these on the 24 hour communication o see. The SLP-A further gh while eating and she					

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
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F 373	recommended a sybut did not think the her recommendation staff to follow throus since he was at sur was vital to follow trecommendations. feed R19 1/2 teasp coughs much less aspiration.	vallow evaluation awhile ago, e facility followed through on on. She relied heavily on the gh with her recommendations ch high risk for aspiration and it	F 3	73			
	assistant director of don't know anything ADON-B added she floor at the facility for the SLP recomm could call his guard stated she found or recommendations overheard a NA instead him. ADON-E pureed food and the	f nursing (ADON)-B stated, "I g about a swallow evaluation." e had been working on the or six weeks which was prior hendation and indicated she lian. In addition, ADON-B ut about R19's last Friday when she struct another NA about how to 8 further indicated he gets at you have to give it to him aware of any portion size but					
	ADON-B stated that HR-A was a certified not say anything to ADON-B added should not following his feet found out she was she contacted respectal action and took with in normal limits she placed a call of informing him of the	a 10/04/17, at 3:06 p.m. at administration told her that ad nursing assistant so she did her about not assisting R19. The not realize she (HR-A) was reding instructions but once she not following his instructions irratory therapy to do an a his vital signs which were as. In addition, ADON-B stated but to R19's primary physician refacility not following the ructions and had not heard					

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F 373	back from him. Furinstructions for feeduring lunch today the facility is they k floors so they do not be floors so they do not stated R19 had conslow to eat, received pureed food. NA-C glass to assist R19 while using the glawould use a spoon give a full teaspoor (approximately 3 m directions on the taspoon for fluids buremoved from the R19 as they did prespoon, and monito unaware he neede fluids and not use a buring interview 10 stated an educator on R19's SLP-A restated, "I told her a won't remember w anything and had reducated." NA-L the since he was on him on 10/5/17, at 8:07 operations (DORO by any manageme feeding and she has feeding before; how	arther, ADON-B stated R19's ding were not at the table and a downfall they have at teep rotating staff from different of know the residents. In 10/4/17, at 3:32 p.m. NA-O ughed a lot while eating, was ed thickened liquids and to stated they use a four ounce to drink. If R19 had coughing as with increased coughing, he for the thickened liquids and not fluid. Previously nonths ago) there were written able that directed staff to use a to these directions were table. They resumed to feed reviously either with a glass or rais response. NA-O was do to give R19 half teaspoon of a glass. In 10/4/17, at 3:42 p.m. NA-L from the facility instructed her commendations but she as soon as you walk away I hat you told me. She didn't say the sign a paper saying I was then stated, "I had not fed him	F 373					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 373	assistant. Althoug was no indication checked with HR-certification was concertification was concertification was concertification was concertified HR-A concertification was identified HR-A concertified HR-A concertified HR-A concertified instruction that the stated she received needed to check the feeding instruction the black book wo cart. A nurse need prior to staff servir started coughing concertified nurse. Interview on 10/5/practical nurse (LF educated on the number would have special would have the instruction indicate to check the located on the begin the dining room staff and assist if the coughing or choking with feeding resident to the immediate jet at 8:12 a.m. was rep.m. when it could document review, had educated diet could and could not needed to be in the were eating, where	h DORO identified this, there any management staff had A if her nursing assistant urrent, even though they mmunicated to them she was a 0/5/17, at 2:15 p.m. NA-Q and new education and the staff he meal ticket for any special a and directions that referred to half be located on the beverage led to be in the dining rooming resident and if anyone or choking they were to alert the 17, at 2:17 p.m. licensed ew process regarding residents diet. The ticket on the table structions and if needed would he black book which would be verage cart. Nurse needed to be prior to serving and supervise there were any issues withing. Only trained staff can assist	F 373				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		COMPLETED		
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F 373	eat. The facility che swallowing guideling were being follower along with other results along with other results and was facility failed to foll instructions while feeding assistants addition, ADON-B the table while HR and made no attenthis occurred. A policy was requesting a policy was requesting assistants addition, ADON-B the table while HR and made no attenthis occurred.	age 159 necked other resident with nes to ensure their programs ed and updated R19 care plans esidents who were at risk. a history of aspiration as at risk for aspirating the ow the SLP-A specific feeding R19, and ensure paid were appropriately trained. In and NA-M were directly across -A was feeding R19 incorrectly, mpts to stop or intervene while ested for following SLP but was not provided.		73			
	diagnoses of cerel aphasia (unable to (paralysis of half o dated 7/7/17, ident cognitively impaire assistance with ea	mission record, identified oral vascular accident (CVA), communicate) and hemiplegia f the body). R97's annual MDS tified she was severely ed, and needed extensive ting. Data Collection and 17/7/17, identified R97 had a					
	regular diet, with n had no problems v only needed staff a updated nutrition p	utritional supplements. She with chewing or swallowing and assistance as needed. An progress note dated 10/4/17, anguage pathology					

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F 373	pieces and place for and assist to feed and assist with meals and cut food into bite size left side. During interview 10 stated she had been on a size of a size	ut resident's food into bite size bod to the left side of resident as needed. dated 10/4/17, identified a on, which directed staff to s needed after total set-up and ze pieces and place food on //04/17, at 9:22 a.m. HR-A in working at the facility since time a NA in 2005 but her NA red in 2008, and had not cate. HR-A stated she assisted facility was short staffed and on the fourth floor. HR-A stated of feed this resident but just not spill her food while R97	F 37	73		
F 412 SS=D	who worked on the up to the 4th floor to assisting R97 to earlier be more specific relations. This in interview that she cospell her food, and 483.55(b)(1)(2)(5) IDENTAL SERVICE (b) Nursing Facilities. The facility-	ROUTINE/EMERGENCY S IN NFS	F 41	2		11/13/17

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	l'	(X3) DATE SURVEY COMPLETED
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part, the following needs of each residents of each residents under the State plate (ii) Emergency der (b)(2) Must, if need the residents (i) In making appoint (ii) By arranging for dental services look (b)(5) Must assist wish to participate dental services as under the State plate This REQUIREME by: Based on interviet facility failed to ension followed through to of 1 residents (R16 concerns. Findings include: R162's annual Min 5/20/17, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record, undated, identified impairment and re with personal hygic Record.	dental services to meet the ident: services (to the extent covered an); and intal services; essary or if requested, assist bintments; and ir transportation to and from the actions; residents who are eligible and to apply for reimbursement of an incurred medical expense an. ENT is not met as evidenced w and document review, the sure a dental referral was address dental concerns for 1 (52) reviewed for dental simum Data Set (MDS) dated R162 had no cognitive quired extensive assistance ene. R162's Admission dentified R162's payer source	F 412	 R162 dental referral has been completed. R162 has been reasses and referral for denal services has be made. Residents residing in the facility the potential to be affected. Residentave been reviewed for last routine service date and need for further follow for dental services. LN Staff and Social Services has been re-educated on the facility's depolicy and procedure to include reference dental care. Caring Partners will 	have ints dental low up ve ental rrals
			ED for follow up. Residents with der referrals will be tracked on the clinic	ntal
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR IT Continued From part, the following needs of each resist under the State plant (ii) Emergency der (b)(2) Must, if necest the resident- (i) In making appoint (ii) By arranging for dental services look (b)(5) Must assist wish to participate dental services as under the State plant This REQUIREME by: Based on interview facility failed to ensifollowed through to followed through the fo	TOTAL PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 161 part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a dental referral was followed through to address dental concerns for 1 of 1 residents (R162) reviewed for dental concerns.	PROVIDER OR SUPPLIER VALLEY REHABILITATION AND CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 161 part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a dental referral was followed through to address dental concerns for 1 of 1 residents (R162) reviewed for dental concerns. Findings include: R162's annual Minimum Data Set (MDS) dated 5/20/17, identified R162 had no cognitive impairment and required extensive assistance with personal hygiene. R162's Admission Record, undated, identified R162's payer source to be Medicaid. The Admission Record further indicated he had been admitted on 05/09/17.	FOORDECTION DENTIFICATION NUMBER: 245186 B. WING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 412	During interview or stated he had lots had a filling that ha R162 stated he we and had all of his thad problems with R162 stated when had requested to so Review of R162's ron 05/12/17, he had poor Step Healthout treatment. A Golden Valley Recommunication Recommunicatio	d R162 had no chewing or ms. n 10/02/17, at 12:36 p.m. R162 of problems with cavities and ad fallen out within the last year. ent to the dentist last summer eeth done, but since then has cavities and a lost filling. he admitted to the facility he	F 412	follow up tool and during the facility clinical meeting processes until resoccurs. 4. The Units Social Worker will trannual dental service date, as well dates of referrals made. The Direct Social Services or designee will be responsible for auditing compliance policy and facility follow through, completing weekly audits of dental service dates and follow up on refer of 5 residents per week. Audits we completed weekly for 4 weeks there monthly times 2 months. Results audits will be forwarded to the QAF committee for opportunities of confunctional quality improvement for 3 months. DON to monitor compliance	ack as ctor of e e of the l errals ill be n of the		

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	seen by a dentist as admission on 05/23	follow thru to ensure he was s he had requested upon s/17, almost five months later.	F 41:			
	483.45(a)(b)(1) PH. ACCURATE PROC. (a) Procedures. A final pharmaceutical serith that assure the accidispensing, and additional pharmacist who (b) Service Consult employ or obtain the pharmacist who (1) Provides consult provision of pharmatisms REQUIREMENT by: Based on observative review, the facility fradministered in accinstructions to ensure residents (R31) obsaddition, the facility insulin's were dated potential administrations.	ARMACEUTICAL SVC - EDURES, RPH Facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed tation on all aspects of the acy services in the facility; NT is not met as evidenced tion, interview and document ailed to ensure insulin was cordance with manufacturer are complete dosing for 1 of 1 served to receive insulin. In failed to ensure opened I when opened to prevent ation after expiration for 2 of 2	F 42	R31 medication regimen review wa completed and continues with use of insulin via insulin pen. Insulin will be administered per manufacturer recommendations. R200 and R84 was noted for record of date opened device. 2. The facility has identified reside	is of e insulin d on	1/13/17
	insulin available for medication cart(s). Findings include: INSULIN ADMINIST	OB4) observed to have undated administration in the GRATION: Coian orders dated 9/25/17, for a Lantus Solostar Pen (long		that are currently diabetic and utilizing insulin regimen. Medication carts we audited for date open documented of insulin pens. Reminder cards were placed on med carts to remind nurse prime pens prior to administering in 3. Licensed staff will be assigned to complete a nursing competency for administration of insulin with pens we education nurse or designee. The formal discourse insuling the second staff will be assigned to administration of insuling with pens we deducation nurse or designee.	vill be on es to sulin. to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 425	and directed staff to [subcutaneous; un management of his increased blood subcutaneous]. A BD (Becton, Dick Duo Safety Pen Nedated 6/2014, iden attach the needle to instructions directed pen, remove the corpen, remove the corpen Needle is attapoint the pen up at Further, the instructional does not appured to the instructional does and LPN-D stated however, added Ridose. LPN-D removed to the divided to determine showed the survey medication adminished the survey medication. LPN-I and questioned ab primed. LPN-D stated however, and the survey medication. LPN-I and questioned ab primed. LPN-D stated however, and questioned above medication. LPN-I and questioned above medication and questi	to reduce blood sugar levels) to, "Inject 71 units der the skin] twice daily," for diabetes (disease causing	F 42	storage of dating medications syringes and needles policy have reviewed. The Education nurverbally review the policy with Nurses, emphasizing on the irecording the date the insulin and priming of insulin pens. 4. Insulin administration audicompleted on 5 residents a wifeweeks then monthly times 2 rall units, by DON or designed Director of Nursing or designed complete audits of Medication weekly for compliance of datifor 4 weeks then monthly times. Results of the audits will be for the QAPI committee for opposite continued quality improvement months. DON to monitor compliance.	las been lise will li all current importance of was opened lits will be lits will be lits for 4 months, on lits mill lits carts lits mill lits carts lits months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 425	was interviewed a need to prime the administration, as insulin pen. LPN-instructions include the surveyor, and When interviewed assistant director insulin pen needle being used to ren "make sure they'd dosage." During interviewed consulting pharm attached to an insulin a, "two unit air shipatient. A facility Insulin In identified a subje and listed a proceinsulin vial with sydirections or proceinsulin v	page 165 and stated she felt there was no e needle before insulin is there was no air inside the D reviewed the safety needle ding priming of the needle with I stated, "that's what I did." If on 10/4/17, at 11:23 a.m. of nursing (ADON)-A stated es should be primed before nove air from the needle to, re [residents] getting the correct on 10/5/17, at 12:07 p.m. acist (CP)-A stated a needle sulin pen should be primed with ot," before being used on a njection policy dated 7/2015, ct to safely administer insulin edure for staff to follow using an yringe, however, lacked any sedures for staff to use when sing a flexpen and attached	F 4	125			
	South medication practical nurse (L cart was opened vials of insulin, goopened) was app	IN DATING: 2:50 a.m. the Second Floor a cart was reviewed with licensed a.PN)-H. The top drawer of the with four opened, uncapped side. One vial of Novolin R (short and for only 42 days after being aroximately 3/4 full, however, and to identify which resident had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, 2 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 425	been using it, or whan additional vial of was approximately writing on the vial to been opened or what LPN-H reviewed be unaware how long which resident receipust be tossed." A vial of Novolin N was labeled for R20 the insulin remaining spacing on a yellow "date opened," and however, both of the There was no reconsidentify when it had she was, "not sure, addition, two separates were stored in the CLPN-H observed the labeled," when they Further, two additions were inside and lab was dated when it is the other was undated to demonstrate when the refrigerate and "need to be thrown recording dates on opened as, "they existed the resident of the control of the c	en it was opened. Further, Novolog (short acting insulin) 1/2 full and had no label or demonstrate when it had ich resident was using it. oth vials and stated she was they had been opened for, nor eived them adding, "these can (an intermediate acting insulin) 00 with approximately 1/2 of ing inside. The label had colored sticker to record the, "exp. [expiration] date," ese spaces were left blank. Indeed, visible date on the vial to been opened. LPN-H stated when they were opened. In the ate opened Lantus flexpen(s) cart and also labeled for R200. In e pens and stated, "nothings of were opened. In al separate Lantus flexpens the led for R84. One of the pens and been opened, however, ted and lacked any markings en it had been removed from opened. LPN-H stated it, "and staff should be all insulin when they are	F 4	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED	
		245186	B. WING _		10/	05/2017	
	PROVIDER OR SUPPLIER	OVIDER OR SUPPLIER /ALLEY REHABILITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 431 SS=E	During interview or consulting pharmac containers should I follow recommends staff, "know how low A facility Storage a Medications, Biologicy dated 10/16, manufacturer/supp dates for opened in record the date opercontainer when the expiration date one 483.45(b)(2)(3)(g)(LABEL/STORE DF) The facility must prodrugs and biological them under an agressive statem under an agressive statem of a licular permits, but on supervision of a licular permits, and adbiologicals) to mee (b) Service Consulting them under the accidispensing, and adbiologicals) to mee (c) Establishes a sign of all consulting the statement of all consulting the state	in 10/5/17, at 12:07 p.m. cist (CP)-A stated insuling the dated when opened to ged storage guidelines and so ng their good for." Ind Expiration Dating of gicals, Syringes and Needles directed staff to follow of the guidelines for expiration needications including to, " ened on the medication emedication has a shortened be opened." In the provide routine and emergency als to its residents, or obtain the ement described in the loart. The facility may permit the load and to the general of the storage of the state of the general opens.	F 43			11/13/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245186	B. WING		10/05/2017		
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION		
F 431	Continued From pa		F 431				
	that an account of	t drug records are in order and all controlled drugs is riodically reconciled.					
	labeled in accordar professional princip appropriate access	gs and Biologicals. als used in the facility must be nce with currently accepted bles, and include the sory and cautionary ne expiration date when					
	the facility must sto locked compartme	with State and Federal laws, ore all drugs and biologicals in nts under proper temperature it only authorized personnel to					
	permanently affixed controlled drugs list Comprehensive Drugontrol Act of 1976 abuse, except whe package drug district quantity stored is in the readily detected. This REQUIREME by: Based on observa	NT is not met as evidenced tion, interview and document		Facility Destruction of Controlle			
	procedures to ensurpatches were disported prevent diversion. affect 2 of 2 reside orders for transder	failed to implement policies and ure transdermal narcotic osed of in methods to help This practice had potential to ints (R188, R161) with current mal patches in the facility. failed to ensure narcotic		Drugs policy states staff are to dest transdermal patches following removing two licensed nurses signing in medication record and to dispose be flushing via sewer system. R188 had order for Fentanyl 50mcg/hr to be a every 72 hours. Order has instruction	oval, the y as applied		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	policies and proce of potential divers (4th Floor, 3rd Flothe survey. This residents with cur substances on the Findings include: A facility Destruct dated 7/2015, direct transdermal patch narcotic medication resident with, "Tweethe destruction of resident's Medica [MAR]." Further, transdermal patch unless it was proceuting the patchea, "drug buster" s An undated Fenta which identified Rorders for Fentan facility. On 10/1/17, at 10 South medication practical nurse (L second metal conkey. The contain narcotic medication including several transdermal patch process for remover transdermal patch patc	s completed in accordance with edures to ensure rapid detection sion on 3 of 3 medication carts for, 2nd Floor) reviewed during had potential to affect 38 of 38 trent orders for controlled ese affected floors. ion of Controlled Drugs policy ested staff to destroy used nes (i.e. Fentanyl [a potent fon]) following removal from a rollicensed nurses must sign for the used patch on the tion Administration Record the policy identified flushing nes was the, "preferred," method hibited, then staff should be se in half and placing them into	F 4	331	fold and flush patch down toilet folkoremoval, as well as two nurses muswitness and record initials when completed. Facility controlled drug outlines section of ongoing inventor controlled drugs at each shift. The section instructs staff to document controlled medications, including soll, III, IV and V, had been counted to off-going and on-coming nurse or TR123 Oxycodone count has been reconciled. 2. Residents with transdermal patile Fentanyl, have been identified, identified medication administration records have been reviewed for instruction to fold and flush patch dotilet following removal, as well as fourses must witness and record inimizes and the controlled drugs have been controlled drugs have been controlled drugs have been controlled drugs have been controlled drugs. Nu Educator will review facility destruction carts/controlled drug policy emphasizing destruction of transdermal patches the ongoing inventory of controlled at each shift, with each Nurse and transdermal patches audit on week basis x4 weeks then monthly for 2 for those residents that have fentar patches. The Director of Nursing of designee will conduct controlled drug reconciliation, with floor staff, on a very market and the page of the product controlled drug page of t	policy ry of all chedule by the TMA. ches, All own two tials ounted arse ation. olicy for rse tion of the and drugs TMA. of ly months by a general grown weekly weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/(05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427	107.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	are removed and d when she removed the sharps contained able to be accesse Further, LPN-H state for R188 that morn she did not have ar was available at the R188's 10/2017 MATHE MAR identified mcg/hr (microgram 72 hours. Further, "Fold and flush patternoval / Two nurse provided spacing for initials when complewere left blank with When interviewed assistant director of used transdermal pwith two nurses presewer." ADON-As without two staff and sharps container we nurse, "needs educed During interview on consulting pharmatic policy was for two rethe used transderm was, "left over drugthe nurse disposing	isposed of. LPN-H stated patches, she placed them, "in er [attached to medication cart, dusing scissors and cutting]." ted she had changed a patch ing (10/1/17), however, added by one else watch it as nobody et time. AR was reviewed with LPN-H. I an order for Fentanyl 50 sper hour) to be applied every the MAR had directions of, ch down toilet following es must witness," and or two nurses to record their eted. However, these spaces no initials recorded. In 10/4/17, at 11:30 a.m. of nursing (ADON)-A stated patches should be removed esent and disposed to, "via stated removing patches and disposing of them in a las, "not acceptable," and the cation." In 10/5/17, at 12:07 p.m. cist (CP)-A stated the facility nurses to witness and destroy hal patches via sewer as there in on the patch." CP-A stated to of the patch in the sharps oving on her own, "didn't follow	F 4	31	will be completed weekly for 4 wee monthly for 2 months. Results of the audits will be forwarded to the QAF committee for opportunities of contiquality improvement for 3 months. DON to monitor compliance	he Pl	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		75	TREET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	identified a directive have procedures in ordering, receipt, and destruction of controutlined a section of Controlled Drugs at staff to document a including schedule counted by the off-off-off-off-off-off-off-off-off-off	Drugs policy dated 7/2016, et o, "assure that all Centers place to safeguard the dministration, storage and colled drugs." The policy of, "Ongoing Inventory of a Each Shift," and directed all controlled medications, II, III, IV, and V, had been going and on-coming nurse or aide (TMA). The policy of the p	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 431	and added, "I don't further narcotic coumedication cart. L counting the medicand stated the nurse count on a flowsheet flowsheets of each nurse signing signatures were reand provide eviden been counted. The September 2017: 9/1/17 - three of the 9/2/17 - all six space 9/3/17 - all six space 9/3/17 - three of the 9/11/17 - all six space 9/10/17 - three of the 9/11/17 - all six space 9/11/17 - all six space 9/11/17 - three of the 9/11/17 - three of the 9/11/17 - three of the 9/15/17 - three of the 9/15/17 - two of the 9/15/17 - three of the 9/20/17 - three of the 9/21/17 - four of the 9/21/17 - one of the 9/25/17 - one of the 9/26/17 - three of the 9/28/17 - three of the 9/29/17 - three of	know what happened." No ints were incorrect on the PN-G reviewed for process for ation carts with the surveyor, sees sign off each time they et contained in a binder. consisted of six columns with off for each shift. A total of six quired to satisfy the flowsheet ce the medication cart had e following was identified:	F 43	31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		700/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	had not been doc an entire day. W following this revi unsure if the cart had just not been right." LPN-G st the medication camight be missing. The narcotic cour the remaining meand identified the 4th Floor "Middle 9/1/17 - two of the 9/3/17 - two of the 9/3/17 - two of the 9/10/17 - three of 9/13/17 - two of the 9/11/17 - three of 9/11/17 - one of the 9/11/17 - four of the 9/11/17 - fou	ad five instances when the cart sumented as being counted for then interviewed immediately ew, LPN-G stated she was had not been counted, or if it documented adding, "it is not ated it was important to count arts each shift as, "medication." Int flowsheets were provided for edication cart(s) on the 4th Floor	F4	31		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION			E SURVEY IPLETED
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, Z 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 431	9/6/17 - three of the 9/7/17 - five of the 9/8/17 - three of the 9/8/17 - two of the 9/10/17 - five of the 9/11/17 - three of the 9/11/17 - three of the 9/13/17 - three of the 9/15/17 - five of the 9/15/17 - five of the 9/16/17 - two of the 9/16/17 - two of the 9/19/17 - two of the 9/21/17 - four of the 9/23/17 - three of the 9/25/17 - one of the 9/26/17 - two of the 9/26/17 - two of the 9/28/17 - five of the 9/29/17 - five of the 9/29/17 - five of the 9/29/17 - three of the 9/29/17 - five of the 9/29/17 - one of the 9/29/17 - three of the 9/29/17 - one of six 9/3/17 - one of six 9/3/17 - one of six 9/3/17 - one of six	e six spaces were left blank, e six spaces were left blank, he six spaces were left blank. 33 a.m. the 3rd Floor South his reviewed with LPN-B who has for counting and reconciling his. LPN-B stated narcotics fing shift change," and heets kept in a binder. These eviewed and consisted of the on the 4th Floor cart(s) and	F4	131			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY MPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	9/18/17 - one of si 9/19/17 - one of si 9/22/17 - one of si 9/23/17 - one of si 9/24/17 - one of si 9/27/17 - one of si 9/29/17 - one of the 9/3/17 - one of the 9/9/17 - one of the 9/17/17 - two of the	age 175 x spaces was left blank, x spaces was left blank x spaces was left blank and; x spaces was left blank immediately following this ted staff must had, "forgot to bunts being completed adding, s] should be filled in." LPN-B rtant to count and document each shift as, "that's how we correct," and nothing was LPN-B and the surveyor t of the narcotics in the and found it to be correct. 50 a.m. the 2nd Floor South as reviewed with LPN-H who ess for counting and reconciling ons. LPN-H stated the narcotics ween each shift exchange, and to sign the narcotic counting and to sign the narcotic counting and in a binder on the cart. were provided and identified e six spaces were left blank, six spaces was left blank, six spaces was left blank, e six spaces was left blank, e six spaces was left blank, e six spaces were left blank,	F 431				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3		TE SURVEY MPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	9/19/19 - one of th 9/21/17 - one of th 9/22/17 - two of th 9/23/17 - three of the sand; 9/26/17 - one of the When interviewed review, LPN-H state had not signed the had counted the new forgot to sign." From the important to count nurses coming on right," and so it count to the medications. The narcotic count the remaining median identified the following to the sign. The narcotic count the remaining median identified the following the sign. The narcotic count the remaining median identified the following the sign. The sign of the 9/5/17 - one of the 9/5/17 - one of the 9/10/17 - one of the 9/10/17 - one of the 9/11/17 - four of the 9/13/17 - two of the 9/13/17 - two of the 9/14/17 - three of the 9/14/1	le six spaces was left blank, le six spaces was left blank, le six spaces were left blank the six spaces were left blank le six spaces was left blank. Immediately following this ted she was unsure why nurses e flowsheet to demonstrate they arcotics adding, "people maybe urther, LPN-H stated it was and sign the flowsheet as are, "taking credit the count is uld be tracked who had access inside. It flowsheets were provided for dication cart(s) on the 2nd Floor	F 43				
	9/20/17 - one of th 9/21/17 - five of th 9/22/17 - two of th 9/23/17 - one of th	e six spaces were left blank, e six spaces were left blank, e six spaces were left blank, e six spaces was left blank, e six spaces was left blank, e six spaces was left blank					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441 SS=F	A facility provided Mated 10/4/17, identified and controlled substitute reviewed med. When interviewed assistant director of medication cart nare between each shift flowsheet(s) so, "your responsible for the missing." During interview on consulting pharmac completes audits on "periodically," and responsible for the missing." During interview on consulting pharmac completes audits on "periodically," and responsibility. CP-A audit, which had be month ago, she ago with the narcotic concept of the interim director and also placed in a website, however, a responsibility to revistated staff should, ensure they are docunt. 483.80(a)(1)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	six spaces were left blank. Month End Operations Report tified 38 different residents stances stored amongst the dication carts. In 10/4/17, at 11:30 a.m. finursing (ADON)-A stated the cotics should be counted and documented on the bulknow which nurse is narcotics should anything go 10/5/17, at 12:07 p.m. the cist (CP)-A stated she in the medication carts, noticed back in June 2017, the re not being signed stated on her most recent en completed less than a sain noticed "isolated issues" unts not being recorded. dit results were reviewed with of nursing (DON) at the time, a report for the facility on their added it was the facility's iew them. Further, CP-A "follow procedures" and cumenting each narcotic.	F 4			11/13/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245186	B. WING _		10	/05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	and control prograr a minimum, the foll (1) A system for program, and communicable discontinuous expression of the providing services arrangement based conducted according accepted national simplementation is for the program, which will be fore they can sprogram in the program of the program in the progr	stablish an infection prevention in (IPCP) that must include, at lowing elements: eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not weillance designed to identify cable diseases or infections read to other persons in the enom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; a isolation should be used for a	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245186	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 441	must prohibit employ disease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for recunder the facility's lactions taken by the (e) Linens. Person process, and transpapread of infection. (f) Annual review. annual review of its program, as necess. This REQUIREMED by: Based on observative review, the facility from the facility from the facility from the facility failed to water-management develop policy to prowhich had potential	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the disease; and the procedures to be followed direct resident contact. cording incidents identified PCP and the corrective a facility. In a must handle, store, bort linens so as to prevent the procedure and update their sary. In a must handle are evidenced the facility will conduct an and update their sary. In a must handle are evidenced the facility and analysis of the potential spread to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to implement a facility and analysis of the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to a facility and the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to a facility and the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to a facility and the potential spread to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to a facility and the potential spread to other the potential to affect 94 taff and visitors to the facility. In a must handle are evidenced to a facility and the potential spread to other the potential spread to other the potential to affect 94 taff and visitors to the facility are evidenced to a facility and the potential to affect 94 taff and visitors to the facility are evidenced to a facility and the potential to affect 94 taff and visitors to the facility are evidenced to a facility and the f	F 441	R31 will have blood sugar monitor a glucometer that has been sanitize to and after use following facility pocleaning. R121 will have dressing changed per order and following in control standards for dressing char including appropriate hand hygiene treatment. Facility will complete surveillance, tracking, and trending infections in the facility. Infection represe will monitor infections through	ed prior blicy for fection nges during of ates will bottrol
	to ensure a commu cleansed in accord	ilty. Further, the facility failed inity-based glucometer was ance with manufacturer nt cross contamination of		nurse will monitor infections throug the month for trends and need for interventions. Facility will develop management program to identify the	a water

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
		245186	B. WING			10/0)5/2017
NAME OF F	PROVIDER OR SUPPLIE	R	' I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				75	505 COUNTRY CLUB DRIVE		
GOLDEN	VALLEY REHABIL	ITATION AND CARE CENTER			OLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From p	page 180	F 4	41			
	•	ogens for 2 of 2 residents (R31,			and prevent legionella exposure.		
		iring their blood glucose			and provent regionalia expectate.		
		had the potenital to affect 8			Residents in the facility who require	blood	
		irst floor with current blood			glucose monitoring and also reside		
	glucose monitorin	g orders. In addition, the facility			who require dressing changes have		
	failed to ensure st	taff infection control practices			potential to be affected.		
		mented during a dressing					
		residents (R121) observed			Licensed nurses will be re-educated		
		e. This had the potential to			cleaning of glucometer per facility p		
	affect all 94 reside	ents in the facility.			LNs will also receive education rega	arding	
					infection control procedures during		
	Findings include:				dressing changes including hand hy		
	INICECTION CON	ITROL PROGRAM:			Facility will contract with agency to		
	INFECTION CON	ITRUL PROGRAM.			water management to reduce risk a prevent legionella exposure. LNs w		
	On 10/3/2017 in t	the afternoon, the assistant			receive education on infection contr		
		g (ADON)-C provided a			program to track and trend infection		
		er containing the facilty's			prevent potential spread of infection		
		nonitoring program. The binder			other residents, staff, and visitors.	1 10	
		ivider tabs, and upon inspection,					
		nents filed only under August			DON or designee will complete		
		017. Review of the materials			observation of 5 blood glucose mor	nitoring	
	identified the follo	wing:			per week for 4 weeks then monthly		
					months to verify glucometers are sa		
	September 2017:				per policy. DON or designee will ob		
		sting Report/Monthly Healthcare			and audit 3 resident dressing chang		
		ion Incident Rate worksheet was			week for 4 weeks then monthly for 2	2	
		(16) infection line listings, which			months to monitor infection control		
		other items: resident, room			practices during procedure. DON a		
		nfection, onset date, if a culture			will review water management plan		
		antibiotic and start date, and if			developed by contracting service who available DON and OARI committee		
		acquired in house or not. There			available. DON and QAPI committee review infection control surveillance		
		ection rate (3.13.%) calculated 17, however, but no rate			monthly. DON will review infection		
		type of infection, for example			tracking weekly for completion of	COLLLO	
		respiratory or gastro-intestinal.			surveillance tools and tracking of		
		the September tab were four			infections is ongoing throughout the	,	
		ance Worksheets" which			month. Audits will be reviewed mor		
		ine items on the report, and			QAPI for 3 months.	.any at	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3		E SURVEY IPLETED	
		245186	B. WING		10/	05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
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F 441	additional informate regarding infection. August 2017: A Monthly Line List Associated Infection filled with twenty-on Norman Monthly infection Surresponded to line addition, there was among the collected There was no additive reports or analyses September 2017. There were no surmonthly line listing through May 2017 infection worksheed was no documente along with no analyduring these monthly line listing through May 2017 infection worksheed was no documente along with no analyduring these monthly line listing the monthly line listing through May 2017 infection worksheed was no documente along with no analyduring these monthly line listing the monthly line listing the was no documente along with no analyduring these monthly line listing the monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring these monthly line listing the was no documente along with no analyduring the was no documente al	e information. There was no ion or other reports or analysis in September 2017. Iting Report/Monthly Healthcare on Incident Rate worksheet was ne (21) infection line listings. On rate was calculated for er the August tab were sixteen weillance Worksheets" which ne items on the report. In a final urine culture report ed worksheets for August 2017. Itional information or other is regarding infections in weillance worksheets or infections in the sunder tabs from January. There were individual its for June and July, but there is the dine listing to track infection in the system of infections completed.	F 44	,	compliance.		
	done. ADON-C state to me in August of me" and stated she	o another, and did not get ated the ICP was formally given 2107, "it was just handed to e still had questions and acation regarding how to run					

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		245186	B. WING _		10	/05/2017	
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	the monthly data, a stated going forward analysis, and review addressed during addressed during a A facility policy, "In Program, revised a goal of the program risks of acquiring a among residents, a workers, volunteer policy indicated "A established to reduce pidemic Healthca residents and HCV policy indicated the and surveillance or document all residents in monthly line list line listing report to	acknowledged current gaps in and lack of the current ICP, but ard, there would be tracking and ew of the findings would be	F 44	1			
	assitant director of was not aware of a water managem. Legionnaire's diseaware of and had lkit. When interviewed director or mainter regional directors of	on 10/3/17 at 2:298 p.m., the finursing (ADON)-C istated she any program begun in regard to ent for the prevention of ase. ADON-C stated she was briefly looked at the CDC tool on 10/4/17 at 1:29 p.m., the nance, (M)-A stated one of the of the facility had contacted him g to talk about the water					

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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 441	management plar company would coassessment of the water management aware of the need plan in place becastated we do not have the management plan in place becastated we do not have the management plan in the M-A stated he computer, but not when interviewed assistant executive currently she had company to begin management plan the CDC toolkit, a conducting a facility provided in regards to policy to address. The facility provided or procedure to accurate to a	in. The M-A mentioned a local oming to help the facility beging a water system as part of the ent plan. The M-A stated he was a to have a water management ause, of "this Legionella" but have policy in place right now. It has the (CDC) "toolkit" on his hing down on paper. I on 10/5/17 at 2:26 p.m. the re director, AED-A stated a date scheduled for a local testing in regard to the water at the AED-A stated when had and the facility would be fity-wide assessment. The far, that was what had been or creating a water management the Legionnaire's concern.	F 441			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245186	B. WING		10	/05/2017
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 441	between resident transmission of the contact." Further clean the meter at (Environmental Programment of the designated wipes. During observation licensed practical community used from a mobile meter and seated in a growth unused lancowipes. LPN-D response to the device was wand seated in a growth unused lancowipes. LPN-D response to prought the device pierced R31's sking obtained a sample Afterwards, LPN-R31's room, place and began to prese administration. Leglucometer with a using it. At 7:43 and unclean glucomed to the other blood away from the meter oom, with the destopped by the sumposed to be using a wipe which LPN-D then clear designated wipes.	aing and disinfecting of meters a use can prevent the mese viruses through indirect r, the manual directed staff to after each use with an EPA trotection Agency) registered solution of 1:10 concentration of 2:10 concentration of 2:10 concentration of 2:10 concentration of 2:10 concentration of 3:10 concentration of 2:10 concentration of 3:10 concentration cart on the first floor. The strain of 3:10 concentration cart on the 3:10 concentration cart on the 3:10 concentration of 3:1	F 4	141		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	` '	
		245186	B. WING _		10	/05/2017
	NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	ECTION (X5) HOULD BE COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	(checks) listing ide had current glucor first floor of the far During interview of assistant director glucometer(s) need each resident, "for case blood or body onto the device. Staff had just received recently. A facility Equipme Cleaning/Disinfect 1/2017, identified prevent resident of from becoming so equipment, "will be applicable before policy listed three semi-critical and runderneath of each "will be cleaned, of according to many CDC guidelines."	ed 1st Floor Gluc(ometer) entified eight different residents meter checks ordered on the cility. on 10/4/17, at 12:34 p.m. of nursing (ADON)-A stated the eded to be cleaned inbetween or infection control issues," in lily fluid had been transferred Further, ADON-A stated nursing vived education on this subject	F 44	,		
	R121's diagnoses orders dated 9/28 Alzheimer's deme	NFECTION CONTROL RING DRESSING CHANGE: s, as identified on physician's /17, included early onset entia. A significant change et (MDS) dated 8/18/17.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		E SURVEY IPLETED
		245186	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 441	indicated R121 ha (open wound, with and supporting tiss 8/30/17, directed supporting tiss 8/30/17, directed supporting tiss 8/30/17, directed supporting to moist [wound particular of the direct of t	age 186 d a stage 4 pressure ulcer depth involving bone, muscle sue). Physician's dated staff to, "Cleanse wound, pat tic medication) 250 mg ablet) crushed into wound, wet ack] using Dakins Solution nser) BID (two times daily). n on 10/2/17 at 12:24 p.m., nurse (LPN)-C completed a part R121's wound. Nursing and NA-W helped to hold and position on the bed during the ment of the wound dressing. In change, LPN-C prepared the tall's room and gathered among which included sterile, but a complete the tall and the packed among which included sterile, but a complete the tall and the packed are bandage and the package are bandage wrapper side table. Next, LPN-C placed are just removed on top of the apper, then poured about 30 ml olution on the gauze package of the bed side table. LPN-C are based gauze and lightly are and lightly are and lightly	F 44'			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505	EET ADDRESS, CITY, STATE, ZIP CODE COUNTRY CLUB DRIVE LDEN VALLEY, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	squeezed out exces with the crushed m R121's wound with LPN-C placed a topack, and the dress. When interviewed explained R121's ostated she opened the gauze 4 x 4, placed (on the outside of in DK solution into the gauze, soaked with the crushed Flagyl R121's wound. LP procedure stated some "clean" and not "stochanging of R121's During observation registered nurse (Find the change for R121's helped hold and moded during procedure RN-B washed his helped stochastic procedures the change for R121's helped hold and moded during procedures washed his helped stochastic procedures with the crushed stochastic procedures and the change for R121's helped hold and moded during procedures washed his helped stochastic procedures with the crushed stochastic proced	iss DK solution. Then, along redication, LPN-C repacked the solution-saturated gauze. In bandage on R121's wound saing change was completed. In a sing change was co	F 4	41	JEHOLITY		
	large gloves, which gloved hands, RN-the packed, gauze and folded the wou while he removed to bandages and glov washing or cleansi another pair of glov 4 package, and rip the package to operemoved the gauze	e table. Next, RN-B donned in he struggled to put on. With B removed the outer dressing, dressing from R121's wound, and packing into the gloves the gloves, then placed the res in the trash. Without first and his hands, RN-B donned res, grasped a new gauze 4 x ped a strip across the top of en it, and with the gloved hand, as With the gauze in his hand, he around the outside of R121's					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		245186	B. WING	i	_	10/0	05/2017
	PROVIDER OR SUPPLIER VALLEY REHABILIT	TATION AND CARE CENTER		STREET ADDRESS, CITY, STAT 7505 COUNTRY CLUB DRIVI GOLDEN VALLEY, MN 58	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 441	wound, folding the second wipe aroun again folded his glo gauze and soiled g pair of gloves, with hands, opened and RN-B then grasped and announced this cleanser" and begainside and out. Immexudate from the word cascaded down out the surrounding skilbed linen. With the to blot R121's wour liquid and wound di wound, the spray be exudate that had cand bedding on R1 damp. RN-B remodisposed the soiled onto it, before final repacking R121's wound, and complete wound, and complete wound, and complete the struggled mostly to RN-B stated he was spray cleanser bott drainage from clean stated he thought the "too bad." RN-B diese and soiled a top bands wound, and complete the struggled mostly to RN-B stated he was spray cleanser bott drainage from clean stated he thought the "too bad." RN-B diese and soiled to bad."	gauze in half and making a d the wound edges. RN-B oves and disposed of the loves. RN-B donned another out washing or sanitize his other package of 4 x 4 gauze. I hold of a liquid spray bottle is was a "liquid wound an to spray R121's wound, both mediately the spray mixed with wound, then drained and to of the wound, as well from an dripping onto the towel and e gauze in hand, RN-B began and, soaking up the dripping rainage. While cleansing the ottle came in contact with ascaded down onto the towel 21's bed; the bottle was visibly ved his soilded gloves and I gauze by folding the gloves disposal into the trash. Before wound, RN-B removed and ir of gloves, tore open an new oked R121's wound. RN-B age to cover the packed	F 4	441			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED
		245186	B. WING_		10	/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	assistant director of when opening a dreshe would expect the asto expose the interpretation on top outside wrapper was "its filthy" ADON-C for staff to follow aptechnique during drechnique directions was very concerning residents with signital A facility policy, Hard 2017, indicated Hard important procedur acquired infections staff was to wash himmediately after recrequired staff to use organic material and 483.90(i)(5) SAFE/FUNCTION/E ENVIRON (i) Other Environment The facility must proposed and comforces idents, staff and comforces idents, staff and comforces idents, staff and complicable Federal, regulations, regarding as to expect the staff and complete the co	on 10/4/17 at 9:01 a.m., the finursing (ADON)-C stated essing package, like gauze, he package to be opened so side of the package, then pour of that. ADON-C stated the as considered contaminated, also stated it was important operopriate hand washing ressing changes, and added egarding infection control was sees. ADON-C stated this issue g because we have other ficant wounds. Individually ind	F 44			11/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10/0	05/2017	
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F 465	non-smoking resident This REQUIREME by: Based on observareview, the facility in an acceptable maffecting 2 resident room. There was a 329, potentially aff were not in safe with window were also affecting R111. Was cleaned in room 16 floor dining room's fans were not clear whom atte their mediates whom attein the facility stamped the facility stamped the facility stamped for the facility stampe		F 46	1) R85 and R2 rooms were deep to remove any odors. Room 329 m ceiling tile was replaced on 10/03/2 Room 104 electric outlets and miss window weather stripping was replaced and teiling fan were cleaned on 10/03/2017. Room 106 wall mount and 1st floor dining room mounted and ceiling fan were cleaned on 10/03/2017. Room 104 cracked tile replaced. 2) Resident rooms have been assefor odor, missing ceiling tiles, propelectrical boxes, missing window wastripping, dirty fans in both resident rooms and in dining rooms, and cratiles. Rooms identified with deficie practices have been corrected. 3) Staff education on reporting environmental concerns in resident areas. Housekeeping education on Procedures for Fan Cleaning. Maintenance has been educated of completing daily rounds. 4) Five fan cleaning audits to be completed weekly for 4 weeks ther monthly times 2 months by housek supervisor. Five resident room audits for physplant concerns to be completed were for 4 weeks then monthly times 2 monthly t	sissing 2017. Sing aced on ed fans fan e was essed er place reather ts' acked nt t care in the electric for sical eekly months geviewed II be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10	/05/2017	
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 465	urine emanating froom was sticky, footsteps to be he HKSP stated that incontinent produ "women". The far 3 times in the las with urine. When try charcoal, clea other rooms on a cleaning schedule When asked if the cleaners (used to proteins), HSKP sthen asked HSPH used, to which HS is not listed in the facility. On 10/3/17 at 2:3 (MT) stated when have been instruct housekeeping. If immediate attention the walkie-talk can also leave wristations, which wistations, which wistations, which wistations are incompleted ceiling tiles. The area absection of ceiling tiles.	from his person. The floor of the causing surveyor and staff's eard. R84 will not wear any lots, while he states they are for mily has replaced R84's recliner to 2 years due to being saturated asked about odor control, they ners and have this room and 5 "6 times a day - everyday e" but the odors still persists. ey have tried a urea-neutralizing obreakdown urine salts and stated that they have not. AED-AC why this product has not been SKP stated that type of product eir contract for use within this each occurrence and there is an issue(s) that needs fon, MT indicated they can call tries, or call on the phone. They critten information at the nursing ould be picked up when I housekeeping rounds through	F	465			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	TIPLE CONS		` ′	E SURVEY IPLETED
		245186	B. WING			10/	05/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 CO	ADDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE N VALLEY, MN 55427	•	
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F 465	should report this department. At 2:57 p.m. in room R111), noted a 4-country the mopboard, that between the wall a hanging at a 45 deintact. The outlet welectric Hi-Lo bed, were aware of this staff lowered the Highly discountry the dislodging it from the right away. The three and bedroom was measuring approximate inches by four this would be reparting an ine inches by four this would be reparting an ine inches by four this would be reparting which allowed a transition. The bedroom wind stripping which allowed a transition of the would be corrected. In Room 106 at 3: next to the bathroom gray dust, that occurred the strings of dust (apout from the fan can had a heavy build.)	sekeeping and/or floor staff to the maintenance om 104-1 (first bed in room - putlet electrical box just above it was pulled off the wall and residents bed, and was egree angle, with the wires was being used to run R111's Neither M-A, MT or HSKP issue. MT stated it appeared di-Lo bed onto the outlet box the wall. This would be repaired reshold between the bathroom cracked with tile missing imately 18 inches in length and biece of title was missing in the pproximately four inches by r inches. The CCE, identified ired, and the area did not n from the room to the other. dow had missing weather bowed an opening to the eximately 1/2 inch wide by t	F4	65			
		1st floor dining room, at 3:24 g fan, appeared gray with a					

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F 465	switch was broke cleaned by turnin stated they would controls so that the clean the fan and fan, also located a heavy build up cage. HSKP state been able to clea could not be turned She stated house the wall fan, and monthly basis. Lie whom was in the approximately 13 room. In review of the family many many many many many many many man	on of gray dust. The on/off fan n off, and the fan could only be g the ceiling lights off. M-A have to fix the ceiling fan he housekeeping staff could fan blades. A oscillating wall in the 1st Floor dining room, had with mats of gray dust on the fan he de the housekeeper would not of an the ceiling fan, because it he doff unless the light was off. Reeping should have noticed should be cleaning this on a censed practical nurse (LPN)-B dining room at this time, stated residents ate in the dining accility policy, entitled: Repair: To Prevent Spread of January 2017), pertained more ealth" (personal protection was to eventative maintenance rather be reported to maintenance / repairs. On page 3 of the same in entitled: Pluming Supply and is, the policy indicated that the re "scheduled regular preventive rescheduled regular prevent	F4	165			

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F 465	electrical, and reside maintained in safe the center 'Prevent The policy further in and housekeeping weekly rounds to in common areas, off policy indicated that concerns found and rounds, providing the development of the last findings and complete however were not resulted. Two separate policities from Healthcare Set Housekeeping In-Set The first, entitled: Condicted the purpose that each resident in a monthly basis. The any of the concerns second policy, entite Room Cleaning, also should do when not fans, fruit flies or of only basis room cleaning the fans noted were supporting document the fans noted were the fans noted were supporting document the fans noted were supported to indicate the fans noted were the fans noted were supported to indicate the fans noted were the fans noted were supported to indicate the fans noted were the f	dent care equipment is operating condition through ative Maintenance Program'." Indicated that the maintenance manager would be performing aclude "resident rooms (10), ices, gym and laundry." This it the facility would correct dikeep results of the weekly hem to quality assurance every at 3 months of weekly rounds, etion records were requested, eceived. The services Group, Inc, - Services Group, Inc, - Service, both dated 1/1/2000. Complete Room Cleaning, see of the policy was: "[insures] froom is discharge-cleaned on this policy made no mention of a mentioned above. The cled: 5-Step Daily Patient so did not mention what staff ting missing ceiling tiles, dirt ther environmental concerns,	F 46				

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F 469 F 469 SS=C	483.90(i)(4) MAINT CONTROL PROGICAL CONTROL PROGICA CONTROL	AINS EFFECTIVE PEST	F 40		ded center nagement of removed services cheduled for aned and rings to be ntial of fied areas to oms to be not in o continue I services needed. com food ving meal maintenance Director, Executive rector to		

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F 469	During interview 10 stated he had been and the "This place stated there is sew elevators. During interview 10 stated he had been The food is cold I did the same thing eve stated he eat's in hand there is lots of During observation observed a small bin her room. An adobserved of a fly in completed lunch transport to the garbakitchenette wall. During observation noted on the garbakitchenette wall. During observation room on 10/03/201 fly's was noted flying was noted flying the gradient of the garbakitchenette wall. During observation room on 10/03/201 fly's was noted flying was noted flying the gradient of the garbakitchenette wall. During observation on a.m., several flies was noted flying the gradient of the gradient of the garbakitchenette wall. During observation and floor. During observation and floor.	age 196 //01/17, at 10:06 a.m. R162 at the facility for five months a sucks"! In addition R162 er flies in his room and the //01/2017, at 10:10 a.m. R130 at the facility about a year. on't eat breakfast because its ry day. In addition R130 is room because of the bugs flies in the dinning room. 10/02/2017, at 12:51 p.m. lack fly over R35's lunch tray ditional observation was R35's room flying over R35's ay again at 12:59 p.m. ion on 10/02/2017 at 1:25 were seen flying around the 1st at 1:42 p.m. four flies were ge bag, and six flies on the of the 3rd floor conference 7 at 8:08 a.m., multiple small g around the room. ecord review at the 1st floor 10/3/17 from 8:41 a.m 11:28 were observe flying around the residents areas on the first on 10/03/2017, at 8:43 a.m. the first floor nurses station flying around the desk.	F 469	4) Facility rounds to address and food storage concerns w completed by Maintenance I designee weekly for 4 week monthly times 2 months. Au reviewed monthly at QAPI fo Director of Nursing and Executil monitor for compliance.	ill be Director or s then dits will be r 3 months.	

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F 469	During environments, maintenance was aware of the dining room which week. He stated the housekeepers cans in this area, in the dining room resolved. When Mitchenette of the black flies emand stated he would coday. On 10/4/17 at 7:5 with M-A and the Pest Control, Inc. reviewed the facilithe "glueboards"	page 197 ental tour, on 10/3/17 at 2:25 the director (M)-A stated that he "flies" being in the 1st floor the was continuing for the past two they were "fruit flies." He had s washing out all the garbage and making sure food is not left the, and thought the problem was M-A tapped the sink on the 1st floor dining room, small sted from the sink area. M-A call a pest control company that 11 a.m., on a environmental tour contracted company's (Adam's) pest control technician (PCT), lity "bug lights" wall sconces and (sticky traps) placed inside of ispected. The following was	F4	169			
	light, was noted to approximately 5 h multiple black-eye fungus gnats. Thi floor dining area. > On the 3rd floor dining area, now area. The light's ghouse flies, a two multiple black-eye fungus gnats. > On the 2nd floor flies, black-eyed to bug light, located the kitchen on the	r, the glueboard within the bug on have trapped the following: house flies, one ground hornet, ed fruit flies and numerous is light was located in the 4th or bug light was located in the old utilized a a open general storage glueboard also had a three moths, a Eurasian beetle, ed fruit flies and a numerous of or dining area collected house fruit flies and fungus gnats. The inside the delivery entrance of e 2nd floor, collected several ple black-eyed fruit flies and					

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 469	reached under the pulled from the flow matter, with food of the last floor of glueboard, was found of black-eyed fruit. During an interview stated that black-eflies, are much largare caused by collin high moisture locontrolled by thorosuch as drain traps PCT stated, like al months of the year these areas. PCT (especially floor drain grates and collection fruit flies. PCT suggester flushed with 3-5 gadrains are free flow fruit flies. PCT furtifloor coverings (incomposed for coverings) (incomposed for c	ing the tour of the kitchen, PCT kitchen ice machine, and or drain, dark gray moist ebris. Idining room bug light and to have a number quantity flies and fungus gnats. If 10/04/2017 9:10 a.m., PCT yed fruit fly / dark-eyed fruit ger than regular fruit flies and ection of food /organic waste cations, which can be ugh cleaning of breeding sites and garbage collection areas. If flies, during the warmer states areas such as drains ains) may need to be sich included removing the floor eaning the undersides as well. It is to M-A that all drains be sinch included removing the floor eaning the undersides as well. It is to M-A that all drains be sinch included removing all forms of the suggested to M-A that all cluding vinyl and ceramic tiles) that and black and potential areas that be the moisture. These areas need and disinfected. PCT stated ats, once it freezes outside by decrease in numbers, but as thouse, fruit and black-eyed fruit dark areas will allow them to throughout the winter. PCT are of "sewer flies" while the would breed, appear to be no open sewer lines not	F 46	9		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY PLETED
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F 490 SS=F	Insect Control (efferindicated: "The centresidents, staff and pests by controlling with outside pest compolicy did not indicated would attempt to compolity of the continuity of the control of the contr	ility's policy, entitled: Pest / ctive July 2015), the policy ter strives to protect the visitors from insects and other infestations through contracts ontrol agencies." However, the ated how they, as a facility, ontrol and prevent infestations i.e.: containment of refuge, and cleaning breeding areas, a / removal of organic matter - e PCT). E //RESIDENT WELL-BEING ion. dministered in a manner that a resources effectively and or maintain the highest I, mental, and psychosocial resident. NT is not met as evidenced or and document review, the e adequate resources and corporate ownership and orrect and maintain compliance ty concerns related to resident at staffing. This had potential	F 49		eated d staff colicies cractice. ions t care are alified,	11/13/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG	\ , ,	E SURVEY PLETED
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F 490	agency (SA). The deficiencies being F164 (a lack of personal perso	e survey resulted in several cited, including examples at ersonal privacy being provided res), F282 (not implementing the re), F312 (not providing activities lependent residents), and F353 equate staffing to meet red needs). The facility listed a for each of these identified hich had a completion date 17. It recertification survey, the resident care and grare still occurring as follows: It o ensure they had followed up rented at resident council residents. During interview on a.m. the resident council residents. During interview on a.m. the resident council residents. The resident resident resident regarding closure of the resident regarding and 11:30 a.m., and reded period of time before reconstinent received care by resident council meeting minutes resident	F 49	reviewed by Executive Director Services and Director of Clinicato be appropriate. Resident Centered Staffing Co (RCSC) created to implement center's ongoing acuity level. It staffing assessments will be continued the resident centered staffing of at a minimum of monthly on the care units and weekly on the T determine staffing ratios and staffing coordinator educated on the acuity based staffing coordinator educated on the acuity based staffing and make adjust needed for acuity of the reside input from the floor staff working assigned units. The Client Sup Center's clinical and operations provide clinical and administration oversight of the facility on weel monitor plan of correction, facing and procedures and standards facility staff will continue with a reviews of the plans of corrections tated under individual F-tags. Will be incorporated into the facing program and will be reviewed by the QAPI comonthly x 3 months for opportion continued quality improvement	al Services mmittee and monitor Acuity onducted by committee e long term CU to taff care. ED, have been staffing Director of asis the ator will stments as nts with ng the port s staff will tive kly visits to lity policies of practice. audits and on as Reviews cility QAPI by the Client of upon visits and visits ommittee unities of	
	from 3/2/17 to 9/7 including staffing slong call light wait living including dreares, and groom nursing staff to ad	/17 identified multiple concerns shortage that was related to s, not providing activities of daily essing, incontinence, personal		to the facility. All findings of reviews, audits a will be reviewed by the QAPI c monthly x 3 months for opportu	and visits ommittee unities of	

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F 490	removing the reside 8/3/17, resident coresidents inquired available for a law management staff nurses/aides avail wanted managemeline staff (nurses, a During interview or director of social shaden acting as the since July of 2017 resident concerns and staffing concerouted to the exect follow through. The frequently address resolution for the sa concern voiced hindication the facilic communicated with concerns, nor was During interview of stated she was apposed month ago, and was regarding staffing were working on the R82's annual Minit 6/27/17, indicated During interview of stated the facility who wever, managed census, so they converse working assistant of the same and the facility of the same and the same an	lent store from the facility. The buncil minutes reflected the whether legal services were suite against the facility and so they would have adequate able to meet their need. They ent staff cut instead of the front and nursing assistants). In 10/5/17, at 10:48 a.m. the ervices (DSS) stated he had a liaison of the resident council. There had been multiple identified related to nursing rns. These concerns were utive director (ED) to review for a DSS stated staffing was seed but there has been no staffing concerns which are still by the residents. There was no ty management had the residents about these a resolution identified. In 10/5/17, at 2:35 p.m. the ED pointed approximately one as aware of residents concerns and provision of cares and	F 490				

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F 490	the past months, g staff to only four. I being answered tir for over an hour be Further, NA-G staft these concerns wi however, nothing i as staff are told by provide additional R48's quarterly MI R48 was cognitive catheter and requi toilet. During intervance and requi toilet. During intervance and make staff one to two hour further, R48 stated she ne catheter and make staff one to two hour further, R48 stated facility to allow her to treat chest pain because it took so administer them make to treat chest pain. R24's quarterly MI was cognitively into total dependence of the country into total dependence of the country into the country into total dependence of the country into the country into total dependence of the country into the country in	floor had been decreased in joing from five scheduled NA NA-G stated call lights were not mely still, at times, being left on efore staff are able to respond. The continued short staffing, is done to improve the situation of management they can not staff due to a low(er) census. OS dated 6/17/17, indicated ly intact, had an indwelling red extensive assistance to view on 10/1/17, at 3:55 p.m. eded to empty her own the her own bed because it took for the own to answer her call light. In the introglycerin (medication used to be left at the bed side, long for staff to come and the edication when she was having to staff for ADL's. When 2/17, at 1:28 p.m. R24 stated ough nursing assistants and the nour or more to have call lights all light would be answered and say they would be back and or two hours. This has being on the bed pan and it gry," and has been incontinent sistance. They don't have the staff they have are leaving	F 49			

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F 490	10/3/17, at 11:02 a was "horrible." So were not being me residents that nee HUC-A stated their assistant on 4th floonly scheduling for frequently called the answer the call light three to four times R2 to his room an clothing, because time to assist him. RN-G stated on 10 two nursing assist wing of the 4th floor assistants. RN-G residents out of 20 people for transfer had a lot higher act with management brought up staffing not in the budget to The management level of care these residents are leavilive because their the lack of staff. Assistant Director 10/3/17, at 3:15 p scheduled in the facall in, the ADON's floor providing per medications. We get the staff of the staf	nator (HUC)-A stated on a.m. the staffing on 4th floor ometimes the resident needs at as there were a lot of ded two people to assist them. The used to be five nursing foor, but now management was fur nursing assistants. R6 for facility, when staff did not that. R55 was soiled with urine as a week along with R2. She got did changed his urine soiled the nursing staff didn't have the	F 49				

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F 490	staff, but we do the schedules by the noregarding their carrincrease in falls and to the staffing level. The facility's Medic 10/5/17, at 2:33 puregular basis for so stated he was awa concerns related to turn-over which has facility and he was cited in the past fo MD-A was not fully concerns (i.e. groot lack of timely repost breakdown, and based had also been ider facility administratifindings at a meeting the plans to address on the back burner again." MD-A state the facility faced where always, "compreplaced with new ownership group sunderstand the new ownership	sidents regarding not enough be best we can. The facility umber of resident not e needs. There has been d incontinence directly related	F 490			
	Further, MD-A stat	oudget and economic issues." ed he could recommend, "a to help improve patient care,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 490	however, if the mor facility it, "just does get it done." On 10/5/17, at 4:18 (ED), assistant exe assistant executive director of nursing quality (DOQ) were identified concerns she was aware resi in the facility adding and that's not what need to get the nursinvolved. DOQ stafacility was better thad originally cited investigation, howe many applicants for the administration is concerns remained survey in July 2017 formal process in practices identified survey process. During interview on director of quality (If facility management Medicare/Medicaid sanctioned the facility management (MC) and Medicaid	rey is not provided to the n't happen," and, "you can't p.m. the executive director cutive director (AED)-A, director (AED)-B, interim (DON) and the director of interviewed regarding the during survey. DOQ stated ident care concerns remained g, "we need exceptional care we have." ED stated they sing management team more ated she felt staffing in the nan it had been when the SA during a complaint ver, they wre still not getting repositions. Further, ED stated had identified care related in the facility since the SA, however, there was no lace to correct deficient by the team on the current 10/5/17, at 5:15 p.m. the DOQ) reported she and the at knew that Center Services (CMS) had lity. They were under the emedy for new admission, ecause the facilty has not at to keep taking new Medicare (MA) admissions, even will not receive any reimbursed	F4	90		

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	PROVIDER OR SUPPLIER VALLEY REHABILIT	ATION AND CARE CENTER		75	REET ADDRESS, CITY, STATE, ZIP CODE 505 COUNTRY CLUB DRIVE OLDEN VALLEY, MN 55427		
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F 490	On 10/5/17, an interest deputy director of right shad left the care available for interving received on 10/10/DDON stated shew here in July 2017, and related to resident staffing. DDON stated to resident staffing. DDON stated develop the however, "that is pure from our corporate some audits being educator. DDON corporation had, "rehelping the staff condition and adding all of the unidentified a need for they are merely toke for it," by the corporation that they are merely toke for it," by the corporation stated staff were not supplied they are told adding quite often indicate they were referred patients, he listen and, "they [the anyway."	age 206 erview was attempted with the aursing (DDON). However, inpus and was no longer ew. A return phone call was 17, at 12:02 p.m. from DDON. was aware the SA had been and cited several concerns care areas and insufficient atted the corporate nurse had plan of correction at the time, retty much all the involvement, "they had received aside from completed by a corporate stated the ownership eally no involvement," in rrect the identified concerns it managers in the facility had a additional staff, however, d, "we don't have the budget rate ownership. DDON stated do been voiced to the facility porate nurse and the regional ins. The DDON went on and obtain the properties of the residents, as and the residents, as and the residents, as and the residents of the residents of the residents of the ed to care for the residents, as and the regional control of the residents of the reside	F 4	.90			
F 497 SS=E	and responsibilities provided.	was requested, but was not SE AIDE PERFORM	F 4	97			11/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245186	B. WING		10/	05/2017	
	PROVIDER OR SUPPLIE	R ITATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	•		
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F 497	The facility must of every nurse aid months, and must education based reviews. In-service requirements of § This REQUIREM by: Based on intervice facility failed to ender reviews were conducted assistants (NA-C whose personnel assistants (NA-C whose personnel assistants include: An untitled, undained for reviewed for reviewed for reviewed for reviewed identified the following that their results in the following for the same in the following for the same in the following for t	Service Education complete a performance review de at least once every 12 trovide regular in-service on the outcome of these ce training must comply with the (483.95(g)). ENT is not met as evidenced ew and document review, the insure annual performance inpleted timely for 5 of 5 nursing in NA-F, NA-G, NA-H, NA-I) records were reviewed. The distingtion of employees was as we during the survey. The listing twing nursing assistant (NA) espective hire date(s): in August 2016, in July 2015, in July 2015, in February 2016 and,	F 4	Identified 1) NA-C, NA-F, NA-G, NA-F had their nursing assistant ecompleted. Like 2) NARs requiring annual perovaluations will be completed evaluations moving forward completed in month of annix Education 3) Human Resource Manageducated on importance of assistant evaluations and trains been created to ensure and monitoring. Nurse manaeducated on timely completinursing assistant evaluation Monitoring 4) HR will audit employee fifor anniversary dates and corperformance evals and forw ED. ED to present findings committee monthly x 3 mon	erformance ed. All to be versary date. Her has been timely nursing acking system compliance agers ion of annual is. Hes monthly completion of vard findings to at QAPI		
	were hired. DWN	luation completed since they I stated the facility was going to m for how performance		Executive Director of monitor	or compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245186	B. WING _		10/0	5/2017
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F 497	completing them go yearly anniversary on none of the reviewed disciplinary actions A facility Employee	ompleted, however, were only bing forward as the employee's came. Further, DWM stated ed NA staff had any current	F 49	7		
F 501 SS=F	completed, "at leas 483.70(h)(1)(2) RE MEDICAL DIRECT (h) Medical director	t annually." SPONSIBILITIES OF OR t designate a physician to	F 50	1		11/13/17
	(i) Implementation (ii) The coordination This REQUIREMENT	of resident care policies; and of medical care in the facility.				
	facility failed to ens the medical directo concerns related to and insufficient staf addressed and reso affect all 94 resider Findings include: A Centers for Medic (CMS) 2567 report abbreviated standar	and document review, the ure on-going collaboration with to ensure identified quality activities of daily living (ADLs) fing were adequately olved. This had potential to ats in the facility. Care and Medicaid Services dated 7/10/17, identified an rd survey had been conducted d to four separate complaint		1) Medical Director was updated or 10/5/17 by ED and DON to promote ongoing collaboration and communito include but not limited to quality concerns related to activities of daily and insufficient staffing. Weekly communication and status call has scheduled with medical director, ED DON. 2) Medical Director updated on 10/2 with ED, DON, and AEDs about deficiencies received in the 2567. GValley team communicated plan of correction for deficiencies with Med	been), and 20/17 Golden	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING						
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F 501	investigations which agency (SA). The deficiencies being F282 (not impleme F312 (not providing dependent resident adequate staffing the needs). The facilities ach of these ident a completion date. During the current following examples identified: The facility did not the care plan for 2 assistance for reportequired range of monitoring not constage 3 pressure uliving (ADL's) were who were depended F282 for additional. The facility did not care, bathing and presulted in resident unkept hair, and stodor for 3 resident staff for activities of information. The facility did not to meet activities of information. The facility did not to meet activities of residents whom we ADL's, 2 residents residents with rangements.	ch had been filed with the State e survey resulted in several cited, including examples at enting the written plan of care), g activities of daily living for ats), and F353 (not providing to meet residents' assessed by listed a plan of correction for tified concerns, all of which had identified of 8/16/17. The recertification survey, the state of continued concern(s) were provide cares as identified on resident who required staff continued to resident whom motion. Pressure ulcer appleted for 1 resident with a allcer, and activities of daily and provided for 3 residents ent upon staff for ADL's. See	F 50°	Director. 3) ED, DON, and AEDs educated reviewed policy of Medical Director coverage and Medical Director agreement. Medical Director prova copy of agreement with center. 4) To ensure the medical director involved in any plan of corrections changes, compliance of polices the will communicate with the Medical Director through the quality assurated meeting, when the medical director rounds to see patients, or a phone conference when appropriate. Experience of Nursing we complete a medical director communication log weekly ongoin Director of Operations will review minutes monthly for medical director communication and medical director communication log for three monther than the property of the policy of the	ided with is s, polices ne facility l ance or e ecutive vill g QAPI ttor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
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F 501	residents and 14 s concerns about th to provide care an facility. Refer to F3 When interviewed medical director (Nacility on a regula MD-A stated he was concerns related to turn-over which has facility. MD-A stated had been cited in however, was not care concerns (i.e. completed, lack of skin breakdown, a which had also be facility administrated findings at a meeting the plans to addre on the back burner again." MD-A stated he was included on to help needs to be done, MD-A stated he was immediate jeoparc current survey from and he would call immediately. On 10/5/17, at 2:5 director (ED), assi (AED)-A, and regis (DOQ) were intervi-	age 210 ed. In additional there were 16 staff members whom voiced e lack of sufficient nursing staff d services to residents in the 353 for additional information on 10/5/17, at 2:33 p.m. the MD)-A stated he came to the r basis for scheduled meetings. as aware the facility had some o staffing and rapid personnel ad, "cut across all," levels of the ed he was aware the facility the past for staffing concerns, fully aware of all the identified . grooming not being f timely repositioning to prevent and bathing not being done) en found. MD-A stated he and ion had reviewed the cited SA ing recently, however, some of ss them must had been, "put r," or, "we're never looked at ed the continued concerns of ompleted for residents, e issues," which he should be of develop a plan with, "what " to correct them. Further, as unaware the facility had an dy (IJ) determination on their m two days prior, on 10/4/17, the facility to discuss this 6 p.m. the current executive start executive director stered nurse director of quality riewed. DOQ stated MD-A was to the facility and available	F 501				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY MPLETED
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F 501	DOQ stated MD-A deficiencies cited of survey, however, and his involvement with to address them. Should have involved addressing the idea of the foliated objectives in the director, " ensured in the monitoring of coordinating medical director, " ensured in the monitoring of coordinating medical director, the agreer responsibilities of the "Provide medical director of the responsible for appropriate steps to the medical director of the medical director	ions or needs arose from staff. had been made aware of the during the last complaint dded she was, "unaware," of the developing any action plans Further, DOQ stated they ed MD-A more when ntified concerns. irector Agreement dated MD-A to be the current, acting or the facility. The agreement cluding to have the medical enthat residents at the Facility dical care," and, " assisting of resident care polices and cal care in the Facility." ment listed several the medical director including, irection and overall dical care in the Facility," and, revaluating and taking of correct situations of possible all care that is identified by or dical Director." (2)(i)(ii)(h)(i) QAA MBERS/MEET NS ment and assurance. maintain a quality assessment mittee consisting at a	F 50°			11/13/17
	(,	· · · · · · · · · · · · · · · · · ·				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TATION AND CARE CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 COUNTRY CLUB DRIVE BOLDEN VALLEY, MN 55427	,	
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F 520	staff, at least one of administrator, own individual in a lead (g)(2) The quality a committee must: (i) Meet at least que coordinate and evaluation in a lead coordinate and evaluation in action to correct id (h) Disclosure of in Secretary may not records of such coordinate and in such committee will section. (i) Sanctions. Good committee to identity deficiencies will no sanctions.	ther members of the facility's of who must be the er, a board member or other	F 520	·		
	facility failed to ensite team developed a improvement progidentified resident	w and document review, the sure the quality and assurance nd revised a quality ram to correct staffing and care issues, previously ctice had the potential to affect siding in the facility.		Identified 1) The center has developed a quassurance and improvement plan. will maintain a QAPI committee whinclude monitoring any deficient profor quality improvements to include not limited to F164, F282, F312, F3 and F309. The medical director will	Center ich will actices but 353,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		E SURVEY PLETED
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F 520	Findings include: A Centers for Med (CMS) 2567 report abbreviated standat the facility relation investigations white agency (SA). The deficiencies being F164 (a lack of personal private of daily living for contract of the which had a composite of the which had a composite of the current following example identified: - See F164; as the personal privacy for during observation. - See F282; as the plan interventions for 2 of 3 resident staff assistance for (R121) whom required addition, skin more resident (R6) with activities of daily I completed for 3 of dependent upon staff assistance for separation of the complete of the comple	dicare and Medicaid Services at dated 7/10/17, identified an lard survey had been conducted ed to four separate complaint ch had been filed with the State survey resulted in several picted, including examples at ersonal privacy being provided res), F282 (not implementing the re), F312 (not providing activities lependent residents), and F353 equate staffing to meet ed needs). The facility of correction listed a correction rese identified concerns, all of oletion date identified of 8/16/17. It recertification survey, the res of continued concern(s) were refacility failed to provide for 1 of 6 residents (R121) resonal cares are facility failed to ensure care was implemented as directed as (R134, R121) who required for repositioning; 1 of 1 resident uired range of motion. In nitoring not completed for 1 of 2 a current pressure ulcer and residents (R183, R55, R2)	F 52	actively involved in the QA and plans. Like 2) Action plan will be deverall the plan of correction dequality assurance and perfimprovement meeting to be monthly basis. QAPI meetheld to include the Execut Director of Nursing, Medicat a minimum 3 other mentstaff. Education 3) Each leadership team in been educated on account actively participating in our assurance and performant process that include efficient for monitoring, revising, and documenting and improving Leadership team members on responsibility for bringing correction audits and mon present compliance results committee. QAPI policy a have been reviewed and leadership team members have been educated monthly for indicated by the individual correction and will be reviewed and will be reviewed and leadership team members have been educated by the individual correction and will be reviewed and leadership team members have been educated by the individual correction and will be reviewed and leadership team members have been educated by the individual correction and will be reviewed and leadership team members have been educated by the individual correction and will be reviewed and leadership team members have been educated by the individual correction and will be reviewed and leadership team members have been reviewed ha	eloped to review deficiencies at formance of reviewed on a setings will be give Director, and Director and onbers of facility on the set of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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F 520	residents were ass 3 of 5 residents (R: activities of daily liv dependent on staff - See F353; The fa nursing staff to meliving for 3 resident dependent upon staff (R134, R121) revier residents (R121) versidents (R19, R: authorized staff duadditional there we R196, R180, R162 R130, R192, R43, members (RN-C, FADON-A, HN-A, LFNA-H, ADON-C, A: about the lack of sicare and services to Con 10/5/17, at 4:18 (ED), assistant executive director of nursing quality (DOQ) were effectiveness of the to correct deficient team met monthly DON, physician, ar	isted with personal hygiene for 55, R2, R183) reviewed for ring (ADL) and who were	F 5	220	the action plan is updated monthly three months. ED and Director of Operations will compliance.		
	meeting discussed such as staffing (re control, financial, re census information identifies an issue	standard quality measures stention and turnover), infection e-hospitalization, safety and . ED stated if the QA team it is made a focus for the next of AED-A and ADA-B stated the					

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F 520	facility started a care each manager meet identify concerns the the manager brings team to address. The process and complimited information, but did forward with the process and complimited information, but did forward with the process are quired. The QA team has identify staff telling people in to it when they have lot of time re-educated discipline. "We need not what we have." improvement since as this team listens important part of starecognize they are nursing managements at the from a staffing an improvement in June and July of 20 was better able to go DOQ stated the fact applicants; however then in June and Justaff retention and the recognize staff such doing a snack cart, staff on medical least five random audits team had identified although the team in caring partners it we no formal process in practices identified	ge 215 ring partners program where ets with a group of resident to the resident may have. Then the concerns to the nursing they have just started the eted the first month of tracking not have a formal plan to go orgam or how they are brought forward are followed to DOQ stated a big factor the fied is a culture among the tisn't their job, or they will get to time. The team has spent a ting staff and following up with the dexceptional care and that's There has been some the change of administrators, to the staff, which is an aff retention. ED stated they not nurses and need to get the ent team involved. The DOQ and perspective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the transpective there has been staffing, and it is better that the coverage for staff call-ins. the transpective there has been staffing and it is better that the transpective there has been staffing and it is better that the coverage for staff call-ins. the transpective there has been staffing and it is better that the coverage for staff call-ins. the transpective there has been staffing and it is better that the coverage for staff call-ins. the transpective there the transpective there the transpective there the transpective the transpective the transpective the transpective the transpect	F 5	520			

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F 520	concerns with deficit articulate what chain correct the previous the facility meets the facility of cacustomers through approach to improve and services. The facility opportunities gaps in systems or implement an improvement and continuously minterventions. Each Client Support Cenparticipating in the Quality Assurance almprovement (QAF efficient mechanism analyzing, document in the following area (Satisfaction), Empuse, Satisfaction),	cient practices and could not inges they made to the plan to saly cited deficiencies to ensure the minimal requirements. Quality Assurance and evement (QAPI) Process ated "The center pursues the fare and services for their a data-driven, proactive fing the quality of life, care, activities of QAPI involve els of our organization to: as for improvement; address processes; develop and evement or corrective plan; conitor effectiveness of Center leadership team with the saccountable for actively formalized and documented and Performance PI) Process that includes ans for monitoring, revising, and improving processes as at a minimum: Customers aloyees (Turnover, Registry Quality of Life/Care (QMs, spital, Restorative, 5Star, NOI, DSO, Labor),	F 52	20		

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245186 10/13/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARE CENTER GOLDEN VALLEY, MN 55427** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE **REGULATIONS HAS BEEN ATTAINED IN** ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 13, 2017. At the time of this survey, Golden Valley Rehab & Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145

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

TITLE

(X6) DATE

Electronically Signed

10/26/2017

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

Facility ID: 00112

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED		
		245186	B, WING			10/	13/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		7505 COUNTRY	S, CITY, STATE, ZIP CODI CLUB DRIVE LEY, MN 55427	E	
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K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defice 2. The actual, or possible for concern a reoccurrence of the defice of the deficiency of the defic	state.mn.us and an@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rection and monitoring to rence of the deficiency. hab and Care Center is a th a partial basement that was 22 and was determined to be of truction. The facility is fully out by an automatic fire and has fire alarm system with a resident rooms, corridors and a corridor that is monitored for officiation.	KO	00			
K 223 SS=C	NOT MET as evid NFPA 101 Doors v Doors with Self-Cl	with Self-Closing Devices	K 2	23			11/13/17

Facility ID: 00112

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY PLETED
		245186	B. WING		10/	13/2017
	PROVIDER OR SUPPLIER	TATION AND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	AND DESCRIPTION TO THE ADDRESS	LD BE	(X5) COMPLETION DATE
K 223	Doors in an exit part or horizontal exit, starea enclosure are closed position, undevice complying volumes all such docompartment or enter the Required manua to Local smoke detection starea to smoke passing through smoke detection starea to the remark to sof power. 18.2.2.2.7, 18.2.2.2. This STANDARD Based on observation facility did not main passageways, stait exits, smoke barried 19.2.2.2.7, 19.2.2.2 could affect all 85 for Findings include: On a facility tour be 1500 on October 1 that the first floor Na fire rating tag.	assageway, stairway enclosure, smoke barrier, or hazardous e self-closing and kept in the eless held open by a release with 7.2.1.8.2 that automatically ors throughout the smoke entire facility upon activation of: I fire alarm system; and ectors designed to detect ough the opening or a required system; and eler system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 is not met as evidenced by: attion and staff interview, the entain self-closing doors in exit arway enclosures, horizontal ers, or hazardous areas.	K 2	Identified The fire door identified that was its fire rating tag will be replaced Person Responsible/Monitoring The Maintenance director or des completed an audit to ensure no doors were missing the fire ratin The maintenance director will re to ensure all fire doors have project rating identification on the doors regular audits to prevent reoccur	ignee has other fire g tag. sponsible per fire through	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00112

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORD	ER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has	issued ion, it is cited violation rdance rule of seen tag below. ure to sidered upon rule will f the item				
	that may result fron orders provided tha the Department wit	hearing on any assen n non-compliance wit at a written request is hin 15 days of receip ent for non-compliance	h these made to t of a				
Minnesota D	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the ele nsure orders consiste artment of Health in 14-01, available at tate.mn.us/divs/fpc/p e licensing orders are	ent with				
		DER/SUPPLIER REPRESEN	TATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed 10/26/17

STATE FORM 6899 If continuation sheet 1 of 212 X11C11

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	
GOLDEN	VALLEY REHABILITATION AND CARE		NTRY CLUE Valley, MN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being subnyou electronically. Although no plan of cis necessary for State Statutes/Rules, plenter the word "corrected" in the box avatext. You must then indicate in the electr State licensure process, under the head completion date, the date your orders wis corrected prior to electronically submittin Minnesota Department of Health. On 10/1 thru 10/5/17, surveyors of this Department's staff, visited the above prothe following correction orders are issue Please indicate in your electronic plan of correction that you have reviewed these and identify the date when they will be confident of Minnesota Department of Health is documented to Minnesota Department of Health is documented to Minnesota State Statutes/rule Nursing Homes. The assigned to Minnesota state statutes/rule Nursing Homes. The assigned tag number appears in the column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in "Summary Statement of Deficiencies" coand replaces the "To Comply" portion of correction order. This column also including shich are in violation of the state after the statement, "This Rule is not me evidence by." Following the surveyors fir are the Suggested Method of Correction Time period for Correction. PLEASE DISREGARD THE HEADING OF FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION APPLIES TO FEDERAL DEFICIENCIES THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUE	orrection ease allable for onic ing II be go to the ovider and d. forders, ompleted. Imenting sing es for e far left ate the oblumn the des the e statute et as and OF THE I." THIS GONLY.	2 000		

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLI IILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00112	B. WI	NG		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILITA	ΔΙΙ()Ν ΔΝΙ) (:ΔΚΙ	COUNTRY EN VALL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PR	D EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 00	00			
		CTION FOR VIOLATIONS (E STATUTES/RULES.)F				
2 130	MN Rule 4658.0050 duties) Subp. 1 Licensee;Genera	2 13	30			11/13/17
	nursing home is res control, and operati managed, controlle that enables it to us efficiently to attain of	I duties. The licensee of a sponsible for its manageme on. A nursing home must be done and operated in a manner its resources effectively a part of maintain the highest land mental, and psychosocial resident.	e er				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have adequate resources and guidance from the corporate ownership and administration to correct and maintain compliance with identified quality concerns related to resident care and insufficient staffing. This had potential to affect all 94 resident in the facility.		nce ent		Corrected		
	Findings include:						
	(CMS) 2567 report abbreviated standa at the facility related investigations which agency (SA). The deficiencies being of F164 (a lack of pers by staff during care	care and Medicaid Services dated 7/10/17, identified an ord survey had been conducted to four separate complains in had been filed with the State survey resulted in several cited, including examples at sonal privacy being providers), F282 (not implementing), F312 (not providing activi	ted tate				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	(not providing adeq residents' assessed plan of correction for concerns, all of white identified of 8/16/17. During the current of following examples concern(s) related inadequate staffing. The facility failed to on concerns present meetings to the rest 10/1/17, at 10:14 a representative, R3 anywhere with anytics.	pendent residents), and F353 puate staffing to meet dineeds). The facility listed a per each of these identified ich had a completion date 7. recertification survey, the reference of continued quality of care to resident care and are still occurring as follows: nensure they had followed up intended at resident council sidents. During interview on the resident council 1 stated, "We are not getting thing." R31 stated there have arding closure of the resident				
	store, understaffing variance of time of the morning from 7 there was an exten residents who were the facility staff. A review of the resi from 3/2/17 to 9/7/2 including staffing sl long call light waits. living including drescares, and groomin nursing staff to admersident complaints removing the resident singuired wavailable for a law smanagement staff.	g, slow response to call lights, medication administration in :30 a.m. and 11:30 a.m., and ded period of time before incontinent received care by dent council meeting minutes 17 identified multiple concerns nortage that was related to not providing activities of daily ssing, incontinence, personal ing. There was not enough ininister medications, and sof the administration ent store from the facility. The uncil minutes reflected the whether legal services were suite against the facility and so they would have adequate able to meet their need. They				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 4 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
	00112	B. WING		10//	05/2017
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10/0	33/2017
GOLDEN VALLEY REHABILITAT	TION AND CARE	INTRY CLUB VALLEY, MN			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
During interview on 1 director of social service been acting as the liar since July of 2017. The resident concerns idea and staffing concerns routed to the executive follow through. The Differequently addressed resolution for the staff a concern voiced by the indication the facility is communicated with the concerns, nor was a subject of the executive following interview on 1 stated she was appoint month ago, and was regarding staffing and were working on these R82's annual Minimus 6/27/17, indicated R8 During interview on 1 stated the facility was however, management census, so they could be staffing on the 4th floot the past months, going staff to only four. NA being answered times for over an hour befor Further, NA-G stated	t staff cut instead of the front d nursing assistants). 0/5/17, at 10:48 a.m. the vices (DSS) stated he had alson of the resident council here had been multiple entified related to nursing s. These concerns were ve director (ED) to review for DSS stated staffing was I but there has been no ffing concerns which are still the residents. There was no management had he residents about these resolution identified. 0/5/17, at 2:35 p.m. the ED inted approximately one aware of residents concerns d provision of cares and	2 130			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 5 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 130	however, nothing is as staff are told by provide additional services R48's quarterly MD R48 was cognitively catheter and require toilet. During interving R48 stated she need catheter and make staff one to two hour further, R48 stated facility to allow here to treat chest pain) because it took so ladminister them me chest pain.	ge 5 done to improve the management they cat taff due to a low(er) S dated 6/17/17, ind v intact, had an indwed extensive assistate where on 10/1/17, at 3:30 ded to empty here owhere own bed because its to answer here call she had to fight with nitroglycerin (medicate to be left at the bed ong for staff to come dedication when she with the staff of the	an not census. icated elling nce to 55 p.m. vn se it took I light. In the ation used side, e and vas having	2 130			
	was cognitively inta total dependence of interviewed on 10/2 there were not enoughed to wait a half he answered. The call then shut off, staff is don't come back for happened while be "made me very angwaiting for staff assenough staff, and the because of the heat Health unit coordinat 10/3/17, at 11:02 a. was "horrible." Sor were not being met residents that need HUC-A stated there	ct and required exte f staff for ADL's. Wh f/17, at 1:28 p.m. R2 ugh nursing assistan our or more to have light would be answ say they would be ba r two hours. This has ng on the bed pan a iry," and has been in istance. They don't in e staff they have are	nsive to en 4 stated ts and call lights ered and ick and is nd it continent have e leaving on h floor needs of sist them.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 6 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 CO	ADDRESS, CITY, S DUNTRY CLUE N VALLEY, MN	BDRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 130	only scheduling four frequently called the answer the call light three to four times at R2 to his room and clothing, because the time to assist him. RN-G stated on 10/1 two nursing assistates wing of the 4th floor assistants. RN-G stresidents out of 26 people for transfers had a lot higher act with management of brought up staffing not in the budget to The management is level of care these is residents are leaving live because their number the lack of staff. Assistant Director of 10/3/17, at 3:15 p.r. scheduled in the faccall in, the ADON's floor providing personnedications. We go and care plans. AD complaints from resistaff, but we do the schedules by the number of the staffing levels to the staffing levels the staffing levels to the staffing le	r nursing assistants. R6 e facility, when staff did not t. R55 was soiled with urine a week along with R2. She go changed his urine soiled he nursing staff didn't have th (3/17, at 2:53 p.m. there are hts scheduled to work each r, for a total of four nursing tated there are at least 11 on her wing that require two and care and the other wing hity level. We had a meeting one to two weeks ago and we concerns and were told it was add more nursing assistants is not taking into account the residents need. Some hig and finding new places to he eds were not being met do the form there are not enough aids cility to begin with. When NA's heed to fill in on work on the honal cares, and passing he behind on the assessments on-A stated there are a lot of his sidents regarding not enough hest we can. The facility higher of resident not he needs. There has been defincontinence directly related	e S. O			
		n, he came to the facility on a				

Minnesota Department of Health STATE FORM

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	TATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	Continued From pa	ige 7	2 130			
	regular basis for so stated he was awar concerns related to turn-over which had facility and he was cited in the past for MD-A was not fully concerns (i.e. groot lack of timely reposibreakdown, and bahad also been iden facility administration findings at a meeting the plans to address on the back burner again." MD-A state the facility faced with were always, "coming replaced with new pownership group so understand the need or staff. Their focu line," and they did rechanges for, "contineare." MD-A stated needs from corpora aren't there," and a was focused on, "b Further, MD-A stated number of things," however, if the mor facility it, "just does get it done." On 10/5/17, at 4:18 (ED), assistant executive director of nursing quality (DOQ) were	cheduled meetings. MD-A re the facility had some of staffing and rapid personnel d, "cut across all," levels of the aware the facility had been of staffing concerns. However, aware of all the identified care ming not being completed, sitioning to prevent skin of thing not being done) which tified. MD-A stated he and on had reviewed the cited SA reg recently, however, some of sits them must had been, "put the administration was they ing and going," and being persons, adding the current reemingly did not fully reds of the resident population is was the, "economic bottom and seem open to discussion or muing the promotion of quality of the support for resident care attended and economic issues." red he could recommend, "a to help improve patient care, mey is not provided to the and he could recommend, "a to help improve patient care, mey is not provided to the and he could rector (AED)-A, and the director of the interviewed regarding the during survey. DOQ stated				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 8 of 212 X11C11

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE SIRRET ADDRESS. CITY. STATE. ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY. MS STATEMENT OF DEPTICIENCIES AND SHARMY STATEMENT OF DEPTICIENCIES SUMMANY STATEMENT OF DEPTICIENCIES CROSS-REPERENCED TO THE APPROPRIATE BEGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COntinued From page 8 she was aware resident care concerns remained in the facility adding, "we need exceptional care and that's not what we have." ED stated they need to get the nursing management team more involved. DOQ stated she felt staffing in the facility was better than it had been when the SA had originally cited during a complaint investigation, however, there was no formal process in place to correct deficient practices identified by the team on the current survey process. During interview on 10/5/17, at 5:15 p.m. the director of quality (DOQ) reported she and the facility management knew that Center Medicare/Medicaid Services (CMS) had sanctioned the facility. They were under the denial of payment remedy for new admission, effective 91/5/17, because the facility has not been in compliance. She was directed by their facility management to keep taking new Medicare (MC) and Medicaid (MA) admissions, even though the facility will not receive any reimbursed for MC or MA residents. On 10/5/17, an interview was attempted with the deputy director of nursing (DDON). However, she had left the campus and was no longer available for interview. A return phone call was received on 10/10/17, at al cited several concerns related to resident care areas and insufficient staffing, DDON stated she was aware the SA had been here in July 2017, and cited several concerns related to resident care areas and insufficient staffing, DDON stated the corporate nurse had	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MANE OF PROVIDER OR SUPPLIER Total Column			00112		B. WING		10/	05/2017
CALLEY REABILITATION AND CART COLDEN VALLEY, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CASS PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRICED WIST BE PRECEDED BY PULL PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRICED WIST BE PRECEDED BY PULL PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRICED WIST BE PRECEDED BY PULL PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRICED WIST BE PREFIXED WIST BE PREFIXED WIST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COMPRISED WIST BE PREFIXED WIST BE PREFIXED WIST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRISED WIST BE PREFIXED WIST BE PREFIXED WIST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRISED WIST BE PREFIXED WIST BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH COPRISED WIST BE PREFIXED WIST BE PROVIDED WIST B	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) 2 130 Continued From page 8 she was aware resident care concerns remained in the facility adding, "we need exceptional care and that's not what we have." ED stated they need to get the nursing management team more involved. DOQ stated she felt staffing in the facility was better than it had been when the SA had originally cited during a complaint investigation, however, they were still not getting many applicants for positions. Further, ED stated the administration had identified care related concerns remained in the facility since the SA survey in July 2017, however, there was no formal process in place to correct deficient practices identified by the team on the current survey process. During interview on 10/5/17, at 5:15 p.m. the director of quality (DOQ) reported she and the facility management knew that Center Medicare/Medicaid Services (CMS) had sanctioned the facility. They were under the denial of payment remedy for new admission, effective 9/16/17, because the facility has not been in compliance. She was directed by their facility management to keep taking new Medicare (MC) and Medicaid (MA) admissions, even though the facility will not receive any reimbursed for MC or MA residents. On 10/5/17, an interview was attempted with the deputy director of nursing (DDON). However, she had left the campus and was no longer available for interview. A return phone call was received on 10/10/17, at 12:02 p.m. from DDON. DDON stated she was aware the SA had been here in July 2017, and cited several concerns related to resident care areas and insufficient	GOLDEN	I VALLEY REHABILIT	ATION AND CARE					
she was aware resident care concerns remained in the facility adding, "we need exceptional care and that's not what we have." ED stated they need to get the nursing management team more involved. DOQ stated she felt staffing in the facility was better than it had been when the SA had originally cited during a complaint investigation, however, they wre still not getting many applicants for positions. Further, ED stated the administration had identified care related concerns remained in the facility since the SA survey in July 2017, however, there was no formal process in place to correct deficient practices identified by the team on the current survey process. During interview on 10/5/17, at 5:15 p.m. the director of quality (DOQ) reported she and the facility management knew that Center Medicare/Medicaid Services (CMS) had sanctioned the facility. They were under the denial of payment remedy for new admission, effective 9/15/17, because the facility has not been in compliance. She was directed by their facility management to keep taking new Medicare (MC) and Medicaid (MA) admissions, even though the facility will not receive any reimbursed for MC or MA residents. On 10/5/17, an interview was attempted with the deputy director of nursing (DDON). However, she had left the campus and was no longer available for interview. A return phone call was received on 10/10/17, at 12:02 p.m. from DDON. DDON stated she was aware the SA had been here in July 2017, and cited several concerns related to resident care areas and insufficient	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
	2 130	she was aware res in the facility adding and that's not what need to get the nur involved. DOQ sta facility was better thad originally cited investigation, howe many applicants fo the administration is concerns remained survey in July 2017 formal process in practices identified survey process. During interview on director of quality (I facility managemer Medicare/Medicaid sanctioned the facil denial of payment reffective 9/15/17, been in compliance facility managemer (MC) and Medicaid though the facility was for MC or MA resid. On 10/5/17, an interest deputy director of rishe had left the car available for intervireceived on 10/10/10/10/10/10/10/10/10/10/10/10/10/1	ident care concerns ig, "we need exception we have." ED stated staying management the ated she felt staffing in an it had been where during a complaint ever, they wre still not repositions. Further, and identified care read in the facility since to a to correct deficitly by the team on the control of the	nal care d they am more in the n the SA d getting ED stated dated the SA d no ent current In the in	2 130			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 9 of 212

Minnesota Department of Health

00112 B. WING 10/05/2017	17
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	(X5) MPLETE DATE
from our corporate," they had received aside from some audits being completed by a corporate educator. DDON stated the ownership corporation had, "really no involvement," in helping the staff correct the identified concerns adding all of the unit managers in the facility had identified a need for additional staff, however, they are merely told, "we don't have the budget for it," by the corporate ownership. DDON stated these concerns had been voiced to the facility administrators, corporate nurse and the regional director of operations. The DDON went on and stated staff were not always even able to get the supplies they needed to care for the residents, as again, they are told, "we don't have the budget," adding quite often nursing management would indicate they were unable to care for newly referred patients, however, corporate would not listen and, "they [the new patient] would show up anyway." A facility policy on administration management and responsibilities was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The corporate owner(s) and or designees could review industry standards for staffing and budgeting for facility fiscal needs, and implement appropriate changes for the quality, health and safety of their resident population. The corporate owners or designees could complete audits of resident cares, resident saffaction surveys, staffing patterns and staff competency to ensure resident needs are consistently met. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			A. BUILDING:			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	TATION AND CARE	JNTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From pa	age 10	2 255			
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and ttee	2 255			11/13/17
	assessment and as of the administrator services, the medic designated by the rathree other member representing disciparesident care. The assurance committees respect to which quality deficiencies address, at a minim	ust maintain a quality surrance committee consisting r, the director of nursing cal director or other physician medical director, and at least ers of the nursing home's staff, lines directly involved in quality assessment and the must identify issues with a lity assurance activities are elop and implement of action to correct identified . The committee must num, incident and accident control, and medications and .				
	by: Based on interview facility failed as a q develop and revise program to correct care issues, previo	ent is not met as evidenced and document review, the uality and assurance team to a quality improvement staffing and identified resident usly identified. This practice affect all 94 residents residing		Corrected		
	Findings include:					
	(CMS) 2567 report abbreviated standa at the facility related investigations which agency (SA). The sideficiencies being of	care and Medicaid Services dated 7/10/17, identified an ard survey had been conducted d to four separate complaint h had been filed with the State survey resulted in several cited, including examples at sonal privacy being provided				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 11 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	ORESS, CITY, S NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 255	by staff during care written plan of care of daily living for de (not providing adeq residents' assessed plan of correction for concerns, all of whi identified of 8/16/17 During the current of following examples identified: - See F164; as the personal privacy for during observations - See F282; as the plan interventions of of 3 residents staff assistance for (R121) whom requit addition, skin monitoresident (R6) with a activities of daily living completed for 3 of 5 dependent upon staff - See F312; as the residents were assisted 3 of 5 residents (R5 activities of daily living dependent on staff) - See F353; The factorising staff to meet living for 3 residents dependent upon staff dependent upon staff (R134, R121) review	s), F282 (not implement), F312 (not providing pendent residents), a uate staffing to meet a needs). The facility or each of these identicated had a completion of the continued concert facility failed to provide of continued concert facility failed to ensure as implemented as (R134, R121) who repositioning; 1 of 1 red range of motion. For incoming not completed a current pressure ulding (ADL's) were not or residents (R183, Raff for ADL's. Ifacility failed to ensure the continuent pressure ulding (ADL's) were not or residents (R183, Raff for ADL's. Ifacility failed to ensure the facility failed to e	g activities and F353 in a listed a tiffied date in the n(s) were de l21) re care directed equired resident In for 1 of 2 cer and so the second second for large entry e	2 255			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 12 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED		
				A. BUILDING:			
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COL DEA	I VALLEY REHABILIT	ATION AND CARE	7505 COU	NTRY CLUB	BDRIVE		
GOLDEN	VALLET KENADILIT	ATION AND CARE	GOLDEN	VALLEY, MN	l 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	authorized staff due additional there we R196, R180, R162, R130, R192, R43, I members (RN-C, FADON-A, HN-A, LFNA-H, ADON-C, AS about the lack of sucare and services to On 10/5/17, at 4:18 (ED), assistant executive	properties of the director (AED)-B, who were not fed to limited staffing not re 16 residents (R48 R47, R6, R31, R24, R31, R66, R183) and IUC-A, NA-C, RN-E, PN-E, LPN-I, NA-E, NB) whom voiced condufficient nursing staff to residents in the factor (AED)-B, in the contive director (AED)-B, in the contive director (AED)-B, in the director (AED)-B, in the director d	eed. In , R28, R82, I 14 staff RN-G, IA-G, cerns to provide cility. director)-A, terim				
	quality (DOQ) were effectiveness of the to correct deficient team met monthly a DON, physician, an members, including meeting discussed such as staffing (recontrol, financial, recensus information identifies an issue i "few" meetings. ED facility started a careach manager meetings.	(DON) and the direct interviewed regardire quality assurance (or practices. ED stated and consisted at minuted at least three others tandard quality measurance and turnover enhospitalization, safe. ED stated if the QA is is made a focus for partners programets with a group of re	ng the QA) team the QA imum r staff the QA asures (asures the next stated the n where sident to				
	identify concerns the manager brings team to address. To process and complete information, but go forward wit the pensuring concerns up the need require factor the QA team among the staff tell	the resident may have a the concerns to the he have just started the first month of the did not have a form brought forward had bed. The DOQ stated a has identified is a cuing people it isn't the life is not the the the concerns.	e. Then nursing the of tracking al plan to are the follow a big ulture ir job, or				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 13 of 212

Minnesota Department of Health

MILLINESC	ta Department of He	aim					
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL	LIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	IUMBER:	A. BUILDING:		COMP	LETED
							
		00442		B. WING		40/0	E/2047
		00112]		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			7505 COL	INTRY CLUE	BDRIVE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		VALLEY, MI			
040.15	CUMMADY CTA	TEMENT OF DEFICIENC					()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENC MUST BE PRECEDED E		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORI		TAG	CROSS-REFERENCED TO THE APPROI		DATE
					DEFICIENCY)		
0.055	0 " 15	40		0.055			
2 255	Continued From pa	ige 13		2 255			
	has spent a lot of ti	me re-educating sta	aff and				
	following up with dis						
	exceptional care an						
	There has been so						
	change of administ						
	the staff, which is a						
	retention. ED state						
	nurse and need to						
	team involved. The						
	perspective there h						
	staffing, and it is be	•					
	2017. AED-B stated						
	get coverage for sta						
	facility was having						
	however, they have						
	and July 2017. AED						
	and the facility addi						
	such as: celebrating						
	cart, thank you care						
	leave. ED stated Q						
	at QA meetings. ED						
	identified care relat						
	team has started in		•				
	was just starting an						
	in place to correct of						
	the team or the sur	•	,				
	recognized ongoing						
	practices and could						
	they made to the pl						
	cited deficiencies to						
	minimal requiremen		incets the				
	minima requiremen	no.					
	The facility policy Q	Juality Δeeurance o	nd				
	Performance Impro						
	revised 1/17, indica						
	highest quality of ca						
	customers through						
	approach to improv						
	and services. The a						
	members at all leve	eis ot our organizati	on to:				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 14 of 212

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 255	gaps in systems or implement an improvement an improvement (Client Support Cenparticipating in the Quality Assurance almprovement (QAP efficient mechanism analyzing, documer in the following area (Satisfaction), Empuse, Satisfaction), Readmission to Ho Abaqis), Financial (I Growth (ADC, MC, SUGGESTED MET The corporate enity review past and curidenfied by both the and create effective revising as needed facility could monito plans made to ensuconsistently met.	es for improvement; address processes; develop and ovement or corrective plan; nonitor effectiveness of Center leadership team with ter is accountable for actively formalized and documented and Performance PI) Process that includes ns for monitoring, revising, nting and improving processes as at a minimum: Customers loyees (Turnover, Registry Quality of Life/Care (QMs, spital, Restorative, 5Star, NOI, DSO, Labor),	2 255			
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			11/13/17
	policies to guide sta physicians, physicia	ust develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 15 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	ORESS, CITY, S NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 265	legal representative member of a reside accident, or death. nursing services, ar attending physician development of the have criteria which appropriate notifica A. an accident results in injury and physician intervention. B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinical conditions or clinical example, a need to of treatment due to begin a new form or D. a decision to resident from the nurside accident.	e or an interested fanent's acute illness, se At a minimum, the ond the medical direct must be involved in se policies. The pol address at least the tion times for: involving the resident has the potential for on; change in the resident has the potential for on; change in the resident psychosocial status at ion in health, mention in health, mention in either life-threated complications; ter treatment signification discontinue an exist adverse consequent for treatment;	erious director of tor or an the icies must at which requiring ent's s, for ital, or ning antly, for ting form ces, or to	2 265			
	by: Based on interview facility failed to ensi representative was changes, updates of requiring injection of resident (R16) revie	and document revieure the resident's notified timely of meon condition and treat medication for 1 of ewed for notification	w, the edication tment		Corrected		
	Findings include:						

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GOLDEN	VALLEY REHABILITATION AND CARE	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE		
2 265	Continued From page 16		2 265				
	R16's quarterly Minimum Data Set (MDS completed on 7/13/17, identified moderate cognitive impairment and moderate dep R16's Admission Record dated 5/1/17, identified moderate dep R16's Admission R16's Admis	ate ression. dentified ontact #1,					
	hand written, undated entry identifying "I guardian."						
	During interview on 10/2/17, at 3:51 p.m stated the facility had called when a rece occurred, but notification had not been not related to medication changes or new or FM-A added R16 has had medication chand she had only became aware of it who reviewing the pharmacy statement. FM-she visited routinely and interacted with any concerns either during visit or via a call.	ent fall made rders. nanges nen -A stated staff with					
	A review of physician's orders of 7/16/17 identified medication changes were mad discontinue Cogentin (a medication used lessen the side effects of antipsychotic medications) and change to amantadine medication used to treat Parkinson's dis review of nursing progress notes did not order changes made, nor did it identify no f FM-A of any changes.	de to d to e (a ease). A t identify					
	A review of physician's orders noted R16 Seroquel 100 milligrams (mg) on 8/22/1 orders for one tablet every four hours as for psychotic behaviors. A review of nurs progress notes did not reflect the new or notification of FM-A of the new medication	7, with s needed sing rder or					
	A review of the nursing progress note da	ated					

Minnesota Department of Health STATE FORM

K11C11 If continuation sheet 17 of 212

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	Seroquel which had needed basis (PRN drug which was ord FM-A was contacte state and of medical documentation ider been medication chrecommendations. The next narrative idated 9/15/17, and joint injection. The nawareness of FM-A provided. A review of the physidentified a joint injection orders were receive nursing progress nonew orders or notification of the new medication) to increasing of orders for medication) to increasing of orders for medication of FM-A Upon review of reconotification of FM-A Upon review of reconotification of family not always docume 10/5/17, at 9:52 a.m. nursing (ADON)-B completed when the A policy was requesible physician orders and the same and	16 was given a dose of dibeen ordered on an as al). Seroquel is an antipsychotic lered for psychotic symptoms. dito inform of R16's mood ation administration. The intified FM-A stated there had hanges based on psychiatric mote on R16's record was addressed physician visit for note did not reflect the a regarding the interventions sician's orders from 9/15/17, ection had been given and ed for a Lidoderm patch. No obtes were present to identify fication of the responsible edication therapy. Togress notes identified a perfect of an arcotic pain ease dosage to twice daily. In documentation regarding a of change in treatment. The medication changes, are garding new orders was ented. During interview on the assistant director of stated this should have been de orders were processed.	2 265			
		bers of change in condition or out was not received.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 18 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		40/0	E/2047
NAME OF	PROVIDER OR SUPPLIER	l .	1	STATE, ZIP CODE	1 10/0	5/2017
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 18	2 265			
2 335	The director of nursidevelop policies for residents / family / physician orders ar or status. The DON licensed staff on the audits of physician resident care or state following those policity of the personne for each employee manner. The personne for each employee manner. The personner for each employee manner. The personner for each employee manner in the personner for each employee manner. The personner for each employee manner in the personner for each employee manner. The personner for each employee manner in the person for each employee manner. The personner in the person's number gender, Mor registration number gender, Mor registration number identifying data; B. a list of the interpretation in the person of the currently held, hour records; and	R CORRECTION: Fourteen D Employees' Personnel I record must be maintained and be stored in a confidential onnel records for at least the year period must be nursing home. The records o representatives of the	2 335			11/13/17

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	00112	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 10/0	0,2011
GOLDEN	I VALLEY REHABILIT	TATION AND CARE	7505 COU	INTRY CLUE	BDRIVE		
	Г			VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 335	Continued From pa	age 19		2 335			
	Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record.						
	by: Based on interview facility failed to ens reviews were comp assistants (NA-C, N	ent is not met as eving and document review annual performance bleted timely for 5 of \$100 NA-F, NA-G, NA-H, Necords were reviewed.	w, the nce 5 nursing IA-I)		Corrected		
	Findings include:						
	An untitled, undated listing of employees was provided for review during the survey. The listing identified the following nursing assistant (NA) staff with their respective hire date(s):						
	- NA-C was hired ir - NA-F was hired ir - NA-G was hired ir - NA-H was hired ir - NA-I was hired in	n July 2015, n July 2015, n February 2016 and,					
	and lacked any evi	nployee files were rev dence a performance n completed since da)				
	director of workford none of the five NA performance evalu were hired. DWM change the system evaluations were completing them go	on 10/5/17, at 1:00 p.ce management (DW staff reviewed had a ation completed since stated the facility was for how performance ompleted, however, voing forward as the e came. Further, DWN	M) stated te they s going to e were only mployee's				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 20 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 335	Continued From pa	ige 20	2 335			
	none of the reviewed disciplinary actions	ed NA staff had any current on record.				
	A facility Employee Performance Appraisals policy dated 7/2015, identified evaluations should be completed, "at least annually."					
	The director of nursing review policy for perstaff on those polici including nursing as performance has be designee could conto ensure the employer.	THOD OF CORRECTION: sing and/or designee could be reformance reviews, educate lies to ensure nursing staff, ssistance, to staffs' een reviewed. The DON or aduct audits of employee files be oyee performance reviews ed on a consistent basis.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 435	MN Rule 4658.0210 Assignments	0 Subp. 2 A.B. Room	2 435			11/13/17
	must develop and in procedures for addinctuding complaint and roommates. A procedures must in A. a mechanism resolution of room complaints; and	complaints. A nursing home mplement written policies and dressing resident complaints, as regarding room assignments a minimum, the policies and clude the following: m for informal dispute assignment and roommate for documenting the complaint				
	This MN Requireme	ent is not met as evidenced		_		

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,1 1979	0.2011
GOLDEN	N VALLEY REHABILIT	ATION AND CARE		INTRY CLUE			
0(4) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES		VALLEY, MI		ON	(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 435	Continued From pa	ge 21		2 435			
	facility failed to ensi- was provided to 2 of reviewed for facility discharge practices	and document reviewure notice of a new roof 3 residents (R130, admission, transfer as.	ommate R48)		Corrected		
ı	Findings include:						
		nimum Data Set (MD R130 was cognitivel					
	During interview on 10/02/17, at 2:22 p.m. R130 stated, "I will never forget the day my roommate moved in, I was watching television and he [R162] was brought in by the paramedics." R130 stated it was sometime this year in May, and stated he was never notified that he was getting a roommate by the facility.						
		nedical record did not of a new roommate.	t indicate				
		S dated 06/17/17, ide intact with no behav					
	stated she has had	10/01/17, at 3:59 p.r at least five new roo d of any new roomma	mmates				
	Review of R48's me R48 was notified of	edical record did not in new roommates.	indicate				
	director of social se a room change the The DSS stated the	10/05/17, at 11:41 a ervices (DSS) stated i y give them seven da e facility tries to let the ey get a new roomm	f they do ys notice.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 22 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
		00112		B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 435	indicated they do not record if they had o resident of a new room. A facility policy Proc Change effective Jathe attending physic room and/or roomm receiving the room indicated to monitor.	know. The DSS furt of document in the m r had not been inforr	nedical med the commate ed: "notify of the sident(s) re further ustment to	2 435			
	Social Service and/ review/revise facility educate responsible roommate changes relayed to all reside with another. The fa room/roomate chan timeliness of notice and ensure residen room/roomate chan	y policy for room char e staff to assure that and/or admissions a nts who will be shari acility could conduct ages in the facilty to a of room/roomate ch t satisfication with	nges, are ng a room audits of ensure anges				
2 560	(14) days. MN Rule 4658.0405 Plan of Care; Conte			2 560			11/13/17
	comprehensive plan objectives and time long- and short-tern and mental and psy	of plan of care. The n of care must list matables to meet the re n goals for medical, ochosocial needs tha nprehensive resident	easurable esident's nursing, t are				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 23 of 212

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa		2 560			
	assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).					
	This MN Requirement is not met as evidenced by:					
	Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R7) with respiratory failure, and 1 of 3 residents (R108) reviewed with behaviors.			Corrected		
	Findings include:					
	diagnoses of morbi hypoventilation (a fa oxygenate adequat chronic obstructive chronic respiratory admission Minimun indicted intact cognoxygen both prior to facility. The MDS all BIPAP/CPAP (a dev	cord, dated 9/14/17, identified d obesity with alveolar ailure of the lungs to ely), obstructive sleep apnea, pulmonary disease (COPD), failure with hypoxia. R7's n Data Set (MDS) of 8/16/17, ition and identified use of and during the stay at the so identified R7 had use of vice used to aid sleep apnea) on and following the cility.				
	was noted to have cannula with liquid R7 stated she was 8/9/17, however, warelated to respirator	on 10/1/17, at 9:57 a.m R7 oxygen in place via a nasal oxygen while up in wheelchair. admitted to the facility on as hospitalized on 8/19/17, by problems and sepsis (and oxygen therapy and a BIPAP of the facility.				
		sing progress notes identified don 8/19/17. The admission				

Minnesota Department of Health

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	history and physical admitted with respiratory was hospitalized with chronic respiratory identified R7 was eleacute psychosis, travalue indicating liver. A review of R7's Markecord (MAR) and Record (TAR) were records initially identified not provide an settings are used of machine for setting cleaning of the massof the humidifier book R7's care plan, revipotential for nutrition medical problems, However, the care complete specific noxygen saturation looxygen to use, or widentify any change status. On 10/4/17, at 9:49 nursing (ADON)-B plan and confirmed any respiratory prolinterventions, with thave impacted her had been recently hyproblems. The ADO	I (H&P) identified R7 was ratory failure and septic shock. Inmary of 8/26/17, noted R7 th diagnosis of acute on failure. The document experiencing septic shock, ansaminitis (abnormal labor failure) due to a shocked redication Adminsitration the Treatment Administration of conducted and although the ntified the use of CPAP/BIPAP, my specifications as to which rewhat to monitor on the st. The directions only outlined sk, humidifier bottle, and filling	2 560			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 25 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	TATION AND CARE	JNTRY CLUE			
	I	GOLDEN	VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 25	2 560			
	return from the hos					
	Totalli ilolli tilo iloo	picai.				
	R108 had diagnose psychotic disorder, schizoaffective and quarterly MDS date intact cognition, dis altercations and ne activities of daily liv Assessment (CAA) identified resident of	sheet, undated, identified es of intracranial injury, paraplegia disorder, bipolar disorder. R108's ed 7/24/17, identified he had sorganized thinking, verbal eded staff assistance for ring. The behavior Care Area worksheet dated 2/24/17, displayed delusions and h could cause behavior				
	R108 was yelling in home at (R71 and yourself in the mirror definition of ugly," a Service (SS)-B who R71 who is very up names all the time leaves the area. R7 confrontation, looki R108 about his yell minutes later, R71 administration offic (ED), and assistant AED-B and director yelling, he was "tire calling him "an Indi You have not done tired of it. All you to nothing gets done a no idea what I or (Fwe get called those The ED, and AED-	on 10/3/17, at 10:12 a.m. at the entry way of the nursing R201) stating, "Look at or and you will see the and R71 yells back. Social om was in the area talks to set yelling (R108) calls us and nothing happens, R71 108 remained in area after the ing around, no one talked with ling at R71. At 10:16 a.m., four was outside of the e yelling at executive director at executive director (AED)-A, or of quality. R71 very upset and of him [R108] yelling" and an", and (R201) a "Nigger". anything about this, and I am sell (R108) to do is calm down, and I am sick of it. You have R201) have gone through when als names. "I am sick of it!" A tried to calm R71 down. R71 stration (R108) "bums				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 26 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
		00112		B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	cigarettes" from (Rihim get mad at her (R108) goes off on and he gets 3-4 cig R71 was yelling at a sitting in his wheeld away, smiling and gwatching R71 yelling staff. R108's Mood and EPlan review on 8/8/disorder, and used and antianxiety medincluded, monitor for altered perception of speech, lethargy, challucinations and of staff interventions into deal with R108's using profanity and residents to help definitely behaviors of with very "colorful" regular basis but all well, his main focus behaviors. Associate told us to develop a cigarettes so his medium would stop him from the started to sell the complained they we not like the taste, so program at the endi	192) all the time. I had, she doesn't like it we people, so she gives arettes a day from headministration. R108 shair approximately 1 grinning with enjoymer geat the facility admit antipsychotic medical dications. The interverside effects, period or awareness, disorghanged in cognitive leading of the ecrease these behaves the sees and the se	then s into him er. While s was 5 feet ent while nistraiton t Care affective ations, entions ds of panized evel, vere no f on how emanding, er iors. n. with as lots of esidents on a em as s y (ACP) roll his nd this sidents. ts, then he and did this ave not	2 560			

Minnesota Department of Health

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	A policy titled Care identified the care pregarding how the owith issues and/or to provide for a resion of well being." The bullet one: "Initate the according to the RA instrument) process change in condition." SUGGESTED MET The director or nurseducate responsibly resident-centered of comprehensive assistant of the process of the pro	Plans, revised January 2017, plan: "Provides information causes and risks associated conditions can be addressed dent's highest practible level procedure identified under the appropriate Care Plan AI (resident assessment and as needed with resident as and as needed with resident the staff in creating and/or designee could be staff in creating the same plans, utilizing resident assessments. R CORRECTION: Twenty-one	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident This MN Requirement by: Based on observation review the facility fare.	omprehensive plan of care personnel involved in the involved invol	2 565	Corrected		11/13/17
	of 3 residents (R13 assistance for repo	4, R121) who required staff sitioning; 1 of 1 resident red range of motion. In				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 28 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	addition, skin monit resident (R6) with a activities of daily livicompleted for 3 of \$\frac{1}{2}\text{dependent upon stars} findings include: REPOSITIONING: R134's significant of (MDS) dated 07/13, cognitively impaired two with bed mobility MDS further indicate ulcers and had no provide the required be repositioned every pressure relief surfaindicated he required be repositioned every pressure relief surfaindicated he was in bladder. R134's Act Care Plan dated 10 of urinary tract infection of urinary traction of urinary tracti	oring not completed current pressure ulding (ADL's) were not residents (R183, Raff for ADL's. Change Minimum Dat 177, indicated he was ly, transfers and toile ed he was at risk for	cer and 55, R2) a Set a severely assist of eting. The pressure ention 13/17, and was to provide a care plan ad ection d a history catheter. 7, from 2 minutes) Broda without changed. 6 from the a.m. R134 ion in the e Broda	2 565			
	dinning room. At 10	ed R134 from the ha 0:02 a.m. RN-K hosp nto the hall across fr	ice nurse				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 29 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112		B. WING		10/	05/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	TATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 29		2 565			
	the hall in his Broda was still in hallway he was still asleep.	10:22 a.m. R134 was a chair. At 10:42 a.m in chair asleep. At 1 At 11:07 a.m. surve ssistant (NA)-M and I	. R134 1:00 a.m. yor				
	During interview 10/03/17 at 11:01 a.m. NA-N stated that he had repositioned and checked him for bowel incontinence right after breakfast around 8:30 a.m.						
	stated she had ass breakfast with repo she did not have a because they did no	0/03/17, at 11:12 a.m. isted NA-N right after sitioning R134. She chance to reposition ot have enough staff f two so she could not by.	indicated him again and that				
	total of 3 hours) NA reposition and chec of bowel and had a	10/03/17, at 11:30 a. A-J and NA-N was ob ck R134. R134 was o catheter for urine. In tact with no open are	served to continent addition				
	turned and reposition facility failed to imp	are plan indicted he woned every two hours lement his care plan three hours without	the and R134				
	orders dated 9/28/1 Alzheimer's demen Minimum Data Set indicated R121 was	as identified on phys 17, included early ons itia. A significant cha (MDS) dated 8/18/17 s totally dependent up al assistance of two	set nge 7, oon and				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 30 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOI DEN	I VALLEY REHABILIT	ATION AND CARE	7505 COU	INTRY CLUE	DRIVE		
GOLDLI	VALLET KEHADILIT	ATION AND CARE	GOLDEN	VALLEY, MN	I 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 30		2 565			
	personal hygiene. a stage 4 pressure involving bone, must R121's "Skin Integrand Treatment Car pressure ulcer to coreposition program	g, dressing, toileting a The MDS indicated F ulcer (open wound, v scle and supporting t rity Assessment: Pre e Plan", dated 4/17, i occyx, and directed a with a frequency of "	R121 had with depth issue). Evention identified a turn and				
	(every) two hours.						
	R121 was lying in begown and covered call light was clipped mattress was on the "4". R121 was laying side of bed, with a cover, slightly lifting covers, the shape of	on 10/3/17 at 11:32 and in his room, dress with a white sheet, to be and running, and on his back, facing pillow visible from up his left, back side. Up a pillow was seen, gs, as well as heel both R121's feet.	sed in a o which a essure ind set at g the exit nder the Jnder the placed				
	1:58 p.m. (2 hours positioning in bed r p.m., nursing assis entered R121's roo them, and annound "check you" and "reeach side of R121's the bed to a workin cares, talking with I R121's brief was challed NA-B removed the side, and NA-D too legs. Together NAbed, then refitted thand now placed R1	observation from 11: and 26 minutes), R1: emained unchanged tants (NA)-D and NA m, closed the door bed to R121 they were position you." Works bed, NA-D and NA-g height, and began R121 as they precedincted and was not pillow from under R1 k out the pillow betwe B and NA-D pulled Fine pillows between hi 21 slightly facing the R121 right back side	21's . At 1:58 -B ehind e going to ing on -B raised their ed. wet 21's left een his R121 up in s legs, window,				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 31 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	pillow between R12 adjusted, then R12 sheet. Before NA-E they removed glove During an interview nursing assistant (NR121 was "done" (rand now it was two busy down there, archecked and turned stated "it was late." When interviewed or registered nurse (Rexpectation that rest that the wound can down more. RN-B stage 4 pressure ul acceptable" that R1 supposed to be. Rithe aides needed more aware of the removed of the interviewed of assistant director of "would expect" R12 repositioned every the RANGE OF MOTION R121's Restorative printed 10/4/17, ind program goal to be	In legs was replaced was covered with the and NA-D exited the sand washed their on 10/3/17 at 2:06 pland). Distated the last repositioned was at o'clock. NA-D state and that (R121) should every two hours. Note that the last repositioned was at o'clock. NA-D state and that (R121) should every two hours. Note that the last repositioned it was his idents be turned "timbe taken care of an stated R121 had a order, and also it was a last residents or turned a last residents care needs from 10/4/17 at 8:52 a. In ursing (ADON)-C at to be turned and 2 hours as care pland.	he bed he room, hands. o.m., time 11:30, d we got d be IA-D m., s nely" so not break pen, "not s he was ht some of eded to be s. m., the stated she ned.	2 565			
	reps each time. Th Explain procedure;	extremities twice a da e program directed: 2. Perform PROM t nd; Report to nurse a	1. o bilateral				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 32 of 212

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE (PA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL FACE) (PA) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL FACE) TAG COMPLETE BEFORE (EACH DEFICIENCY MIST BE PRECEDED BY FULL FACE) TAG CROSS-REFERENCE: DT PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE: DT PROVIDERS PLAN OF CORPECTION SHOULD BE CROSS-REFERENCE: DT PROVIDERS PLAN OF CROSS-REFERENCE: DT PRECATE PLAN OF CROSS-REFERENCE:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
SOLDEN VALLEY REHABILITATION AND CARE To SOLDEN VALLEY, MN 55427			00112		B. WING		10/0	05/2017
XA1 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE TAG PREFIX TAG	NAME OF F	PROVIDER OR SUPPLIER	STF	REET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 32 complaints of pain, refusals. R121's mobility care plan, dated 4/17, Identified contractures and muscle stiffness as a target problem. During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., R121 was again repositioned R121. At 11:32 a.m., R121 was again repositioned R121. Sp. p.m., R121 was again repositioned by NA-B and NA-D. R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff. During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she did not think' R121 has any range of motion or exercise program. When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber." During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted	GOLDEN	I VALLEY REHABILIT	ΔΤΙΟΝ ΔΝΟ CARF					
complaints of pain, refusals. R121's mobility care plan, dated 4/17, identified contractures and muscle stiffness as a target problem. During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., RN-B, NA-D and NA-B assisted with R121 with a dressing change and repositioning. At 1:58 p.m., R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff. During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she "did not think" R121 has any range of motion or exercise program. When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber." During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
R121 with morning cares, including repositioning and oral cares. There was no provision or offer to complete range of motion for R121 during the morning routine. When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a	2 565	complaints of pain, plan, dated 4/17, id muscle stiffness as During observation was lying in his bedwindow, a pillow unwere at his side, ell 45 degree angle froupon his stomach. bilaterally, on his fe observation from 8 remained lying on ha.m., nursing assist nurse (RN)-B repos RN-B, NA-D and N dressing change ar R121 was again rel R121 was not offer of motion during and During interview on stated she assisted did not do any kind stated she "did not motion or exercise When interviewed of stated R121 did nor restorative nursing, from a ROM programms and hands "muscomplete range of morning observation."	refusals. R121's mobility entified contractures and a target problem. on 10/3/17 at 8:18 a.m., I in his room, facing the der his left side. R121's pows folded and forearms on his elbow, and situate R121 wore heel boots, et. During continuous 1:18 am to 11:32 a.m., R1 his bed in his room. At 9: tant (NA)-D and registere sitioned R121. At 11:32 a A-B assisted with R121 was repositioning. At 1:58 positioned by NA-B and Ned nor was provided any by of the visits by nursing 10/3/17 at 2:06 p.m. NA-I R121 only to reposition a of ROM exercises. NA-I think" R121 has any rang program. on 10/3/17 at 4:38 p.m., For however, R121 could be am, so (R121) could keep hore limber." of the morning routine on an, NA-A and NA-C assisted are was no provision or of motion for R121 during the hen interviewed on 10/4/	R121 arms s at d l21 l29 ed a.m., vith a p.m., NA-D. range staff. pand D ge of RN-B enefit o his n ed oning offer to ne l17 at	2 565			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 33 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (X3) DATE SURVEY COMPLETED | (X4) PLAN OF CORRECTION | (X5) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) DATE SURVEY COMPLETED | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) DATE SURVEY COMPLETED | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) DATE SURVEY COMPLETED | (X6) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED | (X7) MULTIPLE CONSTRUCTION | (X7) DATE SURVEY COMPLETED |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
GOLDEN	VALLEY REHABILITATION AND CARE	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
2 565	range of motion program, and has not a him with that. NA-C stated often therapy worked with res in their rooms, but has anyone work with R121 in his room. NA she did not perform ROM for R121. During an interview on 10/4/17 at 9:59 at NA-A stated she did not think R121 had range of motion program, and if he did, have had "someone from therapy" show to do. NA-A stated she did not help R12 any exercise or range of motion. When interviewed on 10/4/17 at 8:43 a.r assistant director of nursing (ADON)-C stated should be completing that task, do cares or when repositioning. ADON-C questioned how R121 could be 'refusing program because of his current disposit stated the ROM program was to be computed adily, 15 reps each time. ADON-C stated the instructions for restorative program the care tracker were part of the care plasted the instructions for restorative program the care tracker were part of the care plasted the instructions for restorative program services as identified. LACK OF SKIN MONITORING: R6's quarterly Minimum Data Set (MDS) 8/11/17, identified R6 had intact cognition required extensive assistance with activity daily living (ADLs), had unhealed pressurant remained at risk for further pressured evelopment.	y often not seen not	2 565						
	R6's Skin Integrity Assessment: Prevent Treatment Care Plan dated 8/7/17, identifications at moderate risk of pressure ulcer development and had a history of past pulcers. The care plan listed several integrated process.	tified R6 pressure							

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 34 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	including keeping hencouraging him to and, "Complete Pus Healing] Tool Week R6's medical record any completed PUS care plan. During interview on stated a care plan to provide care for a implementing the in PUSH tool was use wound was, "getting stalled." Further, R1 were not currently be moment," but would forward. When interviewed conterim director of near plan was used to, "I resident needs and abreast of the interviewed of	is skin clean and moreposition every two she [Pressure Ulcer Stly." It was reviewed and SH tools as directed 10/3/17, at 2:33 p.m. was used to, "direct to a resident, and staff atterventions. RN-A stated the PUSH being completed, "at the being completed, "at the being completed, at the pursing (DON) stated to be on a weekly base on 10/4/17, at 1:37 pursing (DON) stated weep all staff informed staff were expected wentions listed on it. PUSH tool was consive skin assessment in the pursuant of the pursuant	c hours challed for lacked by R6's n. RN-A us," in how should be stated the if the se or I tools this sis going n.m. the I a care ed," of I to keep Further, usidered ent and ns were	2 565			
		######################################					

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	cognitively intact widepression. R183 r of one to two staff t dressing, grooming mobility. A review of R183's 7/28/17 identified R assistance with per hygiene/grooming/or During observation 3:44 p.m., R183 was only with a sheet. From staff for provision my light on, but I do them to come." R18 called 911 when he commode for 45 m responded within fir R183 stated his base but had not yet recefacility which was m R183 stated to receive to be transported or shower while on the received a "A whore to wash up with a base a strong, foul odor of odors. During observation 12:23 p.m. R183 stated to have a was dressed in a he was noted to have a perspiration and oth had been noted during the strong of the strong observation and oth had been noted during the strong of the	th moderate sympto equired extensive as o complete ADL's ind bathing, toileting ar care plan noted initia t183 required person	sistance cluding and sted sal sted sal sted sal steependent can turn will take the had see staff called 911. Indoneys, in to the sago. In the sago. In the sago see sassisted sted to see has sassisted sted to have ther body steependent sand his sand I odor of dors than 10/1/17.	2 565			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 36 of 212

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	TOF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	room, and lingered he chose note to go it took too long to guncomfortable and ulcers. Following the schedule was posted identified R183 receivenings. During interview on stated he had receid (10/3/17). After his up out of bed and viget up. R183 stated change his bed line he wanted fresh betwere changed as received as the control of the provided plan. R183 could restated they provide plan. R183 could restated when provided plan. R183 could restate the catheter. A review of the physical plant removal, in someone here to he demeaned any further the catheter removal, in someone here to he demeaned any further the catheter removal and received plant removal and received plant removal and removal	into the hallway. R183 stated et up for lunch today because et back to bed, he was has had a history of pressure is interaction, the facility bath ed at the nurses station and eived his bath on Tuesday 10/4/17, at 7:05 a.m. R183 ved a bed bath last evening bedbath he requested to get was asked why he wished to he had to instruct staff to ens following his bath because d linens. R183 stated linens equested. 10/4/17, at 2:19 p.m. nursing ated he had provided de a bedbath for R183 and docare according to the care equest what he wanted. NA-S and routine cares, and not a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide state of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide catheter care, eter, and performing hygiene to esician progress notes of a stant to provide a stant t	2 565	DEFICIENCY)		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 37 of 212

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
2 565	Continued From page 37		2 565			
		ssistance provided within ten It may take longer to summon				
	adequate staff to pr	rovide assist of two for stated she was unaware of				
	concerns regarding	personal odors, and				
		e expectation residents are rning and bedtime cares.				
	washed up with morning and bedtime cares, including washing of face, hands, pericare,					
	armpits, and application of lotion and deodorant. ADON-B stated residents hair are routinely					
		y. The resident care tracker 9/28/17 through 10/3/17, with				
	notations made res	ident had received two y. ADON-B stated he wouldn't				
	gotten two in a day	ADON-B stated if short				
		e unable to complete it, the ed on to the oncoming shift to				
	complete. The AD0	DN-B state it would be to be washed up and receive				
	a bath at the time th					
	R55's quarterly Min	imum Data Set (MDS) dated				
		55 had moderate cognitive eded extensive assistance with				
	dressing and perso	nal hygiene. The MDS				
		frequently (seven or more incontinence, but at least one				
		it voiding) incontinent of urine. I dementia and depression.				
		care plan last dated 4/10/17,				
		R55 to be neat, clean and well care plan directed staff to				
		I hygiene and dressing.				
		m. R55 was seated in her				
	brown substances	oorway to her room. A dark was noted to be under her				
	long fingernails on	her right hand.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 38 of 212

PRINTED: 11/01/2017

GOLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE					
2 565	Continued From page 38	2 565							
	During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap.								
	On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.								
	During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated nail care should be done daily with cares if visibly dirty, otherwise weekly with their showers. ADON-A stated residents should not be sitting in urine soiled clothing. ADON-A stated R55's care plan should have been followed.								
	R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently incontinent of urine, with moisture associated skin damage and diagnosis was schizophrenia.								
	R2's ADL/Mobility last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADL's and at times refused shaving. The care plan lacked approaches to refusal of cares.								
	During observation on 10/2/17, at 2:10 p.m. R2								

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	5/2017
NAME OF PROVIDE	ER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN VALL	EY REHABILIT	ATION AND CARE	JNTRY CLUE VALLEY, MN			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
was s strong satura as the were staff r R2 ha place right s satura of uril hallway were up in the bathe of tie his shoes back comb. On 10 dining uncor His g front. when and la offer this ti	g urine smell. ated with urine eright lower si located aroun members offer air was uncomes. At 3:00 p.m side in bed, the ated with urine ne present that ay. 0/3/17, at 10:1 ay in front of the untied, his hair multiple place ack of the colother. ADON-As shoes. R2 all s; however AD to his room are his hair. 0/4/17, at 6:51 g room watching mbed and was ray t-shirt had R2 was in the he walked do aid in bed. Stato change his me. 19 g interview on d R2 frequently would soil his od R2 needed to assisted with to assisted with the sisted with	e nursing desk and had a His sweat pants were in the front and back, as well ide of his shirt. Multiple staff d the nursing desk and no red to assist him with toileting. bed and sticky up in multiple . R2 was observed lying on his e back of his pants were e. R2's room had a strong odor at could be smelled in the 2 a.m. R2 was walking in the ne nursing desk, his shoes ir was uncombed and sticking is, his gray t-shirt had a tear in or from one side of the neck to approached R2 and offered to lowed ADON-A to tie his ON-A did not offer to take him and help him change his shirt or a.m. R2 was sitting in the ng television. His hair was is sticking up in multiple places. a quarter sized hole in the dining room until 9:06 a.m. win the hall towards his room ff did not approach R2 and shirt or comb his hair, during 10/4/17, at 9:12 a.m. NA-G by removed his incontinent pad clothing with urine. NA-G o be checked every two hours bileting needs, and any charted. Further, staff are	2 565			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 40 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	assistance with care R2 due to the lack of although R2 was or did not assist him w who did. During interview on ADON-A stated R2' be looked at for rev follow the current of ADON-A stated R2' physically assist with and dressing. The facility policy C indicated "The cen philosophy and pro- comprehensive car- interdisciplinary communication tool objectives with time services to be provi- resident's highest and psychosocial w be reviewed and re process, and service be consistent with e resident's written of in distinct functiona gaining knowledge status."	s soiled, and needed es but were unable to staffing. NA-G stand her group this morrowith cares, and wasn' 10/5/17, at 9:39 a.m's current care plan resisions; however staffare plan and should is care plan directed the personal hygiene, are Plans dated 7/18 ter follows the CMS cess on care planning e plan should be an at that must have mean a frames and describited to attain or mair practicable physical, wellbeing. The care plans of the care planViews the lareas for the purposabout the resident's	ated hing she t sure I. needed to f did not have. staff to grooming To, RAI g. The asurable es the hair the mental lan must be RAI ged must resident se of s function	2 565			
	The director of nurs educate all floor sta	THOD OF CORRECT ing and/or designee of the utilization are the residents' compressions care.	could nd				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00112	B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 (F ADDRESS, CITY, COUNTRY CLUI EN VALLEY, MI	B DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen	2 565			
2 570	Plan of Care; Revision. care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility dother appropriate staff in mined by the resident's need practicable, with the resident, the resident's legal representative at least seven days of the revision resident assessment requires	ds, Il			11/13/17
	by: Based on observati review, the facility fainclude specific feet residents (R19) ided difficulties received assistance with eati failed to revise the coindwelling catheter reviewed for justifice Findings include: R19's Admission Refine had dementia ar Data Set (MDS)data needed extensive as	on, interview and document ailed to revise the care planding instructions for 1 of 1 ntified with swallowing safe and appropriateing. In addition, the facility care plan to include an for 1 of 2 residents (R48) ation of use for a catheter. ecord, undated, indicated the dysphagia. R19's Minimized 09/08/17, indicated he issist of one with eating and disorder. R19's Care Area	to	Corrected		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
	DER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
Ass he restole furth for set to persuff properties and indicate the restole funding plans record he restole funding plans record he restole funding plans record for the restole funding properties record for the restole funding properties record for the restole funding plans record for the record for the restole funding plans record for the re	required assist variated a mechan her indicated he special diet or a perform physical icient eating assist per positioning in its sharge Summand the received the received kened liquids around and remains and the received kened liquids around and remains and	dated 09/08/17, indicate with feeding at meals a ically altered diet. The had vision problems, lerted consistency had assistance, had availability in wheelchair for dining ary Note dated 11/30/20 aspiration pneumonia, infiltrates. Care Plan dated 09/00 a pureed diet with had needed total assist mind of meal times. The cific speech therapy R19's diet card indicate is to be fed and he resuids and a pureed diet is ing assistant care she is were honey thickened with eating and see S1	and e CAA a need inability ability of y of and l. 16, and l. 18/17, anney with ne care ted that eceived t. In set to follow monitor	2 570			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From page 43		2 570			
	indicated: "D/C [discontinue puree/hon	eport dated 08/02/17, continue] from ST today ey thick liquid diet. Printed ts table to follow during				
	the following: * Bite sizes should * Use spoon to give spoon size) *Allow patient to cle giving another bite * Do not put more fistill chewing	be 1/2 spoonful of puree honey thickened fluids (1/2 ear mouth completely before ood in patient's mouth if he is ning, do not give more food ontinues.				
		ked the specific feeding ed by the speech language v.				
	Catheter CAA dated	ntinence and Indwelling d 3/27/17, indicated R48 was inent of urine and did not have ry catheter.				
	indicated R48's hos	e dated 5/1/17, at 9:00 p.m. spice nurse inserted a Foley be maintained by hospice.				
	R48's quarterly MD R48 had an indwell	S dated 6/17/17, indicated ing catheter.				
		a.m. R48 was observed in catheter attached to her right urine.				
	R48's urinary contir	nence care plan dated 8/7/17,				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 44 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0)5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 570	urine. The care plant Foley catheter. During interview on assistant director of R48's care plan shoreflect the use of a interventions for state. The facility policy Condicated: "The cenphilosophy and procomprehensive carrinterdisciplinary conhave measurable of describes the service maintain the reside physical, mental and care plan must be raccording to the RAP provided or arrange each resident's write. SUGGESTED MET The director or nurse educate responsible comprehensive carromprehensive assidesignee could conto the individual resident residen	occasionally inconting of did not indicated R. 10/5/17, at 10:14 a. If nursing (ADON)- A could have been revisionally for a care Plans dated 7/18 ter follows the CMS cess on care planning e plan should be an immunication tool that bjectives with time froces to be provided to int's highest practical did psychosocial well be reviewed and revised in the care plan."	m. stated ed to ist theter. 5, RAI g. The tames and attain or ole ceing. The desired with	2 570			
2 800	MN Rule 4658.0510 Staffing requiremen		ersonnel;	2 800			11/13/17

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

10/05/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE					
2 800	Continued From page 45	2 800							
	Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.								
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 of 5 residents (R55, R2, R183) whom were dependent upon staff for ADL's, 2 of 4 residents (R134, R121) reviewed for pressure ulcers, for 1 of 2 residents (R121) reviewed for range of motion, 2 of 2 residents (R19, R97) reviewed for paid feeding assistant, and 16 residents (R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183) and 14 staff members (RN-C, HUC-A, NA-C, RN-E, RN-G, ADON-A, HN-A, LPN-E, LPN-I, NA-E, NA-G, NA-H, ADON-C, AS) whom voiced concerns with the lack of sufficient nursing staff in the facility. This had the potential to affect all 94 residents in the facility.		Corrected						
	Findings include:								
	ADL's NOT MET: R55 was observed on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair with a strong smell of urine and had a saturated wet area of her lap. R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting								

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 46 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	(SSD) brought R55 outside for cigarette urinary incontinence. R2 was observed of standing at the nursof urine. His sweat and back, as well as shirt. Multiple staff nursing desk and nassist him with toile observed lying on hof his pants were s strong odor of urine hallway. During intentions was stated they were started to the stated they were started to the stated	i.m. the social service onto the elevator and e. SSD did not addre	m. ng smell e front of his the ered to 2 was he back had a d into the 9:12 a.m. eeds but	2 800			
	R183 had intact co assistance to comp On 10/1/17, at 3:44 had a strong, pung other body odors. Freceived one bath s greater than two m PRESSURE ULCE R134's Skin Integri And Treatment Pladirected staff to rep During continuous 8:35 a.m. to 11:07 a R134 was observed.	RS ty Assessment: Prev n Of Care dated 10/0 position R134 every to observation 10/03/17 a.m. (2 hours and 32 d to be sitting in his E	extensive eating. ing in bed on and yet e facility ention 13/17, wo hours. 7, from minutes) Broda				
	being repositioned/ At 11:07 a.m. surve	e positioning chair), v toileted or check and eyor informed nursing nat R134 had not bed	l change. g assistant				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 47 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D WING			
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S UNTRY CLUE	STATE, ZIP CODE R DRIVE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 47	2 800			
	NA-M stated she ha	er 2 hours and 30 minutes. ad assisted NA-N and they do aff to reposition resident				
	indicated R121 was required the physica bed mobility, and to pressure ulcer. Dur 10/3/17, from 11:32 and 26 minutes), R remained unchange 10/3/17, at 2:06 p.m	ata Set (MDS) dated 8/18/17, is totally dependent and al assistance of two staff for bileting and had a current ring continuous observation on 2 a.m. to 1:58 p.m. (2 hours 121's positioning in bed which ed. During an interview on n., nursing assistant (NA)-D, and R121 should be checked to hours.				
	printed 10/4/17, ide passive range of m on 10/2/17 at 6:22 pstated R121 was no exercises. When she ROM for R121, and placing them in his rolling up and gettin 10/4/17 at 9:48 a.m	Program History report, entified R121 was to receive otion (ROM). During interview p.m., family member (FM)-C ot getting his ROM program ne visits, she completes the d has been rolling towels and hand to keep them from ng tight. When interviewed on a., NA-C stated R121 did not otion program, and has not nat.				
	stated she had bee 03/07/17, and beca certificate had expir renewed her certific	/04/17, at 9:22 a.m. HR-A in working at the facility since ime a NA in 2005, her NA red in 2008, and she had not cate. HR-A stated she assists they are short staffed and has				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 10/0	00/2011
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	STAFFING CONCE R48's quarterly MD R48 was cognitively catheter and require toilet. During intervi R48 stated she nee catheter and make staff one to two hou Further, R48 stated facility to allow her in to treat chest pain) because it took so I administer them me chest pain. R28's quarterly MD R28 was cognitively to total dependence 4:10 p.m. R28 state out of bed when he week it was common get assistance. R196's admission IN R196 was cognitive extensive assistance interviewed on 10/2 stated she had to w bed pan and it was the staff put her on you to put the call light is R180's quarterly MI R180 was cognitive	LAINTS REGARDING ERNS: S dated 6/17/17, indiversity intact, had an indwered extensive assistance on 10/1/17, at 3:5 and to empty her owher own bed becausars to answer her call I she had to fight with nitroglycerin (medicate to be left at the bed slong for staff to come adication when she was unable to guith ADL's. On 10/1 and he was unable to guith ADL's. When to wait over 30 min and the mount of the period of the was unable to guith ADL's. When the was unable to guith ADL's. When the was unable to guith and the was unable to guith ADL's. When the was unable to guith and the was unab	cated elling noce to 55 p.m. on e it took light. othe tion used side, and vas having cated extensive /17, at get in and of the nutes to endicated for the first took light and tell to return dicated pervision	2 800			
	stated staff often di	On 10/2/17, at 12:25 a dn't answer call "butt id when they finally a	ons" for				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 49 of 212

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
2 800	Continued From pa	ge 49	2 800			
	R180 stated it can t medications, somet	as told "I'll tell the nurse." take a long time to get pain times 45 minutes. The nurses inds of excuses" why they are				
	R162 was cognitive extensive assistance interviewed on 10/2 there was a 20 percept be answered timely say they need to go the staff walk out at told by a nursing as during lunch I would were so understaffer answer call lights definition.	DS dated 8/17/17, indicated by intact and required be with ADL's. When 1/17, at 12:35 R162 stated beent chance your call light will of the answer your light and of get someone to help, then and no one comes back. I was esistant if I needed assistance do need to wait, because they are there was not anyone to uring lunch. R162 also stated getting bathed do to the lack of				
	R47 was cognitively to total dependence interview on 10/2/1	DS dated 9/18/17, indicated y intact and required extensive from staff for ADL's. During 7, at 12:37 p.m. R47 stated d there were not cleaning				
	was cognitively inta assistance with ADI 10/2/17, at 1:19 p.n enough staff, and h and a half to have h	dated 8/11/17, indicated R6 ct and required extensive L's. When interviewed on n. R6 stated there was not as waited an hour to an hour nis call light answered. R6 mes didn't even answer the				
	was cognitively inta	dated 7/24/17, indicated R31 ct and required extensive to f staff for ADL's. On 10/2/17,				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 50 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00112		B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDE	N VALLEY REHABILIT	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	ILD BE	(X5) COMPLETE DATE
2 800	at 1:19 p.m. R31 w there were only two scheduled on the fl most of the resider staff members to a When staff take the or two staff membe of help during mea assistance to toilet incontinent two to t lack of assistance I R24's quarterly MD was cognitively inta total dependence of interviewed on 10/2 there were not eno had to wait a half h answered. Also at t answered and shut back and don't com happened while be "made me very and been incontinent w don't feel they have more people to tak are leaving becaus R82's annual MDS was cognitively inta total dependence of interview on 10/2/1 facility was always management said they couldn't sched needed to wait ove incontinent product happened at least to worse on the day s	tho resided on 1st floor to three nursing assoor, and it was not ents on that floor requissist with cares and eir breaks that leaves ers on the floor. Then I times and you can't during meal times. I have times a week, or by staff. 2S dated 9/1/17, indicated and required extended and required extended and required extended and required extended and the call light work off, staff say they were back for two hours ing on the bed pan and gry." R24 also stated aiting for staff assistated and required extended and required exten	sistants nough, as red two transfers. sonly one e is a lack get le is lo to the cated R24 nsive to en 4 stated de lights ould be so This has and it they have ence. I ney need ts. Staff oad. ated R82 nsive to ing stated the sus, so stated she have her d that id it was ng to the	2 800			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 51 of 212

Minnesota Department of Health					,		
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	`.	A. BUILDING:		COMP	LETED
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STE	REET ADD	RESS CITY S	STATE, ZIP CODE		
				NTRY CLUB			
GOLDEN	I VALLEY REHABILIT	ΔΤΙΟΝ ΔΝΟ CARF		ALLEY, MN			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
					DEI IGIENOT)		
2 800	Continued From pa	ge 51		2 800			
	have to wait."						
	navo to wait.						
	R130's quarterly MI	DS dated 8/15/17, indicat	ted				
		ly intact and required					
		e with ADL's. During inte					
		17 R130 stated he had l					
		out a year. I hate it here l don't like the food. I dor					
	,	lways understaffed. I tak					
		swer the call light I wait 4					
		I have had a accident wa					
		me feel horrible. I wear					
		to use a urinal I have to p	out on				
		them to bring the urinal.	2420				
		on 10/2/17, at 2:19 p.m. F el there was enough staf					
		คา เกอเอ was enough รเลเ nes waited 30 to 45 minเ					
		and when they don't com					
		d it doesn't make me fee					
	good.						
		MDS dated 9/6/17, indica	ted				
		vely intact and required	7 ot				
		ce with ADL's. On 10/2/17 ted she has put her call li					
	- 1	vers it for 25 minutes or r	9				
		S dated 8/17/17, identifie					
		nition, required extensive					
		ivities of daily living (ADL	s)				
	and had, "total dependence," on staff for		0.17				
	transfers. During observation on 10/3/17, at 8:47 a.m. R43 was seated in a wheelchair outside her						
	-	ght turned on. At 8:54 a					
		er) R43 remained in the					
		her room. RN-E approac	ched				
	R43 and stated, "Ar	re you waiting for someor	ne to				
		3 responded she was bu					
		k right on by." RN-C stat					
	she would tell staff	and walked away. Wher	۱				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 52 of 212 X11C11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE (MUST BE PRECEDED BY SC IDENTIFYING INFORM)	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 800	just want to lay down her right leg, howey R43 stated she has assistance with laying anxiety attacks." Resultance where approached her with and assisted her to R31's annual MDS exhibited intact cognicular delirium. R16 was reassistance of one to including transferring grooming and bath 10/2/17 at 12:52 p. Inchance to get a bath When they are should do everyday been, "Three weeks a bath." R31 stated only two staff on the complete a shower	lately following, R43 /n," as she was havinger, "I don't get help. waited so long beform g down, "I have one 43 remained seated allway until 9:04 a.m. an unidentified NA h the mechanical lift	ng pain in ' Further, re to get e of my in her . (17 machine resident of nsive te ADL's l, on get a shower. a bed hey s it had t receive ere are wo staff to gh staff	2 800			
	indicated R66 exhib and required total to the activities of dail dressing, grooming During interview on expressed concern assistance with bat R66 stated if they a receive a bath." R6	S completed on 9/3/ bited no cognitive imposextensive assistant y living (ADL's), incluse, bathing and mobility 10/1/17, at 4:10 p.m regarding staffing, shing occurred infrequences short staffed "You 6 went on to say hele to wash his hair on	pairment ce with ading y. R66 tating uently. don't had				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 53 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUE			
0(0) ID	CLIMMA DV CTA		VALLEY, MN		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 53	2 800			
	occasions in the last placing the call light is not a guarantee y turn off the call light back, but often donextended period of R183 stated on 10/the facility was undincontinent of bowe staff to assist him. I called 911 because commode for 45 m Further, he needed to be put to bed and buttocks and need staff. R183 stated occuple of weeks agon the floor all day as to the staff of t	st year and a half. When to not o summon assistance, it you will get help. Staff will often and say that they will come to return, or return after an time. 1/17, at 3:36 a.m. R183 stated erstaffed. He had been and it took over an hour for R183 stated at one time her the staff had left him on the inutes and it "pissed" him off. to wait long amounts of time do had a pressure ulcer on his to lay down and not wait for on 10/05/2017 9:24 a.m a oo, there were only two aides and the evenings. "When you ll suffer," and we are not				
	STAFF CONCERNS REGARDING STAFFING CONCERNS Registered nurse (RN)-C stated on 10/1/17, at 10:01 a.m. due to the allowed staffing in the facility, nurses tried hard to get there medication passes completed, however, treatments were not consistently being done as ordered. RN-C further stated the four nursing assistants and two nurses working the cart was not enough staff to meet the resident needs on the 4th floor. Health unit coordinator (HUC)-A stated on 10/3/17, at 11:02 a.m. the staffing on 4th floor was "horrible." Sometimes the resident needs were not being met as there were a lot of residents that needed two people to assist them. HUC-A added when the staff were in rooms assisting other residents, the residents who had					

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 54 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	yelling. There used 4th floor, but now n scheduling four nur added R6 frequentl did not answer the urine about three to R2. She stated she and changed his ur the nursing staff did him. NA-C stated on 10/ frequently take 30 to because we are as care and there isn't stated "that's a long bathroom. NA-C staincontinent because Maybe if they could wouldn't be incontined saked for more star us and think we do purpose. RN-E stated on 10/ difficult to get all tasfloor there are a lot people to assist wit people are assisting wait. RN-E stated is a two person transfichange their incontined with toileting.	waiting for assistance start to be five nursing assistant on nanagement was only sing assistants. The HUC y called the facility, when staff call light. R55 was soiled with a four times a week along with has directed R2 to his room ine soiled clothing, because dn't have the time to assist assisting other residents with enough staff. NA-C further a time" to wait to go to the ated resident are frequently the there are not toileted timely. I be toileted timely they nent. The facility will only on the 4th floor and have ff. The residents are angry with an't answer call lights timely on 3/17, at 2:26 p.m. it can be sk completed timely. On 4th of residents who require two h cares and when those two g someone others need to taff can't stop in the middle of fer to assist someone to inent product or help someone	2 800			
	two nursing assista wing of the 4th floo	/3/17, at 2:53 p.m. there are nts scheduled to work each r, for a total of four nursing tated there are at least 11				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 55 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 800	Continued From pa	ige 55	2 800			
	residents out of 26 people for transfers had a lot higher act with management obrought up staffing not in the budget to The management i level of care these residents are leavir live because their rithe lack of staff.	on her wing that require two is and care and the other wing uity level. We had a meeting one to two weeks ago and we concerns and were told it was add more nursing assistants. It is not taking into account the residents need. Some and finding new places to needs were not being met do to of Nursing (ADON)-A stated on				
	Assistant Director of Nursing (ADON)-A stated on 10/3/17, at 3:15 p.m. there are not enough aids scheduled in the facility to begin with. Then they call in and the ADON's need to fill in on the floor, doing cares and passing medications and then we get behind on the assessments and care plans. ADON-A stated there are a lot of complaints from residents regarding not enough staff, but we do the best we can. The facility schedules by amount of resident not there care needs. She stated there have been an increase in falls and incontinence issues related to the staffing levels.					
	Hospice stated on fourth floor does no stated there is a lot and one evening the had 52 residents we trained medical assement all of there no pain medications no physician orders no	I)-A from North Memorial 10/03/17, at 9:30 a.m. the ot have enough staff. HN-A of mental illness on that floor were was a nurse who said she ith only a nurse and two sistance (TMA)'s and you can't weeds, and had concerns with ot being given as ordered and of being transcribed.				
	10/03/17, at 2:57 p.	nurse (LPN)-E stated on .m. she works on the first floor se working on the floor. LPN-E				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 56 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N VALLEY REHABILIT	ATION AND CARE		INTRY CLUE Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	five residents from were told they when now help out but it stated she was sup assistant (TMA) to that didn't happen of the total the to	y, with in the last more the third floor to first re going to get more never happened. LF oposed to get a trained help with medication	floor and staff to PN-E and medical pass but I do not ly arriatric cine that e obesity) she feels up own work I stated In there were in the answer meone they have I adaily o two with other e on the 4th e on the 4th of the residents of four partment	2 800			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 57 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00112	B. WING		10/0	10/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 800	timely. Sometimes assistants on the 4th hard" and it has been the residents deserbasic needs met. Sevening residents as Management tells at to our census. NA-dare neglecting the repurpose. NA-H stated on 10/whom are a check they only get changafternoon, because do. There are not eresident needs. ADON-C stated on assessments requires a change in condicate plan, that are stated she was need of staff scheduled, and care plans need not enough time. Anonymous staff in 10/5/17, 2:20 p.m. shave to be delayed there are not enough the dining rooms, heresident in eating. A busy with other care they are short.	e still can't get things done there are only three nursing th floor and its "really really en this way last two months. In the way last two months and fighting. In the way last like neglect we way last like neglect way last like neglect we way last like neglect way last like way last	2 800				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S' JNTRY CLUB VALLEY, MN	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	- 8/15/17 concer for medications - 8/21/17 concer for cares - 8/30/17 concer - 8/30/17 concer - 8/30/17 concer wait times and residence of the second of the	erns regarding long verns regarding long verns regarding long verns regarding staff adents wandering her service concerns her service concerns related to cares erns related to cares erns related to inconserns related to inconserns regarding care erns regarding cares to part, on the census each morning admin to review staffing, and gon the needs of ene is not sure if there determined. SA-A for ered an additional scents.	wait times wait times attitude, se and time times for timent ght time concerns se and time taffing is se of each istration d changes each floor. e is a urther heduler, to ursing sing y and a Tuesday ussistants	2 800			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 59 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	TATION AND CARE	JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 59	2 800			
	assistants, PM Shit assistants, Night S	nift 2 nurses and 3 nursing ft 2 nurses and 2 nursing hift 1 nurse and 2 nursing 7 there were 21 residents on				
	> 3rd Floor: AM Shift 1 nurse and 1 nursing assistant, PM Shift 1 nurse and 1 nursing assistant, Night Shift 1 nurse with no nursing assistant on Sunday night, however only had 1 nursing assistant Monday through Wednesday night. (10/1/17 there were 5 residents on this floor)					
	> 4th Floor: AM Shift 4 nurses Sunday and Monday, and 3 nurses Tuesday and Wednesday and 5 nursing assistants on Sunday, but only 4 nursing assistants on Monday through Wednesday, PM Shift 3 nurses and 6 nursing assistants (one a trainee), with only 4 nursing assistants on Monday and Wednesday, and 5 on Tuesday, Night Shift: 1 nurse and 3 nursing assistants. (10/1/17 there were 48 residents on this floor)					
	executive director (staffing was not op schedule extra if th always possible. W been attempting to issues. ED stated t additional schedule with call-in replace stated that the sche weekends. The ED director of nursing's call, and have staff	on 10/4/17, at 2:10 p.m. the (ED) stated she was aware that timal, and attempted to here is a call in, which is not when asked how the facility had correct the facility's staffing that the facility has hired an er, who's shifts over lap to help ments throughout the day, but edulers do not work on the o stated that the assistant is (four in total) take weekend is scheduling information with to so. The ED stated each				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 60 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 800	management review staff, so shortages addressed. ED state extra staff each day "no-shows" so not to stated through qual the facility is working recruitment. ED states things as employee up theme days, mobirthday cake and go managing time off of the states of the state	Friday) during "stand the "allocation" of fand cares concerns ed that they try to so so that "call-ins" and o impact resident callity assurance and stag on employee retented that they are trying snack cart, employeenthly staff recognition tetting a better system equests of staff. THOD OF CORRECT DON or designee content staffing based of so residents received y assistance with toiling, pressure ulcer callity could edured perform routine even sure residents are or adequate staffing, the findings of these ce performance impror further recomments	acility can be hedule d re. ED aff input, ation and ng such se dress n, monthly m in FION: uld ms are on the d safe, eting, are, and acate staff valuations receiving The audits to ovement dations to	2 800			
2 830	MN Rule 4658.0520 Proper Nursing Car		and	2 830			11/13/17
	receive nursing care	general. A resident e and treatment, per supervision based o	sonal and				

Minnesota Department of Health

PRINTED: 11/01/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00112 10/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7505 COUNTRY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 61 2 8 3 0 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document Corrected review, the facility failed to ensure 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance from nursing staff when there was an identified concern while feeding a resident. The findings constituted an immediate jeopardy (IJ) situation for R19, with the potential for serious harm, injury or death. The immediate jeopardy began on 10/04/17, at 8:12 a.m. when the resident was observed to have on-going issues with coughing while eating. Staff were not following the feeding program established by the speech language pathologist

Minnesota Department of Health STATE FORM

Jeopardy.

due to dysphagia (difficulty swallowing). The executive director (ED), interim director of nursing (DON), director of clinical services (DOCS), assistant ED-A and ED-B were informed of the immediate jeopardy on 10/04/17, at 4:15 p.m.. The IJ was removed 10/05/2017, at 2:54 p.m., but non-compliance remained at the lower scope and severity of (D) isolated, with potential for more than minimal harm that is not Immediate

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	•	<u>. </u>	STATE, ZIP CODE	1 10/0	0/2011
GOLDEN	VALLEY REHABILIT	TATION AND CARE	JNTRY CLUB Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	In addition, the faci plan was in place for bullying behaviors waltercations. Also, to comprehensively as pain medications the who had complaints failed to coordinate residents (R138, Residents). In addition, the faci assess safety with (R21, R20) reviewed Findings include: Eating R19's Admission Resident and the had dementia and swallowing). R19's (MDS) dated 09/08 extensive assistance on swallowing disorder Area Assessmindicated he require meals and had a neconsistency which in the CAA further includent and the cating assistance. A Discharge Summan aspiration pneumor infiltrates of the lunging to the lunging to the lunging will show up the lunging will show up the lunging will show up the lunging the lunging will show up the lunging the lunging will show up the lunging will show up the lunging the lunging will show up the lunging	Ity failed to ensure a behavior or 1 of 1 residents (R108) with which contributed to verbal the facility failed to ssess for pain, and provide mely for 1 of 3 residents (R48) s of pain. The facility also hospice services for 2 of 2 48) reviewed for hospice. Ity failed to comprehensively smoking for 2 of 4 residents	2 830			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 63 of 212

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUB			
240.15	CUMMADV CTA		VALLEY, MN		ON.	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 63	2 830			
	or some sort of infe is in the lung).	ection with edema/swelling that				
	indicated PT (patient to address dysphage to receive discharge followed up with nu printed compensator reduce aspiration ridiscontinuation of sprogress due to decues. Nursing staff compensatory swalfor ongoing signs a A 24 Hour Status R for nursing staff) da [discontinue] from Status R	rapist note dated 08/02/17, nt) seen for skilled ST services gia and complete final session e documentation. Therapist rsing staff regarding use of cry swallowing strategies to sk. A 24-hour log updated for ervices due to inability to mentia and inability to follow to implement use of lowing strategies and monitor and symptoms of aspiration. The communication report and the documentation of the documenta				
	staff to do the follow * Bite sizes should * Use spoon to give spoon size) *Allow patient to cle giving another bite * Do not put more for still chewing	y instruction sheet directed ving swallowing strategies: be 1/2 spoonful of puree honey thickened fluids (1/2 ear mouth completely before ood in patient's mouth if he is ning, do not give more food ontinues.				
	nursing assistant (NR19 a drink of his juthickened liquids to drink it instead of use	on 10/01/17, at 12:12 p.m. NA)-B was observed to give uice bringing his cup of honey his mouth and having him sing a spoon as required. She him take three drinks and R19				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 64 of 212

Minnesota Department of Health

Minnesota Department of Health							
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL	IER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION N	UMBER:			COMP	LETED
				B WING			
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				JNTRY CLUB	,		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE					
				VALLEY, MN			1
(X4) ID	-	ATEMENT OF DEFICIENCIENCE		ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		Y MUST BE PRECEDED B' .SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
140		00152	, (1.3.1)	IAG	DEFICIENCY)	1	
				 			
2 830	Continued From pa	ige 64		2 830			
	started to cough wh	nile drinking from the	o oun				
		n he coughed waited					
		entinued to give him					
		potatoes, and then					
		reed roast beef and					
		12:19 p.m. NA-B fe					
		of his mashed potate					
		A-B stated to R19 'It'					
		f his juice from his c					
		eyor intervened and					
		vare of R19's specifi					
		from the speech lan					
		and showed her the					
		ere on the window sil					
	dining room. NA-B	stated she was not	aware and				
	NA-M instructed he	er that he should only	y receive				
	1/2 teaspoons of fo	ood and liquids at a t	ime. NA-B				
		oon at the table and					
		d juice and proceede					
		of his food and beve					
	his coughing had d		, c.g - :				
		00104004.					
	During observation	10/04/17, at 8:12 a.	m HR-A				
		e first floor dining ro					
		eating. R19 had scr					
		age, oatmeal and ho					
		y juice. At the same					
		y juice. At the same า HR-A, sat assistan					
		-B whom was assist					
		gave R19 a level teas					
		and then immediate					
		ul of his oatmeal, wit					
		swallow the spoonful					
		mediately giving a h					
		al to R19. R19 imm					
		oudly turning his hea					
		ght. HR-A stopped t					
		back and waited fo					
		-A then brought R19					
	honey thickened cra	anberry juice just be	low his				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 65 of 212

Minneso	<u>ta Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOI DEN	I VALLEY REHABILIT	ATION AND CARE 7505 COL	INTRY CLUE	DRIVE		
GOLDEN	I VALLET KEHADILIT	GOLDEN	VALLEY, MN	I 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 65	2 830			
	chin and began spospoonfuls of thicker without first waiting HR-A fed R19 a full not a half teaspoon swallowing strategic R19 a heaping spod and R19 immediate stopped again and and HR-A then brouthickened cranberry began feeding R19 juice, and a level tedid not wait for R19 she gave him anoth cough loudly and hi covered his mouth while he coughed. A across from HR-A wattempts to stop HR though HR-A was n strategies and R19 being fed. R19 had eggs, pureed sausa and 3/4 of his hone ADON-B left the sa R19 and NA-M ther across the same ta approximately 8:25 room, and surveyor observation. HR-A protector and SLP-A the table and instrubeen following her which is 1/2 spoonf then stated that NA	on feeding R19 three and juice, one after another for R19 to swallow each bite. teaspoon of thickened juice, as identified by the ST as. HR-A proceeded to give onful of his pureed sausage by began to cough. HR-A let him cough without waiting ught R19's glass of honey juice to his chin and quickly three level teaspoonfuls of aspoon full of oatmeal. HR-A to swallow each bite, before her bite to eat. R19 began to sface turned red while HR-A with his clothing protector ADON-B whom was directly while she fed R19, made no R-A from feeding R19 even ot following the ST swallowing continued to cough while I eaten 100% of his scrambled age, and half of his oatmeal by thickened cranberry juice. The same table HR-A was assisting as at down to assist R134 ble R19 was sitting at. At a.m. SLP-A entered the dining informed her of the above was removing R19's clothing A immediately walked up to ceted HR-A she should have recommendations of bite sizes and she had stopped feeding and she had stopped feeding				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00112	B. WING		10/	05/2017	
NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITA	TION AND CARE 7505	ET ADDRESS, CITY, S COUNTRY CLUE DEN VALLEY, MN	DRIVE			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
indicated he received thickened liquids and the dining room and The care plan did no recommendations. Review of R19's diet needed total assistate honey thickened liquicaddition, R19's nursi undated, indicated his consistency and he reating with a note, "sinstruction." During interview on a licensed practical nursion aware of any fee R19 and stated, "Whyou!" During interview on a SLP-A stated she has with R19's plan of carecommendations for trained staff that ass SLP indicated she let the table where he adisappear and she with the serecommendation, the these recommendation to say the say the stated and she recommendation awhile ago, but did not recommended and she recommendation	Care Plan dated 09/08/17 d a pureed diet with honey d needed total assistance reminded of meal times. It list specific speech thera t card, undated, indicated nce to be fed and received aids and a pureed diet. In ing assistant care sheet, als liquids were honey needed total assistance were ST [speech therapy] 10/04/17, at 12:25 p.m. are (LPN)-D stated she were ding recommendations for the light of the light of the light of the light of the state of R19 on 7/24/17, and disted with feeding him. The fit the feeding instructions were and the instructions would have to make new magain at his table. SLP-the interim nurse manage she no longer works at the SLP-A stated she wrotes.	to apy he d ith as r ns ne at uld A r e e ng				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 67 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S NTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	heavily on the staff recommendations of aspiration and it with SLP's recommendations of aspiration and it with SLP's recommendation. During interview 10 stated, "I don't know evaluation" and that floor at the facility for "before me and I was recommendation" a guardian. In addition out about R19's recommendation. A gets pureed food an slowly and she was but to just feed him. A gets pureed food an slowly and she was but to just feed him. During interview on stated R19 had couslow to eat, receive pureed liquids. NA-ounce glass to assicoughing while using spoon for the thicket teaspoon of fluid. Per months ago) there we table that directed of but these directions NA-O added staff repreviously, either we monitor his response.	to follow through with since he was at such he was at such he was vital to follow through with since he was vital to follow through 1/2 teaspoons of his fouch less and it reduce 1/04/17, at 1:01 p.m. All we anything about a swat she had been working it aware of the sind reported she could be anything as the could be anything to say the six weeks. This hap asn't aware of the six weeks. This hap asn't aware of the six weeks and reported she could be anything as the could be anything to say the could be anything to say the	nigh risk bugh a stated food and ed his DON-B allow g on the pened I call his e found riday or NA-O g, was dur had use a full ely 3 on the r fluids he table. s did nd e he	2 830			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	During interview on stated an educator on R19's SLP-A red stated, "I told her as won't remember whanything and had meducated." NA-L the since he was on his During interview on stated she received needed to check the feeding instruction at the black book wou cart. A nurse needed prior to staff serving started coughing or	10/04/17, at 3:42 p. from the facility instructions but a soon as you walk a nat you told me. She ne sign a paper sayinen stated, "I had no	tucted her she away I e didn't saying I was t fed him 1. NA-Q the staff a special eferred to beverage room one to alert the	2 830			
	stated she had bee process regarding diet. The ticket on t instructions and if no the black book which beverage cart Nurs room prior to serving assist if there were choking. Only trained residents. Although R19 had a pneumonia, and was the facility failed to instructions to prevenon-trained staff as ADON-B and NA-M while HR-A was fee	10/5/17, at 2:17 p.n n educated on the n residents who have able would have the needed would indicated would be located to be in the grand supervise stated any issues with coursed staff can assist when the staff can assist whe	ew special e to check on the e dining ff and ghing or ith feeding n birating, LP-A ad s meal. s the table g, and				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 69 of 212

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 69	2 830			
	occurred.					
		sted for following SLP out none was provided.				
	at 8:12 a.m. and re p.m. when it was ve document review, a could and could no needed to be in the were eating, where guidelines were loc what guidelines to facility checked oth guidelines to ensure	pardy that began on 10/4/17, moved on 10/5/17, at 2:54 erified by observation, and staff interview of whom the feed residents, that a nurse endining room when residents individual resident swallowing ated in the dining room, and follow to assist R19 to eat. The er resident with swallowing the their programs were being ed R19 careplan's along with the owere at risk.				
	R108 had diagnose psychotic disorder, schizoaffective and quarterly MDS date intact cognition, dis altercations and ph activities of daily liv worksheet dated 2/	sheet, undated, identified as of intracranial injury, paraplegia disorder, bipolar disorder. R108's ad 7/24/17 identified he had organized thinking, verbal ysical staff assistance for ing. The behavior CAA 24/17, identified resident and hallucinations which iors problems.				
	R108 was yelling in home at (R71 and I yourself in the mirro definition of ugly," F (SS)-B whom was i very upset yelling (I	on 10/3/17 at 10:12 a.m. the entry way of the nursing R201) stating, "Look at or and you will see the R71 yells back. Social Service in the area talks to R71 who is R108) calls us names all the appens. R71 leaves the area.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 70 of 212

Minneso	<u>ta Department of He</u>	ealth					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	JMBER:	A. BUILDING:		COMP	LETED
		00112		B. WING		10/0	5/2017
						1 10/0	0,2011
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE		INTRY CLUE			
			GOLDEN	VALLEY, MN	I 55427		
(X4) ID		TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
170			,	IAG	DEFICIENCY)		
2.020	O	70		2.020			
2 830	Continued From pa	ige 70		2 830			
	R201 who was in th	ne same area, stated	d, "yeah" in				
	agreement to what	R71 was saying. R	108				
	remained in area at	fter the confrontatior	n, looking				
		ced with R108 about					
		m., four minutes late					
		administration office					
		ED), and assistant e					
	, , ,	ED-B and director o					
		ing, he was "tired of					
		l calling him "an Indi You have not done					
		n tired of it. All you t					
		, nothing gets done					
		no idea what I or (F					
		we get called those					
		ne EĎ, and AED-A tr					
	R71 down. R71 ke	pt telling administra	tion (R108)				
	"bums cigarettes" f	rom (R192) all the ti	me. I have				
		at her, she doesn't					
	, ,	people, so she give					
		arettes a day from h					
		administration. R108					
		chair approximately					
		grinning with enjoym					
	·	ng at the facility adm	inistraiton				
	staff.						
	R71's admission M	DS identified he was	2				
		nd needed minimal					
		ivities of daily living.					
		facility on 10/2/17.					
		able as a result of R					
	in her assessment	period.	· ·				
		10/4/17 6:53 a.m. h					
		B stated R108 was					
		'instigates riots here					
		er residents. He is v					
		r residents and staff					
	wants cigarette. He	tells resident's and	staff that				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 71 of 212 X11C11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	ORESS, CITY, S NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	he will pay you tome say no to him, he so which occurs sever curses at everyone not do what he want During observation was sitting in the difront of him. He stapractical nurse (LPI approximately 50 fe LPN-H, "Why did you dilaudid [narcotic pasomeone else "has continues to yell at During interview on stated R108 was you doesn't get his coffe cigarettes right away explosive and demanames like, "fat flog	orrow. HUC-B indica wears at them using al times a day. He ye and bully's them who	profanity ells, en they do en. R108 ee pot in ed llway velling at ed my udid. LPN-H If he or He gets residents indicated	2 830			
	and NA-C both stat the "F word", and ra back to the country very mean, and has especially yells who reposition or toilet have try to calm him be nice, I can yell we that we can get him morning when he we cigarette. We tell hi you can get up and gets what he wants	10/4/17 at 7:18 a.m. ed (R108) yells, sweacial profanities telling that we came from. It is a lot of behaviors. He want to do care im. He tells us no, and down he says. "I don't hen I want." The one to do anything is in the vants to get up and he m, after we change yhe agrees to this. W, then he starts yelling to smokes he will bug	ars, uses g us to go He is He es for him, and when It have to ly time the early ave a you then hen he g again. If				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 72 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O		` ′	E CONSTRUCTION		SURVEY PLETED
				A. BOILDING.			
		00112		B. WING		10/0	05/2017
NAME OF I	PROVIDER OR SUPPLIER	S	TREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUB VALLEY, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	OLDER	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE DATE
2 830	Continued From pa	nge 72		2 830			
	resident until he gets a cigarette. NA-A and NA-C both were unaware of any behavior plan to help deal with R108's behaviors. During interviews on 10/4/17 at 7:30 a.m LPN-A						
	During interviews on 10/4/17 at 7:30 a.m LPN-A stated R108 frequently refuses treatments, turning and repositioning along with yelling, screaming, and cursing. He calls other residents and staff, "Niger, Indian and calls the ladies bitches." He is very demeaning and tells staff I pay for you to work, so you have to listen to me. If he wants something he expects you to drop everything and do what he wants. LPN-A indicated she attempted to talk with him softly and make a plan with him, sometimes it works, other times not. He always wants his pain medicaiton						
	due at 3:00 p.m., at them, but you have him not until 3:00 p you need to make s	uled. His pain medication at 2:00 p.m. he tries to stay firm with him ar .m. Once 3:00 p.m. consure that you are there when he seems to build to	to get nd tell nes, with his				
	pain medications, then he seems to build trust with you, as long as you follow through with what you told him. This seems to work, but not all the time. If you break his trust, this will not work. There is no behavior plan the NA or nurses are following for R108, we just do our best.						
	stated R108 calls n ass, and good for n everything but a "ch cursed at and maki not. He hurts my fe	n 10/4/17 at 7:47 a.m. R ne a, "Niger, bitches, ho nothing person." He calls nild of god." I hate being ing me something that I eling when R108 talks b	bes, fat s me g am bad to				
	"no", then he goes this was not right the and he makes me to anything. When he	m a cigarette", and I tell off, yelling at me. R201 nat they have to put up vifeel that I am not worth wants something he cawhat he wants, and the	stated with this an be all				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 73 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
	0.18.844.514.074		VALLEY, MN		1011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 73	2 830			
	to himself. Staff ta changes.	lk with him, but nothing				
	stated he was com other day trying to get yelled at him, "Hey you not on the reset time that I am a, "full ignore him, and tell but nothing works. member FM-A) on found out about this sorry and was good I was in the dining to me and asked for He tells me, I just sknow you have one then tells me, "I wo I turned around and and left the dining in hallway entrance you administration. Not nothing about this, see nothing, and no	hing changes here, staff do and they tell me they try, but I o changes to this at all.				
	behavior varies, he pot of coffee. He c word", and has bur treat him with respealong. If you do little respect he is better by his facial express a frown, has a glas	for (M)-A stated R108's asks for coffee so I get him a alls the kitchen staff the "C ned his bridges with them. I ect, talk with him and we get e things for him and get his r, but sometimes not. I can tell sion his mood. When he has sy eyed look and staring out				
	roll him cigarettes,	ot a good day. SS-A used to not sure what happened to a lot, and by the third week of				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 74 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	E/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	1 10/0	05/2017
		7505 COL	INTRY CLUB	•		
GOLDEN	I VALLEY REHABILIT	GOLDEN GOLDEN	VALLEY, MN	1 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From page 74		2 830			
	he had ran out of m	aviors get really bad because noney. When he gets his better, until he spends his				
	stated R108's beha everyone and is de used to have a beh cigarettes for him. I get more cigarettes residents. The mo cigarettes he dema last. As long as the cigarettes, he gets residents he will pa	a 10/4/17, at 9:12 a.m. HUC-A aviors are bad, he yells at meaning and not nice. He avior plan and SS-A rolled R108 would come back and a rolled, then sell them to other re SS-A rolled, the more unded so that program did not y (residents) give him along with them. He tell y them back, but he never d him. There is no behavior				
	Plan review on 8/8/ disorder, and used The interventions in effects, periods of a awareness, disorga changed in cognitive constipation. There idenfied to assist state	Behavior Assessment Care 117, identified bipolar affective Risperdal, Xanax and Vistaril. Included, monitor for side altered perception or anized speech, lethargy, we level, hallucinations and are no staff interventions taff of how to deal with R108's lemanding, using profanity and er residents in the facility to e behaviors.				
	(ACP) notes from 3 R108 had areas of which included: cor wound care, fluid re therapies, medicati control, activity leve	ciated Clinic of Psychology 8/31/17 to 9/29/17 identify concern that increased his risk appliance with medical advice, estrictions, participation in on compliance, impulse and social isolation. The 8 main focus was cigarettes.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 75 of 212

Minneso	<u>ita Department of He</u>	ealth					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:				(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	JMBER:	A. BUILDING:		COMP	LETED
		00442		B. WING		40/0	E/0047
		00112		D: WIIVO		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
				JNTRY CLUB			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE					
			GOLDEN	VALLEY, MN	1 55427		
(X4) ID		ATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM.		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG		00 10 211111 11110 1111 21 1111	711.01.7	IAG	DEFICIENCY)	1000	
				 			
2 830	Continued From pa	ige 75		2 830			
	The ACD recomme		- atifical				
		endations were as ide	anuneu.				
		to make sure he is	4. 4- falland				
		his medicaiton, need					
		endations, and comp					
		08 can be successfu					
		agreed not to empt					
		side; FM-B is helping					
		cigarettes so he has					
		the cigarettes, to he					
		vants his motorized v					
		R108 was unsafe us					
		s power chair has br					
		ty was working on ge					
	for this chair, but th	is is difficult since th	e chair				
	model has been dis	scontinued. A 3/31/20	017 ACP				
	note indicated that	using the word "bou	ndaries" is				
		08 knows and respor					
	redirecting him by r	eminding him of the					
		eers and staff may b					
		o further mention of					
		1/17, and 7/28/17, n					
		provided R108 with					
		emotional support as					
		9/15/17 and 9/29/17					
		used problem solvir					
		motional support and					
		ositive behaviors as					
	interventions.	OSILIVO DONAVIOIO AO	GIICOLIVO				
	During interview on	10/4/17 at 9:23 a.m	with				
		both stated, R108 h					
		at staff and residen					
		d has called 911 whe					
		of bed and was very s					
		so and is a difficult p					
		ular basis but also re					
		ne does this about or					
		only verbal behaviors					
		are his main focus					
	∣ behaviors. ACP tol	d us to develop a cig	jarette				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 76 of 212 X11C11

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	plan, and roll his ciglonger and this would other residents. This then he wanted mostarted to sell them complained they we not like the taste, so program. This progume 2017, and we other behavior plan uses profanity to gehim why, he says that tention. He is a we figure out what we a plan in place for he behaviors have got on 2nd floor. They the	garettes so his money lasted alld stop him from bothering is program initially worked, but ore and more cigarettes. He to other residents, then he ere not packed right and did to he (R108) stopped this gram stopped at the end of have not implemented any a since, we do our best. He et your attention, and if you ask nat he does this to get their tork in progress, we try to need to do but we do not have his behaviors and his ten worse since he was placed try to keep him occupied but rn over it has been tough to be	2 830			
	Although ACP has made some recommendations, there was no indication the facility has consistently used these recommendations or had a plan to place to handle or divert R108 behaviors of using profanity, yelling at residents, staff and refusing his cares. Pain					
	R48 was cognitively diagnoses of anxiet and received hospid R48 was receiving medication, however pharmalogical inter MDS pain interview occasionally, which night and limited R4	S dated 6/17/17, indicated y intact. The MDS identified ty, depression and fracture ce care. The MDS identified scheduled and as needed painer, did not receive any nonventions related to pain. The indicated R48 had pain made it difficult to sleep at 48's daily activities. R48 rated 10 at the time of the MDS. R48				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 77 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 77	2 830			
	did not have a Pain	Care Area Assessment.				
	During interview on stated she had pair way around to her is She rated her pain worse pain. R48 statime, and it went avecould fall asleep. Resymptoms of pain of the following medically on opiat disease, migraines, 5th metatarsal bone metabolic encephait the following medically in the foll	10/1/17, at 3:53 p.m. R48 in from her belly button all the back, including her shoulders. 9 out of 10, with 10 being the lated she hurt like that all the way only when she slept, if she 48 did not display any signs or during the interview. Index signed 8/31/17, included iagnosis: chronic pain, let therapy, degenerative joint, closed fracture of the 4th and les of the right foot and lopathy. The orders included ations used to control pain: recotic for moderate to severe milligrams (mg) every 4 hours led), started on 7/11/17. Table tab 5 mg every hour PRN, 10.4 mg dissolve 1 tab under the lutes up to 3 doses PRN, let erve pain) 400 mg 2 caps 3/6/17. The evening every 12 hours, 7. In the evening every 12 hours, 7. In the evening every 12 hours, 13 minophen) 500 mg 2 tabs are order did not indicate a start didministration Record (MAR) indicated the following				
		00 mg 2 caps twice daily a.m. and 8:00 p.m.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 78 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	- morphine sulf a.m. and 2 tablets i scheduled for - MPAP (acetar three times daily, so p.m. and 8:00 p.m. and 8:0	ate ER 15 mg 1 tabl n the evening every 9:00 a.m. and 9:00 minophen) 500 mg 2 cheduled for 8:00 a.i p.m.	12 hours, p.m. 2 tabs m., 12:00 2 tabs m., 12:00 3 care plan 3 erved m. R48 did ain, but sheduled not ed hospice important she stated behind 148 stated ication as ries to er pain a 9 3 stered them to 4 m. RN-E packaging from the s morning is were e staff the ter iched	2 830			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 79 of 212

PRINTED: 11/01/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00112 10/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE **GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 79 2 830 administering R48's morning medications, that included pain medications. RN-A then stated, "that's not good." At 10:48 a.m. RN-E stated she administered R48 the following medications after the scheduled time: omeprazole (treatment of gastroesophageal reflux disease) 40 mg, ativan (anti-anxiety) 0.5 mg, morphine sulfate (narcotic) 15 mg, two tablets of Tylenol (pain reliever) 500 mg, two capsules of diltiazem (treat high blood

During interview on 10/3/17, at 11:46 a.m. NA-C stated R48 had never complained of pain to her, but if she did NA-C would notify the nurse. NA-C further stated the nursing assistants did not interact much with R48 as she was independent with most cares.

pressure, angina and certain heart rhythm disorders) 180 mg, duloxetine (treat major depressive disorder,) 60 mg, and two capsules of gabapentin (treat nerve pain) 400 mg.

During follow up interview on 10/3/17, at 2:06 p.m. R48 stated her pain was "pretty bad" right now, and after receiving her pain medications late, it didn't help her pain much. R48 stated she was going to lie down and try to sleep to relieve her pain.

On 10/3/17, at 2:35 p.m. RN-E stated R48 was asked her pain level at least every shift, occasionally she requested PRN pain medication, and usually rated her pain a 7 out of 10 or better. RN-E stated she thought the medications helped her and stated going to chapel was a non-pharmalogical intervention. RN-E stated a comprehensive pain assessment was done on admission, but was not sure if the pain assessments were completed any other time.

Minnesota Department of Health STATE FORM

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUI. TAG REGULATORY OR LSC (DENTIFYING INFORMATION) 2 830 Continued From page 80 During interview on 10/5/17, at 9:12 a.m. ADON-C stated it was important to receive pain under control, and when it gets out of control R48 becomes more anxious increasing the pain. When interviewed on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain, or had changes to her pain medications within the last few months. ADON-A reviewed R48's chart and stated there should be a comprehensive pain assessment and care plan to help manage R48's pain. During telephone interview on 10/5/17, at 11:25 a.m. hospice RN-F stated the had communicated to the floor nurse on how giving pain medications timely was very important for R48. RN-F stated it was important not only to control her pain, but for her psychosocial well being as she gets very anxious which increased her pain levels. HOSPICE R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had an intovilling urinary catheter. R134's care plan dated 10/17, indicated he had a history of urinary tract infections and	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
CALLEY, MR 55427 COUNTRY CLUB DRIVE GOLDEN VALLEY, MR 55427 COUNTRY CLUB DRIVE GOLDEN VALLEY, MR 55427 COUNTRY CLUB DRIVE GOLDEN VALLEY, MR 55427 DEPERENCE OF THE APPROPRIATE CLOSS - CROSS-REFERENCE OF TO THE APPROPRIATE COUNTRY TAG CROSS-REFERENCE OF TO THE APPROPRIATE COUNTRY TAG CROSS-REFERENCE OF TO THE APPROPRIATE DATE OF THE APPROPRIATE DEFICIENCY DEFICIENCY			00112		B. WING		10/	05/2017
CALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427	NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET				STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 80 During interview on 10/5/17, at 9:12 a.m. ADON-C stated it was important to receive pain medications timely, because it is hard to get pain under control, and when it gets out of control R48 becomes more anxious increasing the pain. When interviewed on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain, or had changes to her pain medications within the last few months. ADON-A reviewed R48's chart and stated there should be a comprehensive pain assessment and care plan to help manage R48's pain. During telephone interview on 10/5/17, at 11:25 a.m. hospice RN-F stated he had communicated to the floor nurse on how giving pain medications timely was very important for R48. RN-F stated it was important not only to control her pain, but for her psychosocial well being as she gets very anxious which increased her pain levels. HOSPICE R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had an indwelling urinary catheter. R134's care plan dated 10/17, indicated	GOLDEN	I VALLEY REHABILIT	ATION AND CARE		_			
During interview on 10/5/17, at 9:12 a.m. ADON-C stated it was important to receive pain medications timely, because it is hard to get pain under control, and when it gets out of control R48 becomes more anxious increasing the pain. When interviewed on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain, or had changes to her pain medications within the last few months. ADON-A reviewed R48's chart and stated there should be a comprehensive pain assessment and care plan to help manage R48's pain. During telephone interview on 10/5/17, at 11:25 a.m. hospice RN-F stated he had communicated to the floor nurse on how giving pain medications timely was very important for R48. RN-F stated it was important not only to control her pain, but for her psychosocial well being as she gets very anxious which increased her pain levels. HOSPICE R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with tolleting and was always continent of urine. R134's MDS failed to indicate he had an indwelling urinary catheter. R134's care plan dated 10/17, indicated	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
had a Foley catheter. R134's Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed	2 830	During interview on ADON-C stated it was medications timely, under control, and was becomes more and When interviewed of ADON-A stated she having pain, or had medications within reviewed R48's chas a comprehensive puto help manage R4. During telephone in a.m. hospice RN-F to the floor nurse or timely was very imply was important not continued to her psychosocial was anxious which increased extensive as was always contine failed to indicate he catheter. R134's can he had a history of had a Foley cathete Incontinence Care of 7/27/17, indicated his with toileting and was bladder and staff mand used incontined assessment indicated in the catheter.	10/5/17, at 9:12 a.m. vas important to recei because it is hard to when it gets out of co ious increasing the portant to a treat and stated there shain assessment and stated he had common how giving pain me portant for R48. RN-Fonly to control her painell being as she gets eased her pain levels. The chart and stated the rease and a stated he had common how giving pain me portant for R48. RN-Fonly to control her painell being as she gets eased her pain levels. The chart and indwelling under plan dated 10/17, urinary tract infection are plan dated total dependent products. The CAA area has a urinary urged to the had urinar	ive pain get pain ntrol R48 ain. a.m. was ADON-A hould be care plan at 11:25 unicated dications stated it n, but for very 7/13/17, paired, ting and IDS inary indicated s and AA) dated adence rel and ance cares a gency and	2 830			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 81 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o.	2) MULTIPLE BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00112	В. \	WING		10/0	5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 750	REET ADDRES O S COUNTR O L DEN VAL	RY CLUB			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	. F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	to indicate he had a R134's hospice car indicated R134 had elimination and had catheter. Home hea bladder function, hy urinary catheter car hospice care plan in caregiver will demo On 10/03/17, at 8:2 the dining room to h below his Broda cha chair). During interview 10 nurse-North Memor been put on their ca has had his cathete to hospice. In addit not changed his cat was the facility's res During interview on assistant director of R134 had went to th he was on third floo when he returned fr stated his catheter weekly and the cath monthly. ADON-B he returned from th and she was not su completed since the ADON-B stated the for his catheter care During observation	e plan dated 07/07/17, alteration in bladder an indwelling urinary alth/hospice was to assest dration and education or e as needed. In addition adicated patient, family, instrate proper catheter of 2 a.m. R134 was observed as a catheter bag attack air (tilt and space position) (03/17, at 9:30 a.m. hospital (HN)-A stated R134 has e load on 07/06/17, and are ever since he was admitted at the endomination, HN-A stated hospital in July 2017, and sponsibility. 10/05/17, at 8:43 a.m. In a finursing (ADON)-B statement of the hospital in July 2017, and transferred to first from the hospital. ADON-bag should be changed enter should be changed enter should be changed stated there no orders when the hospital for catheter care if either had been ey had no orders. The facility should be responsible and the control of the property	ss of the care. ed in ched hing ched hing ched had that ed when floor B hen are asible	830			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 82 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				P WINC			
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	catheter anti-reflux covered in a thick, During interview on stated he did not not catheter. He indicathospital and returned catheter. NA-J states bag each shift. During interview on ADON-B stated the when to change the indicated she was undicated she was undicated she was undicated to changed the since he returned for (almost two months noticed the sediment know why he had a one before his hospital to catheter was pleading interview on had contacted R13 orders to remove the not have a reason of ADON-B further incisigns and his temposigns of sepsis. Although R134 had hospice or the nurse.	to the left side of the valve and tubing ins mucus gray matter. 1 10/05/17, at 9:00 a. ormally see gray sed ted R134 had been it ed to the first floor wited staff empty the cate of the ted staff empty the cate of the ted staff empty the catheter, bag and to unable to locate ordeted she would assume catheter, tubing arrom the hospital on (as). ADON-B further since the catheter since he not catheter since he not catheter since he not catheter since the for R134 to have the dicated she had take erature was 98.2 and an indwelling catheter in the dicated she had coord on was responsible for R134 to have the dicated she had coord on the R134 to have the dicated she had coord on the R134 to have the dicated she had the R134 to have the dicated she had the R134 to have the dicated she had the R134 to have the R134 to have the R134 to have the R134 to have the R13	m. NA-J iment on a n the ith the atheter m. orders on ubing and ers for ne staff nd bag 07/05/17, stated she d did not ever had 8 stated on the stated she ceived facility did catheter. n his vital d had no ter, neither inated his	2 830	DEFICIENCY)		
	A Service Agreeme	ent By And Between I	Hospice				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET				STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILITA	ATION AND CARE	7505 COU	INTRY CLUB	DRIVE		
GOLDLIN	VALLET KENADIEN	ATION AND CARL	GOLDEN	VALLEY, MN	55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 83		2 830			
	dated 05/23/16, ind Care means a writte maintained, reviewe collaboration betwe Facility that includes patients needs, (b) Services, including and symptom relief need and related no Family, and (c) deta frequency of such h	lity (North Memorial Hicated: "Combined Plen care plan established, and modified, in en Hospice and the Nos (a) an assessment an identification of Homanagement of disconceded to meet such eeds of the Hospice Fails concerning the sollospice Services. (d) untability of services".	an of hed, Nursing of each ospice omfort he patient's Patient's ope and				
	R48 was cognitively diagnoses of anxiet hospice care. The Marceliving scheduled medication, however pharmalogical intermedication medication, however pharmalogical intermedication, which night and limited R4 her pain a 7 out of a did not have a Pain	S dated 6/17/17, indice intact. The MDS identified R48 was needed painer, did not receive anywentions related to pain indicated R48 had pained it difficult to slease the state of the MC are Area Assessment.	ntified ceived as / non- in. The ain eep at 48 rated MDS. R48				
	care plan directed to care plan dated 8/1 end of life care related and congestive heat indicated physical sideclining status. However, the convey theses choice are plan directed to the care plan direc	n assessment and ca owards pain. R48's P 7, indicated R48 was ted to coronary artery rt failure. The care pl ymptoms of pain and ospice and nursing sta	alliative receiving disease an aff were				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 84 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	needed, liberalize de condition, encourage contraindicated and support resident's dand see pain mana no facility pain man R48's hospice docuseparate binder at thospice changes in orders. The most recomprehensive Ast Update Report was of care was on 3/9/recertified for hospidate Acurrent problem in Pain remained a 7, change after collab facility nurse, discound increased long bedtime. During interview on ADON-A stated she having pain and any the last few months recent hospice care ADON-A stated the with the floor staff, the care in facility with the floor staff, the care in facility with the care in facility with the floor staff, and her hospice team of the form of the floor staff, and her hospice team of the floor staff, and the floo	liet according to medge fluids unless a per resident comformation not to eat or gement care plan. It agement care plan at the nursing desk, and the hospice care plans at the hospice IDG sessment and Plans at dated 6/15/17. Hos 17, and was current and care from 6/7/17, ist included altered at 8, or 9 out of 10 with oration with resident not included short acting acting MS Continued short acting acting MS Continued at 10/5/17, at 10:14 a. It was not aware R48 by pain medication changed a plan was from July hospice nurse may but the ADON-A stated the plan was from July hospice nurse may but the ADON-A stated the plan was from July hospice care plan to effected care. ADON-A sween the facility and a stated she had never a care conference warm.	in a d included an and of Care pice start ly to 9/4/17. comfort. In little and morphine 30 mg at 2017. Check in managed ied in ectively tated the l hospice er been with R48 at 11:25	2 830			
	a.m. from AserCare	e Hospice RN-F state etween hospice and	ed the				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 85 of 212

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, '	(X3) DATE SURVEY COMPLETED	
00112	B. WING		10/05/2017	
NAME OF PROVIDER OR SUPPLIER S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
GOLDEN VALLEY REHABILITATION AND CARE	505 COUNTRY CLUB DRIV OLDEN VALLEY, MN 5542			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID LL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE E DATE	
was going okay. RN-F further stated there only been one care conference between he and the facility since the start of care in Ma RN-F stated there were no facility nursing present and only the social services assist (SS)-A and R48's spiritual advisor were present the care conference. RN-F stated hospice reviewed their resident care plans every two weeks and the company was to fax over the updated forms when completed. RN-F was sure why the facility's most recent hospice plan was from July 2017, and there needed better coordination of care. The Hospice Care Services Agreement be the facility and AserCare Hospice set to ex 11/10/17, indicated: "The facility shall furnishour room and board care, meeting the pecare and nursing needs of the Hospice Pacoordination with the Hospice representative ensure that the level of care provided is whould have been provided by the primary caregiver at home and at the same level or provided before Hospice care was elected. R21's quarterly Minimum Data Set (MDS) 8/23/17, identified R21 had severe cognitive impairment and required extensive assistation with activities of daily living (ADLs). A Resident Smokers listing dated 9/29/17, provided upon entrance to the facility on 10 The listing identified all current smoking rewhich included R21. On 10/1/17, at 3:37 p.m. R21 was seated it room in her wheelchair. R21 stated she wwith waiting to go outside to smoke adding, "I son my own," after staff help her get outside	ospice arch. staff ant esent at 70 ne s not care d to be tween pire on sh 24 rsonal tient in we and nat f care " dated re nce was 0/1/17. sidents n her as moke			

Minneso	<u>ta Department of He</u>	alth					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		00112	B. WING		10/0	5/2017	
					1 10/0	00	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CARE	JNTRY CLUB VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 86	2 830				
	12:50 p.m. R21 was main entrance with R96, smoking with No staff were present R21, and she had result and ash without droor her clothing. R2 take me," outside to cigarettes for her. (AA)-A approached and conversed with bingo stating he wowhen you're done so inside. Afterwards, another resident, R cigarette. R21 hand who used it to light p.m. registered nurs resident outside to smoking. RN-A ask a cigarette?" R21 r	observation on 10/2/17, at a outside on the patio by the other residents, including a lit cigarette in her right hand. In outside on the patio with no visible smoking apron on. Ing the cigarette to her mouth opping any ash(es) on herself 1 stated, "People [staff] always o smoke adding they light the At 12:58 p.m. activities aide R21 while outside smoking her. AA-A invited R21 to uld, "come back out here moking," and bring her back R21 was approached by 134, who asked her for her lit ded her lit cigarette to R134 his own cigarette. At 1:02 se (RN)-A brought another smoke and observed R21 ked R21 aloud, "who gave you responded to her, "I smoked it wing it on the ground next to					
	completed Smoking Assessment dated unable to communi smoking standards demonstrate appropriate ability to appropriate was identified to be directed to refer to	rd was reviewed. A g Safety Data Collection and 10/2/17, identified R21 was cate understanding of the and procedures, did not priate use of an ashtray, nor ely extinguish a cigarette. R21 a "dependent smoker," and the facility smoking policy for					
	signed on 10/2/17, (ADON)-A (the same	ments. The assessment was by assistant director of nursing te day the surveyor observed the without staff supervision)					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION | A. BUILDING:

(X3) DATE SURVEY
COMPLETED

00112

B. WING __

10/05/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	GOLDEN			
(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) COMPLET DATE
2 830	Continued From page 87	2 830		
	R21's progress note dated 10/2/17, at 1:25 p.m. identified an entry of, "[R21] was outside smoking. Smoking assessment completed. Resident is deemed a dependent smoker. Smoking materials removed from resident & [and] put in med room."			
	When interviewed on 10/3/17, at 9:28 a.m. nursing assistant (NA)-F stated R21 used to smoke but, "does not anymore." NA-F stated R21 was not going outside to smoke to her knowledge.			
	During interview on 10/3/17, at 9:51 a.m. ADON-A stated R21 was not a smoker until yesterday when staff found cigarettes in her room. ADON-A stated she was directed to complete a smoking assessment yesterday because R21 went outside and was smoking. ADON-A stated she was not sure why R21 had been included on the list of smokers presented upon entrance, however, added it was important to assess safety with smoking for residents to prevent injury or burns.			
	R96's annual MDS dated 6/21/17, identified R96 had intact cognition. When interviewed on 10/3/17, at 3:04 p.m. R96 stated staff bring R21 outside to smoke, and had done so several times in the past.			
	When interviewed on 10/3/17, at 3:06 p.m. assistant executive director (AED)-B stated the Resident Smokers listing provided on entrance was created by asking the nurse managers and social services staff on each floor who is currently smoking. AED-B stated the listing was current upon the survey team entrance as, "that's who they [staff] gave me," as current smokers.			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	7505 COU	INTRY CLUB	DRIVE		
GOLDLI	VALLET KENADIEN	ATION AND CARE	GOLDEN	VALLEY, MN	55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 88		2 830			
	R20's Admission Roidentified resident hidiagnoses, in additing hypertension, and continuous continu	ecord, dated 10/3/17 ad multiple mental h on to heart failure, liabetes.	ealth				
	R20's quarterly MDS dated 7/9/17, identified moderate cognitive impairment with fluctuating episodes of attentiveness and disorganized thinking, as well as moderate symptoms of depression. R20 was noted to receive extensive assistance with transfers and supervision for locomotion on the unit. The MDS failed to identify R20's tobacco use status.						
	hospice nurse (HN) smoke." HN-A state while outside smok	1/03/17, at 9:49 a.m -A identified R20 "Lo ed R20 experienced ing independently du rtly thereafter was ur	oved to a fall ring the				
	8/22/17, at 3:50 a.m on the floor in front R20 was noted to hose and was sent evaluation and treat at 5:15 a.m A substitute of the supervised smoking initiated. A review of identify any addition minutes checks or some of 9/1/17, identify the parking logarithm of the parking logarithm of the parking logarithm of the parking logarithm.	sing progress notes noted R20 wo of the facility at 2:45 have a cut on bridge of to the emergency rotment, returning to the sequent note of 8/23. R20 was non-compligand a 15 minute characteristics. A tified R20 had been to on two occasions. The side without supervisuard would be placed capacity to get back I for injury with traffic	vas found a.m of the om for he facility /17, at hiant with heck was not ding 15 progress noted to The note she sion to I due to into the				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 89 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
	00112	B. WING		10/0	5/2017
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN VALLEY REHABILITA	ATION AND CARE	INTRY CLUE VALLEY, MN			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
A review of R20's ca for injury related to a smoking assessment, dated felt to be a depender supervision) due to clothing and would smoking. The care change in status, in supervision. The cawere in place for 5/c changes made to care plan did not rewanderguard for sa During interview on health unit coordinarequire supervision weeks prior to her of was unsure of the radirection of upper more wanderguard for sa direction of upper more kept in the mesupervision was recommended. During interview on NA-U stated R20 has smoking but was an approximately two to was unaware of the During interview on stated R20 had been until the last month,	are plan noted R20 was at risk smoking. The care plan noted nent had been completed on iffed R20 met the criteria to the ty. A subsequent smoking 2/13/17, identified R20 was ent smoker (requiring cigarette burn holes noted in require supervision with plan did not reflect any dicating a need for the plan review and signatures 11/17 and 8/11/17, with no are plan interventions. The flect recent placement of fety, effective 9/1/17. 10/3/17, at 2:37 p.m. the stor (HUC)-A stated R20 did with smoking for the last two death on 9/23/17, however, ationale as this was under the management. R20's cigarettes edication room once quired. 10/03/2017, at 2:53 p.m. and been independent with ware this had changed on three months ago, although a reason.	2 830	DELIVOIT)		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00112		B. WING			05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	During interview on director of social se mood state was im cigarettes, stating to R20 would pick up ground. The DSS saware of this behave placement of the whe had not observe posing a risk for but During interview on ADON-A and ADON previously been independent of the wanderguard was provided the provided of the state of the state of the state of the social state	10/5/17, at 10:57 a.r ervices (DSS) stated I pacted upon availabil hat when her supply cigarette butts off of tated staff members vior and this contribute anderguard. The DSS of R20 ashing on hers rns. 10/5/17, at 11:14 a.r N-D. ADON-A stated be pendent with smoking alth declined R20 was facility easily and a placed at that time. The use of the wanderguard R20's ability to smoked and attempts to exit was provided to the state of the wanderguard.	R20's ity of was gone the were ed to S stated self, m. with R20 had ng, s unable uard ke, but without	2 830			
	supervision. A revie completed by ADOI to be an independe not been make follo 2/13/17. ADON-A stated was	ew of the care plan wa N-D and noted R20 w Int smoker, and a rev owing the assessmen s unaware R20 was t smoker, further statin	as vas noted ision had it of o have				
	smoking the care p updated. ADON-As comprehensive car done.	ny indication for dependent in should have been stated due to staff ture plan review had no	nover, a t been				
	4/2017, identified the residents, "who he independent smoke	esota) Smoking Polic ne facility allows smol ave been assessed t ers or have a safe sm ther, the policy direct	king for o be oking				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 91 of 212

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	FATION AND CARE	UNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 91	2 830			
		ng abilities upon admission, any significant change in				
	The director of nurse educate and monitor					
	Also - The director of nursing and/or designee could educate licensed staff how to comprehensively assess and care plan for residents who wish to smoke, to do so safely.					
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			11/13/17
	that is directed tow through positioning implemented and n comprehensive res of nursing services	f motion. A supportive program rard prevention of deformities g and range of motion must be maintained. Based on the sident assessment, the director must coordinate the nursing care plan which				
	receives appropriat	th a limited range of motion te treatment and services to motion and to prevent further of motion.				
	This MN Requirem	ent is not met as evidenced				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	by: Based on observatireview, the facility frange of motion (Riresidents (R121) reange of motion and Findings include: R121's diagnoses, orders dated 9/28/1 Alzheimer's demen Minimum Data Set indicated R121 was required the physic bed mobility, eating personal hygiene. Recommendations R121, dated 4/6/17 Active Range of Mc Program History re R121's passive RO Resident will maintawith assistance of cextremities twice a The program direct Perform PROM to Report to nurse and R121's mobility car contractures and m problem. During interview on member (FM)-C stated when ROM for R121, and towels and places in hand to keep them	ion, interview and docailed to consistently pomiservices for 1 of eviewed whom had a lid restorative nursing. as identified on physical forms as identified on physical as identified early onstia. A significant charm (MDS) dated 8/18/17 is totally dependent up all assistance of two sold assistance of port, printed 10/4/17, M program goal to be an current range of noticing PROM to bilated day for 15 reps each ed: 1. Explain procesoilateral lower extrem y complaints of pain, as the plan, dated 4/17, identification is a complaint of pain, and the plan assistance of late had be colled up hand towels from rolling up and gishe "questioned" if (Figure 1) in the plan and graphs of the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs and graphs are graphs as a figure 1) in the plan and graphs are graphs and graphs are graphs as a figure 1) in the plan and graphs are graphs and graphs are graphs and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs as a figure 1) in the plan and graphs are graphs are graphs are graphs as a figure 1) in the plan and graphs are graphs	cian's et inge in cian's rative indicated e: notion ral time. edure; 2. ities and; refusals. entified target in R121's etting in R121's etting	2 895	Corrected		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 93 of 212

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	ROM program was R121 was to get R0 not sure staff are do During observation was lying in his bedwindow, a pillow unwere at his side, ell 45 degree angle froupon his stomach. bilaterally, on his fe observation from 8 remained lying on ha.m., nursing assist nurse (RN)-B repos RN-B, NA-D and Nodressing change ar R121 was again reprogram group the stated she assisted did not do any kind stated she "did not motion or exercise" When interviewed of stated R121 did not motion or exercise When interviewed of stated R121 did not restorative nursing. program from there are doing that." RN-B stated from a ROM program arms and hands "mand in the staff of the	getting done. FM-C stated DM twice daily, but stated "I'm oing that." on 10/3/17 at 8:18 a.m., R121 in his room, facing the der his left side. R121's arms rows folded and forearms at om his elbow, and situated R121 wore heel boots, et. During continuous it am to 11:32 a.m., R121 his bed in his room. At 9:29 tant (NA)-D and registered sitioned R121. At 11:32 a.m., A-B assisted with R121 with a repositioning. At 1:58 p.m., positioned by NA-B and NA-D. ed nor was provided any range by of the visits by nursing staff rames. 10/3/17 at 2:06 p.m. NA-D I R121 only to reposition and of ROM exercises. NA-D think" R121 has any range of program. on 10/3/17 at 4:38 p.m., RN-B thave any orders for RN-B stated if there was a apy, "licensed staff would be stated there were no orders in d for range of motion for I, however, R121 could benefit am, so (R121) could keep his	2 895			
		., NA-A and NA-C assisted				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILITA	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	R121 with morning cares, including repositioning and oral cares. There was no provision or offer to			2 895			
	complete range of motion for R121 during his morning routine.						
	When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a range of motion program, and has not assisted him with that. NA-C stated often therapy often worked with						
	resident in their rooms, but has not seen anyone work with R121 in his room. NA-C stated she did not perform ROM for R121.						
	During an interview on 10/4/17 at 9:59 a.m., NA-A stated she did not think R121 had any range of motion program, and if he did, we would have had "someone from therapy" show us what to do. NA-A stated she did not help R121 with any exercise or range of motion.						
	A review of the ROM (Range of Motion) detail report from 7/8/17 to 10/4/17 indicated the following number of times ROM was provided R121; number of refusals; and number of times ill:		e ided				
	July 20x (times August 34x F September 15	s) ROM; 4x refusals; al ROM; 1x refusal; and 2 x ROM; 3x refusals; 1 gh 10/4) 2x ROM; 0x	x ill x ill				
	director of therapy (therapy case load a return from hospital restorative program The DT stated she		peen on his or R121.				
	discussion that ROI	wo months ago and red M that was being comp unable identify how his	oleted				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 95 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	program was being The DT stated R12 and would be a car motion exercises. When interviewed ophysical therapist (evaluated last April that time R121 was in range of motion remained unchanged definitely "would be described the planknees, ankles, bilated (repetitions) each, atwice daily. When interviewed assistant director of R121 had a restoration aides should be concares or when report aides should be concared or when report aides should be concared the ROM program because of stated the ROM protection that is the care plan, the inprogram in care trained she "expected motion services. A facilty policy, Conduct July 2015, indicated improve joint mobil maintaining or reduction of the Policy included	inge 95 I monitored for compliance. It had muscle contractures indidate for passive range of an 10/4/17 at 8:16 a.m., PT)-A stated R121 was indidate for passive range of an 10/4/17 at 8:16 a.m., PT)-A stated R121 was indide to actively participate and his condition has ed. PT-A stated R121 incefit" from ROM and ito include PROM to legs, iterally, and usually 10 reps and the exercises be done and to include PROM to legs, iterally, and usually 10 reps and the exercises be done and iterative program and futher the impleting that task, during in positioning. The ADON 21 could be 'refusing' the of his current disposition and in gram was to be completed in each time. ADON-C also in this was not "spelled out" in instructions for restorative incker was part of the care plan, in R121 was to receive range of a intracture Prevention, dated in the contracture of deformity. It is a sit purpose "To maintain or ity to assist resident in eving independent function, or cing contracture or deformity. It is providing PROM (passive is an intervention to achieve the	2 895			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 96 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED		
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, S INTRY CLUE	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 96		2 895			
2,000	The director of nurse educate the response resident range of matheir assessed need contraction and/or aphysical ability. The conduct of range of residents to ensure consistently. TIME PERIOD FOR (14) days.	THOD OF CORRECT sing and/or designee isible staff in the proviotion programs, accords, to prevent resider maintain current level to DON or designee of motion programs for the services are imp	could ision of ording to ot of ould lemented urteen	2 900			44/42/47
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of a nursing services development of a nursing services that: A. a resident who without pressure sores unle condition demonstrate authenticates, that authenticates, that services necessary promote healing, promote healing, promote healing, promote sores from developments.	sores. Based on the ident assessment, the must coordinate the ursing care plan which o enters the nursing lores does not developes the individual's clastes, and a physician they were unavoidable who has pressure sore y treatment and service y treatment and service event infection, and yeloping.	e director ch nome p linical le; and es ces to prevent	2 900			11/13/17

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE Valley, Mi			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	nge 97		2 900			
	review, the facility frepositioning for 2 cwhom had or were ulcer development. provide a compreheresidents (R6) in the pressure ulcer.	ion, interview and do ailed to provide timel of 4 residents (R121 identified at risk for p In addition the facilt ensive assessment for e sample with a stag	y , R134) pressure ty did not or 1 of 2		Corrected		
	Findings include:						
	TURNING REPOS	ITIONING					
	R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent and required the physical assistance of two staff for bed mobility, and toileting. The MDS indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue). The care area assessment (CAA) worksheet for pressure ulcers, dated 8/21/17, also identified R121's total dependence upon staff for bed mobility. The CAA indicated R121 was incontinent of bowel and bladder, was unable to communicate needs and did not speak,further staff anticipated R121's needs. The CAA also indicated R121 had a stage 4 area to coccyx, and was seen by a wound doctor weekly.						
	10/2/17, at 12:34 p observed. R121's coccyx area, and m centimeters (cm) b cm. The wound be surrounding skin w	of R121's dressing of c.m., R121's wound wound was open, on neasured approximate y 2.5 cm with depth of dwas dark pink in coas intact, normal in coor swelling. The wou	vas the ely 4 of 1.25 olor. The olor, and				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 98 of 212

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN	I VALLEY REHABILLIALION AND CARL	INTRY CLUB VALLEY, MN		
(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) COMPLET DATE
2 900	Continued From page 98 without odor, and had minimal drainage. During continuous observation on 10/3/17, from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed which remained unchanged. At 1:58 p.m., nursing assistants (NA)-D and NA-B entered R121's room, closed the door behind them, and announced to R121 they were going to "check you" and "reposition you." Working on each side of R121's bed, NA-D and NA-B raised the bed to a working height, and began their cares, talking with R12. R121's brief was checked and was not wet. NA-B removed the pillow from under R121's left side, and NA-D took out the pillow between his legs. Together NA-B and NA-D pulled R121 up in bed, then refitted the pillows between his legs, and then placed R121 slightly facing the window, with a pillow under R121 right back side. The pillow between R121 legs was replaced, and legs adjusted, then R121 was covered with the bed sheet. Before NA-B and NA-D exited the room, they removed gloves and washed their hands. During an interview on 10/3/17, at 2:06 p.m., nursing assistant (NA)-D stated the last time R121 was "done" (repositioned) was at 11:30, and now it was two o'clock. NA-D stated we got busy, and that (R121) should be checked and turned every two hours. NA-D stated "it was late." The "Skin Integrity Assessment: Prevention and Treatment Care Plan" for R121, dated 4/17, identified R 121's pressure ulcer to coccyx, and directed a turn and reposition program with a frequency of "Q2" (every) two hours. The care plan also directed staff to monitor wound weekly and PRN (as needed).	2 900	DEFICIENCY)	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00112	B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 COL	DRESS, CITY, S JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Initial Evaluation, has wound on cocc (length, by width by measurable cm (ce tissue. At request p stage 3 pressure ul day duration. There is no indicatic condition. Wound and Plan of Care R pressure ulcer wou Discontinue house skin Prep once daily mattress (pressure twice daily, zinc sul days, off load wound	Ge 99 Care Specialist Evaluations: dated 4/26/17, indicated R121 yx. Wound size (L x W X D) height): 2 x 0.5 x no ntimeters). 100% granulation provider, R121 presents with a cer wound Coccyx of a least 1 e is no exudate (drainage). On of pain associated with this size 1.0 Under assessment ecommendations: stage and -coccyx-initial evaluation. barrier cream twice daily; add y, foam, once daily; group 2 reducing), vitamin C 500 mg phate 220 mg once tail for 14 d, reposition per facility omplicating wound healing:	2 900			
	evaluation dated 5/24/17: Pressure wound,;stage 4; duration greater than 27 days; wound size 6.5 cm x 7 x 0.3 cm; light ser-sanguinous exudate; 15% thick adherent devitalized necrotic (dead, scar) tissue; 40% granulation (new growth) tissue; 45% skin; wound progress: deteriorated. Assessment and Plan of Care recommendations: surgical excisional debridement; continue skin prep once daily; foam once daily; Santyl once daily. evaluation dated 6/14/17: Pressure wound stage 4; duration greater than 26 days; wound size: 6.2 x 3 x 0.3 cm; light sero-sanguinous exudate; 100% thick adherent devitalized necrotic tissue; wound progress: deteriorated. Assessment and Plan of care recommendations: surgical excisional debridement; continue skin prep, foam and Santyl once daily.					

6899

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLDEN	I VALLEY REHABILIT	ATION AND CARE 7505 COU	NTRY CLUB	DRIVE		
GOLDEN	I VALLET KENADILIT	GOLDEN	VALLEY, MN	I 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	0 Continued From page 100		2 900			
	evaluation dated of stage 4, greater that x 2.3 cm; light sero thick adherent devit granulation tissue; Assessment and Pl Recommendations debridement. Disconfoam once daily; Sapressure three times wound are three times wound are three times are the times are the commendation of the commendation of the commendation of the commendations debridement; continuation thick are the commendations debridement; continuation of the commendation of	6/21/17: pressure wound, in 53 days; wound size 4.5 x 3 sanguinous exudate; 75% talized necrotic tissue; 25% wound progress improved. In of Care surgical excisional ontinue skin prep once daily; antyl once daily; add negative per week, skin prep to perime per week. 7: pressure wound stage 4, is in duration; sound size 4 x 4 and (area around wound): odor eep tissue injury) acceration; moderate Sero te; wound progress ssment and Plan of Care surgical excisional nue negative pressure three n prep to periwound area				
	greater than 66 day 5.2 x 4.8 x 2.4 cm; undermining (tunne o'clock (position on Sero-sanguinous edevitalized necrotic tissue; wound progand Plan of Care Rexcisional debriden times per week; ski three times per week on 7/5/17 evaluation 8/9/17:	xudate; 60% thick adherent tissue; 40% granulation gress improved. Assessment ecommendations: surgical nent; negative pressure three in prep to periwound area, ek. Prealbumin recommended pressure wound stage 4,				
		s; wound size 4.4 x 4 x 3.8				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	l ` ′			LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		7505 COL	JNTRY CLUE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	VALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PREFIX	-	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEHOLINOTY		
2 900	Continued From pa	ge 101	2 900			
	cm: light Sero sang	uinous exudate; 100%				
		wound progress improved.				
	Assessment and Pl					
		: improved as evidences by				
		area, increased granulation,				
		e dressing, twice daily, wet to				
	moist, twice daily.					
	Di	Annual Annual Chin Chin				
	Review of recent Wound Assessment Skin Grid,					
	for R121 indicated the following:9/27/16 stage 4 pressure ulcer (PU) measuring					
		s) in length, x (by) 2.8 cm in				
		epth; no drainage from the				
		and had tunneling (open				
	areas under the wo	und) at 12 o'clock (location on				
		od noted, area is painful to				
	touch.	DI 4 00 00 II I				
		PU; 4 x 3.2 x 2.0 cm, bloody				
		dead tissue) slough and mild at 12 o ' clock; debrided by				
		necrotic tissues, wound				
		or; air mattress frequently at				
		cation done with staff by writer.				
	9/11/17stage 4 F	PU; 3.6 x 3.0 x 1.0 cm;				
		rainage, red in color, no odor,				
	tunneling 3 to 8 o'cl					
		U; 3.8 x 3.0 x 1.3 cm;				
	and tunneling 3 to 8	drainage, red in color, no odor,				
		ly skin grid assessment found				
		grid assessment found				
		PU, 3.8 x 3.6 x 2.5; sero				
	tunneling/undermin	ing 3.8 cm depth at 12 o'clock				
	8/2/17 no weekly skin grid assessment					
	sanguineous pink drainage; no odor and tunneling/undermining 3.8 cm depth at 12 o'clock8/9/17 no weekly skin grid assessment7/26/16 no weekly skin grid assessment7/19/17 no weekly skin grid assessment7/12/17 no stage PU listed; 5.0 x 4.0 x 3.0; serosanguinous drainage with necrotic/slough					

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 102 of 212

Minnesota Department of Health

Millineso	ita Department of He	eaim					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPP		(X2) MULTIPL	E CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION N	NUMBER:	A. BUILDING:		COMF	PLETED
		00440		B. WING		40"	05/0047
		00112		B: Wii(0		10/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			7505 COL	INTRY CLUB	DRIVE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		VALLEY, MN			
(X4) ID		TEMENT OF DEFICIENC MUST BE PRECEDED E		ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFOR		PREFIX TAG	CROSS-REFERENCED TO THE API		DATE
			,		DEFICIENCY)		
2 900	Continued From pa	ge 102		2 900			
	tissue 40%; no odo	r: tunnel/undermini	na at 2				
	o'clock with depth 4		ng at Z				
			O. F. a.m.				
	7/5/17 no stage						
	serosanguinous dra	O ,					
	mild odor; tunneling	Jundermining at 4	O CIOCK				
	with depth of 4 cm.						
	6/28/17 no stage						
	serosanguinous drainage; red in color; foul odor;						
	no undermining/tunneling identified						
	6/21/17 no stage listed; 4.5 x 3.0 x 2.3 cm;						
	serosanguinous dra)				
	tunneling/undermin						
	6/14/17 no stage						
	serosanguinous dra	ainage; 100% necre	otic tissue;				
	no odor; no tunnelir	ng/undermining ide	ntified				
	5/31/17 no stage	e PU listed; 6.5 x 2.	5 x 1.2 cm;				
	serosanguinous dra						
	odor, no tunneling/u	undermining identif	ied				
	5/24//17 no PU st	tage listed; 6.5 x 7	x 3.0 cm;				
	serosanguinous dra	ainage; necrotic tiss	sue; no				
	odor; no underminii	ng/tunneling					
	5/17/17 no PU st	age listed; 6.0 x 2.3	3 x 0.1;				
	serosanguinous dra						
	no odor; no underm		•				
	5/10/17 no PU st		6 x 0.1;				
	serosanguinous dra	ainage; pink tissue	noted; no				
	odor; no tunneling of		,				
	5/3/17 no PU sta		x 0.1: no				
	drainage; pink tissu						
	or undermining	, ,	3				
	4/26/17 no PU st	age listed: 2.0 x 0.9	5 x 0 cm: no				
	depth, no drainage,						
	undermining/tunnel		-				
	4/19/17 no PU s		cm no				
	depth; no color; no						
	tunneling /undermir		, 110				
	4/12/17 (onset); i		nt unon				
	admission; site is c						
	no drainage, no col	or, no odor, no uno	ıcııııııı				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 103 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUB			
	I	GOLDEN	VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 103	2 900			
	member (FM)-A state "bed sore" and state was not getting rep FM-C stated there is she was at the facilithree hours" before she told the aides " (repositioned) every to the wound, staff stays as dry as posinot think R121's rejright. FM-C stated "staffing," no consist people always work	10/2/17, at 6:14 p.m., family ated she was aware of R121's ed she had concerns that he ositioned off his bottom timely. Were frequently times when ity when R121 was left "for he was turned. FM-C stated he's supposed to be y two hours." FM-C stated due need to make sure [R121] sible." FM-C stated she did positioning always got done there was an issue with stency, with so many new sing. FM-C stated she had told eat (R121) "like you'd treat				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 104 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	505 COU	ORESS, CITY, S NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	assistant director of R121 had a current also skin and woun completed by licens would expect the as least weekly. ADOI R121 to be turned as care planned. R134's significant of (MDS) dated 07/13, cognitively impaired two with bed mobilified MDS further indicated ulcers and had no parea Assessment (indicated he was do of daily living (ADLs and transfers with a lift. The CAA futher wheelchair with a concontinent of bower in addition, the CAA pressure and requires ufficiently to relieve and required regular R134's Skin Integrif And nutrition, friction further indicated he two hours and to produce the pressure relief surfaindicated he was almovement (BM) will		ted , and be , and heted at d 2 hours Set everely sist of g. The essure s Care tivities er staff anical theter. sk for nove e site ion plan every f Care uent e, a re plan wel	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		00112	B. WING		10/0	5/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE Valley, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	schedule and will be toileting. 32 minutes sitting in his Broda positioning chair), verpositioned/toileted 8:35 a.m. R134 was nurses station on the was moved across hall, at 9:12 a.m. Rechair, at 9:30 a.m. In hospice nurse moved dinning room. At 10 back into the hall ach	e cooperative with assisted es) R134 was observed to be chair (tilt and recline vithout being d or check and change. At a observed across from the se first floor, at 9:00 a.m. R134 from the nurse's station in the 134 was asleep in the Broda registered nurse (RN)-K/ ed R134 from the hall to the 0:02 a.m. RN-K moved R134 cross from the nurse's station. Was asleep in the hall in his 42 a.m. R134 was still in eep. At 11:00 a.m. Observation 10/03/17, from a.m. (2 hours and he was still m. surveyor informed nursing and NA-J of findings. 1/03/17, at 11:01 a.m. NA-N repositioned and checked him that after breakfast around 8:30 1/03/17, at 11:12 a.m. NA-M rested NA-N right after sitioning R134. She indicated from the enough staff and that after so so she could not	2 900				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 106 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

10/05/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN	I VALLEY REHABILITATION AND CARE	NTRY CLUB VALLEY, MN		
(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) COMPLETI DATE
2 900	Continued From page 106	2 900		
	intact with no open areas or redness of the skin.			
	A Procedure Turning and Positioning, effective July 2015 indicated: "The center provides assistance with turning and positioning. Residents will be turned and positioned according to their co-morbidities and individual abilities. The center strives to avoid musculoskeletal injury and fatigue and reduce the risk of injury of residents with the use of positioning techniques. The center strives to prevent pressure ulcers with turning and repositioning. Turning and repositiong may prevent pooling of lung secretions and improve circulation."			
	Although R134 was assessed to be at risk for pressure ulcers and was care planned to be turned and repositioned every two hours, R134 went almost three hours without being repositioned to help prevent development of pressure ulcers.			
	A facility policy, Pressure Ulcer Prevention/Treatment, dated July 2015, indicated all residents would be assessed upon admission and at regular intervals. Further, the policy identified interventions to manage pressure, including the use of turning and repositioning, and also directed to review and revise the skin integrity assessment to reflect interventions to heal pressure ulcers and stabilize, reduce or remove underlying risk factors.			
	LACK OF ASSESSMENT:			
	R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs), had unhealed pressure ulcers and remained at risk for further pressure ulcer			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG			
2 900	rejection of care(s) than daily." R6's Di identified R6 had di disease (PVD), sch disorder, and bipola R6's progress note identified R6 to have pisodes of wound change refusals, inwhen staff removed "[approximately] 30 R6 was further door writer do rest of tx [R6's Braden Risk A 8/14/17, identified F pressure ulcer deve R6's Skin Integrity A Treatment Care Pla was at moderate ris development and hulcers. The care plincluding keeping hencouraging him to and, "Complete Pus Healing] Tool Week During observation was laying in bed in mattress in place, a catheter drainage b stated he had pain my tail bone," which the wheelchair." Fu and try to reposition want them to.	her, the MDS identifier on a regular basis, "basing approved abetes, peripheral variation and pressure ulcer drouding an entry on 9/d R6's sock and, maggots fell on to the umented to, "would not treatment]." Assessment Scale date and pressure ulcer drouding an entry on 9/d R6's sock and, maggots fell on to the umented to, "would not treatment]." Assessment Scale date and the elopment and skin breaks of pressure ulcer and a history of past proposition every two shall pressure ulcer and a history of past proposition every two shall pressure ulcer and a history of past proposition every two shall pressure ulcer and a history of past proposition every two shall pressure ulcer so the pressure ulcer shall pressure ulcer so the pressure ulcer and a history of past pressure ulcer and a	ut less 17/25/16, scular y /3/17, nted ressing 13/17, et floor," ot have ed risk of eakdown. on and fied R6 ressure ventions st, hours rale for m. R6 had an air rinary rinary rinary R6 had on itting in come in doesn't	2 900			
	During interview on	10/2/17, at 1:42 p.m.					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUB Valley, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
2 900	current pressure ul (ulcer extends into subcutaneous tissu. On 10/3/17, at 2:36 complete a dressin ulcer. R6 declined the wound stating, R6's Skin Grid - Prulicer/Other trackin identified R6 had a coccyx with an, "Ini 9/16/17, measuring cm by 3.0 cm in siz tunneling or underridrainage or odor pridentified R6 refuse on 9/20/17. The neidentified the ulcer measuring 2 cm by however, now had (thin and watery, of odor with 5.4 cm of R6's medical recordany completed PUS care plan, nor a con R6's skin risk factor refusals, and subser R6's coccyx pressured P/26/17. When interviewed stated R6 does not	RN)-A stated R6 had cers including a stag the dermis exposing to have the surveyor "He'd rather not." The dated 9/26/11 stage III pressure ultial Identification," regalial Identification," regalial Identified, and resent. The tracking the date have his ulcer a extrecorded entry on remained a stage III or by 3 cm in size serosanguineous draften pink in color) and	e 3 or 4 fatty ng to essure r observe ficiency 7, cer on his corded on s) by 0.5 recorded no g chart assessed a 9/26/17, e, ainage d mild lacked by R6's ssment of ory of to address ened on .m. RN-A alcer	2 900	BELLIOITY		
	pressure ulcer(s) w skin grid tracking c	vere primarily tracked harts on a weekly ba pressure ulcer was,	I using the sis. RN-A				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 109 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	worse," and staff we wound physician to address it. RN-A st coccyx ulcer to be or RN-A stated she was comprehensive skin of, and added she wone, if one had bee record. Further, RN was completing the R6's care plan, nor the medical record. During subsequent p.m. RN-A stated the determine if the wone getting worse or state tools were not being but would be completion of the properties of the current treatments of the current treatments of the current treatments of the current different. An undated, uncomfor Healing (PUSH) observe and measures ulted scores addressed scores measured of the improvement ulcer healing." The Healing Graph," seen number(s) from 17	ere trying to have him help develop a plan tated R6 had not allow observed again since	to wed the 9/26/17. consist locate nedical are who ied on ated in , at 2:33 ed to help ger, ne PUSH moment," sis going m. the a include ermine if er Scale ons to tal the of total indication ressure ure Ulcer (healed)	2 900			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 750	05 COU	ORESS, CITY, S NTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 900	The director of nurs review/revise policic assessment, and in ulcer interventions a staff on these policic could conduct audit needs of each reside pressure ulcer develor individual comprehe consistently met. TIME PERIOD FOR days.	THOD OF CORRECTION sing and/or designee courses for pressure ulcer implementation of pressure and educate the responses. The DON or designets to ensure the reposition dent with and/or at risk for elopment, according to the ensive assessment are	ld re iible e ning r r	2 900			
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:		2 910			11/13/17	

6899

Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7805 COURTY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH OFFICIENCIES) (EACH OFFICIENCIES (EACH OFFICIENCIES) (EACH OFFICIENCIES) (EACH OFFICIENCIES (EACH OFFICIENCIES) (EACH OFFICIENCIES (EACH OFFICIENCIES) (EACH OFFICIENCIES (EACH OFFICIENCIES	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
CALLEY REHABILITATION AND CARE TS05 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			00112		B. WING		10/0	5/2017
Column C	NAME OF F	PROVIDER OR SUPPLIER			, ,	•		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 910 Continued From page 111 Based on observation, interview and document review, the facility failed to provide medical justification for use of an indwelling catheter for 2 of 3 residents (R48, R134) reviewed for indwelling catheter. In addition, the facility failed to comprehensively assess the bladder function and put into place interventions to minimize incontinence for 2 of 4 residents (R55, R2) reviewed for urinary incontinence. Findings include: CATHETER R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and had an indwelling urinary catheter. Diagnoses included anxiety, depression and a fracture. The MDS did not indicate R48 had diagnoses of neurogenic bladder or obstructive uropathy. On 10/3/17, at 9.37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine. R48 stated hospice placed a Foley catheter as R48 was having to urinate every two hours and was not getting any sleep. R48 did not display any signs or symptoms of pain. R48's Bladder Data Collection and Assessment dated 8/15/16, and reviewed 1/10/17, indicated R48 was continent of urine. The assessment did not identify any form of incontinence or nocturia. R48's nursing progress note dated 5/1/17, at 9:00 p.m. Indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by	GOLDEN	I VALLEY REHABILIT	ATION AND CARE					
Based on observation, interview and document review, the facility failed to provide medical justification for use of an indwelling catheter for 2 of 3 residents (R48, R134) reviewed for indwelling catheter. In addition, the facility failed to comprehensively assess the bladder function and put into place interventions to minimize incontinence for 2 of 4 residents (R55, R2) reviewed for urinary incontinence. Findings include: CATHETER R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and had an indwelling urinary catheter. Diagnoses included anxiety, depression and a fracture. The MDS did not indicate R48 had diagnoses of neurogenic bladder or obstructive uropathy. On 10/3/17, at 9:37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine. R48 stated hospice placed a Foley catheter as R48 was having to urinate every two hours and was not getting any sleep. R48 did not display any signs or symptoms of pain. R48's Bladder Data Collection and Assessment dated 8/15/16, and reviewed 1/10/17, indicated R48 was continent of urine. The assessment did not identify any form of incontinence or nocturia. R48's nursing progress note dated 5/1/17, at 9:00 p.m. indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
R48 had a Foley catheter placed and lacked a	2 910	Based on observation review, the facility figustification for use of 3 residents (R48 indwelling catheter. to comprehensively and put into place in incontinence for 2 conviewed for urinary. Findings include: CATHETER R48's quarterly Min 6/17/17, indicated Find an indwelling unincluded anxiety, defined an indwelling unincluded anxiety, defined for the management of th	ion, interview and docialled to provide mediciof an indwelling cather, R134) reviewed for In addition, the facility assess the bladder for interventions to minimi of 4 residents (R55, Rivincontinence. Image: R48 was cognitively interventions and a fractuate R48 had diagnoses for obstructive uropations. R48 was observentiate R48 was observentiate R48 was observentiate. R48 was observentiate as R48 was haviours and was not getting display any signs or symptomic and the session of incontinence or new as to be maintained the ession of the did not indicate was noted as noted a	y failed unction ize (2)) dated tact and oses (2)) dated tact and oses (3) red in the right pice (3) ner right pice (4) ner to did (5) sement (6) icated (6) nent did (6) octuria. 7, at 9:00 ted a (6) by (6) ate why	2 910	,		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 112 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
	T	GOLDEN	VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 112	2 910			
		comprehensive bladder eted when the Foley catheter				
	R48 had an indwell direction for hospic	rder dated 8/31/17, indicated ing Foley catheter with e to place and maintain. The nosis for the Foley catheter.				
	R48's physician's order dated 10/2/17, included a diagnosis of incontinence and nocturia for use of the Foley catheter.					
	nursing (ADON)-A	p.m. assistant director of stated R48 had an indwelling ncontinence and nocturia.				
	ADON-C stated she	10/5/17, at 9:12 a.m. e felt incontinence and reason to place a Foley				
	During interview on 10/5/17, at 10:14 a.m. ADON-A stated the physician diagnosis on 10/2/17, was obtained at that time because R48's record lacked a diagnosis for the use of a Foley catheter when requested by the surveyor. ADON-A stated hospice placed the Foley catheter prior to her start of employment at the facility, however, she felt education should have been given to hospice prior to placing the catheter, as incontinence and nocturia were not acceptable reasons to place a Foley catheter. ADON- A stated if R48 was having issues with frequency of urination a comprehensive bladder assessment should have been completed. She indicated prior to use of the catheter, alternatives should of been considered such as offering a bed pan, overnight briefs, medication review, and review of R48's sleeping patterns.					

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 113 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 910	During telephone in a.m. hospice registroatheter was placed having to get up our urinate. RN-F state managed by her cu. The facility policy In indicated: "The cen resident who enters catheter is not catheclinical condition de catheterization was an indwelling cather justification for the ifor catheter use. A includes underlying justification, determined be reversed and de appropriate indicate indwelling catheter. R134's significant or indicated he was seneeded extensive a was always contine failed to indicate he plan dated 10/17, in urinary tract infection R134's Urinary Inconstant of bower managed all incontinent of bower managed all incontininent productindicated he had urindicated he	aterview on 10/5/17, and as R48 had complated as R48 had complated as R48 did have paint and a rent pain medication and welling Catheter dater strives to ensure a center without an eterized unless the remonstrates that an ecessary. All reside the require a medical initiation and continuous comprehensive assertations of which fact evelopment of a plantons for continuing us beyond 14 days." The had a catheter. R1 and a catheter. R1 and a catheter. R1 and a catheter. R1 and a Foley on tinence Care Area dated 7/27/17, indicated he had a histons and had a Foley on tinence Care Area dated 7/27/17, indicated he had a histons and had a Foley on tinence Care Area dated 7/27/17, indicated he had a histons and bladder and stand blad	tated the faints of purs to but it was ins. ated 7/15, that a indwelling esident's ents with ling need essment inductions can for se of an arrange and MDS ad's care story of catheter. ated he fand was affeed inent eeded	2 910			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	505 COU	ORESS, CITY, S NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 910	R134's hospice car indicated he had alt and had an indwelli On 10/03/17, at 8:2 the dining room to helow his Broda chachair). During interview on assistant director of R134 had went to the was on third flow when he returned from the was on the cath monthly. ADON-B orders when he returned she was not sure if since they had no on the cath was observed in be observed attached catheter anti-reflux covered in a thick, in the cath of the c	e plan dated 07/07/17, teration in bladder eliming urinary catheter. 2 a.m. R134 was observave a catheter bag attair (tilt and space position 10/05/17, at 8:43 a.m. for transferred to first the hospital in July 2017 or and transferred to first the hospital. ADON bag should be changed better should be changed the stated this was not put ourned from the hospital either had been completed that the left side of the between the left side of the left	ted in ached oning ted when t floor N-B don his and eted et was et d. The was the hift.	2 910			
	when to change the indicated she was u R134. ADON-B sta	e catheter, bag and tubin unable to locate orders to ted she would assume so e catheter, tubing and b	ng and for staff				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 115 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE					
2 910	Continued From page 115	2 910							
	since he returned from the hospital on 07/05/17 (almost two months). ADON-B further stated she noticed the sediment in the catheter and did not know why he had a catheter since he never had one before his hospitalization. ADON-B stated the catheter was placed in the hospital on 6/23/17, and the record did not indicate the reason for the catheter.								
	During interview on 10/05/17, ADON-B stated she had contacted R134's physician and received orders to remove the catheter since the facility did not have a reason for R134 to have the catheter. ADON-B further indicated she had taken his vital signs and his temperature was 98.2 and had no signs of sepsis.								
	Although R134 had a indwelling catheter the facility failed to have medical justification for the catheter and orders to maintain the catheter.								
	A facility Procedure Indwelling Urinary Catheter effective July 2015, included to inform care giving team of plan, educate on techniques and interventions as indicated.								
	URINARY INCONTINENCE								
	R55's quarterly MDS dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with toileting. The MDS included a diagnosis of dementia and had moisture associated skin damage. The MDS also identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine.								
	A trial toileting program had not been attempted since admission. R55's Urinary Incontinence								

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 116 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE (MUST BE PRECEDED BY SC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	further assessment with toileting and w Modifiable factors of included: pain, uring and restricted mobil urinary urgency and toileting. A care pla maintain R55's currous The facility was una comprehensive blas for R55. R55's Urinary Cont 7/17/17, indicated Fincontinence and in prompted voiding used meals, at bedtime a care plan did not id The care plan also adult pull up and for needed. R55's undated nurs indicated R55 had '[incontinence] upor and at bedtime. " T sheet did not direct assistance R55 need to go outside for a deal of the continuity of the continuit	6, indicated R55 trigged due to extensive as as always incontiner contributing to incontine and for assistance of the contribution of the	sistance at of urine. In of urine were the in ed to ing. Impleted vised on a of a dafter mes. The med times. The med times are full up as the et are full arms of urine ear of her questing ssed by m. the R55 onto	2 910			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 117 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	nge 117	2 910			
	not address R55's	urinary incontinence.				
	unit coordinator (HI the nursing desk fo R55 was soiled with times a week.	10/3/17, at 11:02 a.m. health UC), who indicated she was at or a large part of the day, stated in urine about three to four				
	During observation on 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevators and nursing desk. R55 stated she was waiting to go out for a cigarette at 9:00 a.m At 7:08 a.m. assistant executive director (AED)-B took R55 outside to smoke, after smoking AED-B brought R55 back to the 4th floor and brought her to the dining room for breakfast. At 8:07 a.m. after breakfast, NA-H brought R55 to her room and cleaned her nails. NA-H did not offer to toilet R55 at this time following breakfast and after R55's nails were cleaned, she moved R55 back to the area near the elevator and nursing desk. At 8:56 a.m. NA-I brought R55 to her room and assisted with removal of her chin hair and clipped her nails. NA-I did not offer to toilet R55 at this time. At 9:05 a.m. R55 was assisted outside to smoke by NA-I. At 9:08 a.m., after smoking, NA-I wheeled R55 to the dining room to watch television at 9:08 a.m. NA-I did not offer assistance with toileting at that time.					
	During interview on 10/4/17, at 9:43 a.m. NA-I was not sure when R55 had last been toileted. NA-I stated NA-H was assigned to her for the day and she only shaved her chin and cut her nails. NA-I stated she did not offer to toilet R55 during those cares.					
	stated she had not	10/4/17, at 9:46 a.m. NA-H toileted R55 today, but R55 urine when she woke her up				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 118 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N VALLEY REHABILITA	ΔΙΙΟΝ ΔΝΙ) (:ΔΚΙ	JNTRY CLUB			
	TALLET KENASIEN	GOLDEN	VALLEY, MN	l 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 118	2 910			
	NA-H stated the state and change her brid once in the afternoof for a nap. NA-H state in between those tirestated after assisting R55 back to here were no sheet probably wet them I she would like to go check and change I R55 to transfer from With gloved hands incontinent brief, when I stated R55's urine in it. Further, so linens that morning with urine. She indicate in the stated R56 in the stated R55's urine in its she indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate in the stated R55's urine in its She indicate Indica	nanged her brief. Further, aff do not toilet R55, but check of once in the morning and on, when the staff lay her down ted the staff would change her mes if her pants are wet. NA-H g another resident she would her room and check her pad. on 10/4/17, at 9:55 a.m. NA-H to her room. R55 indicated ts on the bed because, "I ast night." R55 further stated to on the toilet, but the staff just her brief. NA-H then assisted in her wheelchair to her bed. NA-H changed R55's nich was saturated with urine. brief had a large amount of she had to remove R55's bed because the linens were wet cated it was usual to change morning because the linens				
	ADON-A stated R55 bladder assessment plan, R55's inconting related to inability to stated a bladder as hours of bladder modetermine R55's toil subsequent schedul stated R55 was to be and changed. ADOI be reassessed for hoever seen R55 toil	10/5/17, at 10:01 a.m. 5 did not have a current at. ADON-A stated per the care bence was functional and be transfer herself. ADON-A sessment should include 72 conitoring to effectively leting patterns and ling needs. ADON-A further be toileted and not checked N-A indicated R55 needed to ner toileting needs as she had eted. ADON-A also stated toileted according to her				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 119 of 212

Minnesc	Minnesota Department of Health							
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00112	B. WING		10/0	5/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB Valley, MN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE		
2 910	Continued From pa	ge 119	2 910					
	meals and at HS.							
	dated 4/4/16, and re R2 was always inco included: "clothes w pads." The assessr excessive intake of bladder irritants. Th had urge and functi treatment program no scheduled times prompted voiding p							
		ence care plan last reviewed 2 was incontinent and resident						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	refused to wear inco occasionally soiled behavior which indi- urinate, soiling hims to be changed was did not address how behavior, other than his clothing. The ca R2 with incontinent offer prompted void offering every two h plan also directed s at individualized time himself. The care p individualized times listed conflicting info and change. R2's undated nursind directed staff to "rei hours], chart both in [continent]." During observation was standing at the strong urine smell. the front and back, of his shirt. Multiple nursing desk and n assist him with toile observed lying on h of his pants were sa strong odor of urine smelled in the hallw During interview on stated R2 was soile four times a week.	ontinent products and self. The care plan incated R2 would lie in self and the bed and rated. However, the work the staff should han a to encourage him to briefs and directed staff to check and chains as resident refuse lan did not include as as resident refuse lan did not include as for toileting needs for toileting needs for toileting needs for toileting needs for toileting and to toilet q2h [event [incontinent] and continent] and continent of the sweatpants were as well as the right lower as the staff were located are of staff members offer thing. At 3:00 p.m. R2 his right side in bed, the aturated. R2's room her present that could all present that the present th	cluded a bed and refused care plan dle the change rovide raff to imes of The care nge R2 s to toilet r R2 and nd check et ery two ont. The care nge R2 and nd check et ery two ont. The care nge R2 and nd check et ery two ont. The care nge R2 and nd check et ery two ont. The care nge R2 and nd check et ery two ont. The care nge R2 and nd check et ery two ont.	2 910			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 121 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	00112	STREET AD	I DRESS, CITY, S	STATE, ZIP CODE	1 10/0	012011
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	did not have the timeshe directed R2 to change out of his we because the nursing assist him. During interview on stated R2 frequently and would soil his constant of the stated R2 needed the and assisted with the refusals were to be aware when R2 was assist R2 due to the During interview on ADON-A stated she walking around with on 10/2/17, however him. ADON-A stated offered to toilet and charted and the nutry and assist R2. R2 removed and renot sure if adult pull reviewing R2's blact 5/11/17, ADON-A state assessment and re-assessed and in was not sure why the state of th	ne to assist him. HU0 his room to clean hir yet clothes on 10/2/1 g staff did not have to a 10/4/17, at 9:12 a.m y removed his incon- clothing with urine. N to be checked every pileting needs, and a charted. Further, sta as soiled, but were ure lack of staffing. a 10/5/17, at 9:39 a.m e did not recall seein an clothing saturated ver, staff should have bet any refusals should arse alerted, so other ADON-A stated she offused to wear briefs I ups had been tried alder assessment dat tated she did not agi d felt R2 needed to be terventions looked an here were no individual and R2. all Report from 7/7/17 R2 resisted care one was able to redirect F de any further incided	mself and 7, ime to n. NA-G tinent pad A-G two hours ny aff were nable to n. g R2 with urine assisted een be staff could was aware, but was After ed ree with be t as she halized 7 to time on 82. The nts of	2 910			
		Irinary Incontinence on The center strives to e					

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ΔΤΙΟΝ ΔΝΟ CARF	NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	residents who are in appropriate treatment much normal bladd policy directed: "The (accurate assessmin implementation and with evaluation of the effinterventions and reappropriately mana Recording and evaluation and reappropriately mana Recording and responsible ting and responsimportant for determ decline. Various confusionation aggravate the seven incontinence. Steps these conditions/sit SUGGESTED MET The director of nursidevelop and or revisind welling catheter function. The DON responsible staff or for designee could with bladder incontinud with bladder incontinud indwelling catheter bladder assessmen medical justification indwelling catheters."	ncontinent of bladder receive ent and services to restore as er function as possible." The e care process is followed ent, care planning, consistent dimonitoring of the care plan fectiveness of the evision, as appropriate) to ge urinary incontinence. uating specific information and times of incontinence and use to specific interventions) is mining progress, changes, or nditions or situations may rity of urinary should be taken to alter uations whenever possible." THOD OF CORRECTION: sing and/or designee could see policies for use of an and assessment of bladder or designee could educate the athese policies. The DON and conduct audits of residents nence and or use of an to ensure comprehensive at sare done and to ensure a for the continued use of	2 910			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			11/13/17
		of daily living. Based on the ident assessment, a nursing				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 920	home must ensure B. a resident who activities of daily livi	that: is unable to carry or ing receives the nece n good nutrition, groo	essary	2 920			
	by: Based on observati review, the facility fa assisted with perso residents (R55, R2,	ent is not met as evi on, interview and do ailed to ensure resid nal hygiene for 3 of 9 R183) reviewed for and who were depe	cument ents were 5 activities		Corrected		
	9/1/17, indicated Rs impairment and need dressing and persoidentified R55 was episodes of urinary episode of continent with moisture associated R5/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	imum Data Set (MD 55 had moderate cog eded extensive assis nal hygiene. The MD frequently (seven or incontinence, but at it voiding) incontinenciated skin damage. If dementia and depre	gnitive stance with OS more least one nt of urine,				
	included a goal for groomed daily. The assist with persona On 10/1/17, at 9:50 wheelchair in the do	care plan last dated R55 to be neat, clea care plan directed s l hygiene and dressi a.m. R55 was seate porway to her room. as noted to be unde ght hand.	n and well staff to ng. ed in her A dark				
		on 10/1/17, at 11:10	a.m. R55				

Minnesota Department of Health

STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00112		B. WING		10/0	05/2017
NAME OF PROVIDER OF		TATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
was sea and nurs and was lap. During so outsid not inter services elevator address During so 9:58 p.m substand hand. At down net R55 state the elevator on the substand potato of mouth. and NA-NA-C or NA-C state bath day were dialoger and the substand potato of mouth. And NA-C or NA-C state bath day were dialoger and the substand potato of th	sing desk. In noted to be noted to bring he R55's uring the second of the this time of the thi	wheelchair by the elek R55 smelled strongly be saturated in the are R55 was loudly recognize the saturated in the are R55 was loudly recognize the saturated in the are R55 was loudly recognize the saturated R55 on the saturation on 10/3 tinued to have a dark for long fingernails or registered nurse (RN and asked her how so the saturation of the saturat	of urine ea of her questing to ed by her, ne social ato the D did not 1/17, at a brown n her right)-A bent he was. tinued to ting in her d her right rown cked a ed it in her (NA)-C leither ngernails. dents' ess they ail care. ed in her ng desk. before. A her	2 920			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GOLDEN	N VALLEY REHABILIT	TATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM,	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 920	During observation assistant executive R55 outside to smother right hand and never offered to habrought her back uroom for breakfast. During observation brought R55 out of room and started of stated her nails we should be cleaned noticed they were of morning, however, smoke before she NA-H stated nail care should habrought for a should habrought and on their bath of scheduled for a should habrought and interview or assistant director of care should be dorn dirty, otherwise were ADON-A stated resurine soiled clothin. R2's significant chaindicated R2 had mand needed extensional hygie was frequently income associated skin daschizophrenia. R2's (CAA) dated 8/19/1 a functional decline medications, physically and the properties of the propertie	a on 10/4/17, at 7:08 and director (AED)-B as been done. If on 10/4/17, at 8:07 and director to the 4th floor done in 10/4/17, at 8:07 and director done in 10/4/17, at 8:37 and director done. If on 10/4/17, at 8:37 and director done in 10/4/17, at 8:37 and director done. If on 10/4/17, at 8:37 and director done in 10/4/17, at 8:37	esisted garette in te. AED-B ed and or dining a.m. NA-H k to R55's ils. NA-H and they ted she er up this er out to an them. Is needed d R55 was fore and a R55 was fore and stated nail visibly ers. Is sitting in moisture luded was sessment at risk of e	2 920			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 126 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00112		B. WING		10/0)5/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	be developed to side complications and indirected to see care and interventions. R2's ADL/Mobility laindicated R2 would groomed daily. The assist with persona and undressing with care plan indicated and ADLs and at tircare plan lacked appropriate to buring observation was standing at the strong urine smell, saturated with urine	oression. A care plan ow or minimize a deciminimize risks. The Ce plans for problems, ast reviewed on 8/5/1 be neat, clean and vecare plan directed so I hygiene, grooming, in physical assistance R2 was resistant to the proaches to refusal or on 10/2/17, at 2:10 per nursing desk and has his sweatpants were in the front and bactide of his shirt. R2's his worminimized in the shirt. R2's his worminimized in the front and bactide of his shirt. R2's his worminimized in the shirt. R2's his worminimized in the front and bactide of his shirt. R2's his worminimized in the shirt.	line, avoid CAA goals 7, vell taff to dressing e. The therapy The of cares. o.m. R2 ad a e. k, as well	2 920			
	uncombed and stic Multiple staff were I desk and no one of room to assist with combing his hair. A lying on his right sic were saturated with strong odor of urine in the hallway. On 10/3/17, at 10:1 hallway in front of the were untied, his hair up in multiple place the back of the collate other. ADON-A tie his shoes. R2 all	king up in multiple place of the place of the place ocated around the number of the place of the	aces. ursing ck to his and observed f his pants d a oe smelled ng in the shoes d sticking d a tear in ne neck to offered to his				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 127 of 212

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING	_	10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOI DEN	I VALLEY REHABILIT	ΔΤΙΟΝ ΔΝΟ CARF	NTRY CLUB			
GOLDLIN	VALLET KEHADIEH	GOLDEN	VALLEY, MN	I 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 127	2 920			
	back to his room ar comb his hair.	nd help him change his shirt or				
	dining room watchir uncombed and was His gray t-shirt had front. R2 was in the when he walked do and laid in bed. Sta offer to change his this time.	a.m. R2 was sitting in the ng television. His hair was sticking up in multiple places. a quarter sized hole in the dining room until 9:06 a.m. wn the hall towards his room ff did not approach R2 and shirt or comb his hair, during				
	services assistant (that he had contact new shoes and the pair. SS-A stated he R2's clothing and h help in obtaining ne a residents right to however, R2 would	10/4/17, at 8:47 a.m. social SS)-A stated R2 had a brother ed in the past about getting brother bought him a new e had not noticed the holes in ad not notified R2's brother for ew clothing. SS-A stated it was wear what they wanted, never complain about having unless they were really large.				
	stated R2 frequently and would soil his constant of R2 needed to any assisted with the refusals were to be aware when R2 was assistance with car R2 due to the lack of although R2 was or did not assist him who did. NA-G state but needed hands of did allow staff to constant of the R2 was or did allow staff to constant of the R2 was or did allow staff to constant of the R2 was or did not assist him who did. NA-G state but needed hands of did allow staff to constant of the R2 was or did allow staff to constant of the R2 was or did not assist him who did.	10/4/17, at 9:12 a.m. NA-G y removed his incontinent pad clothing with urine. NA-G to be checked every two hours bileting needs, and any charted. Further, staff are soiled, and needed es but were unable to assist of staffing. NA-G stated in her group this morning she with cares, and was not sure ed he was fairly independent on assistance frequently and mb his hair and assist with s, it just depended on how m.				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER	00112	STREET AD		STATE, ZIP CODE	1 10/0	J3/2017
	I VALLEY REHABILIT	ATION AND CAPE		INTRY CLUE			
	Г			VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	age 128		2 920			
	10/4/17, indicated F	ail Report from 7/7/17 R2 resisted care one vas able to redirect R	time on				
	ADON-A stated in this own personal confering assistance be offered toileting hours, staff should changing his clothing refusals needed to nurse so others concares. ADON-A statholes in there cloth	n 10/5/17, at 9:39 a.m. the past R2 had done ares, however, staff s as needed. Although and assistance every have assisted him wing soiled with urine. be charted and reported try and assist with a lot of residents es and have no one to aware R2 had clothing the recall if she	e some of should be a, R2 is to y two ith Any rted to a a needed have to buy				
	assistance. Staff sh combing his hair. A	s need to social servi nould be helping R2 v NDON-A also stated R looked at further for a	vith R2's care				
	identified multiple n heart failure, diabet	Record, dated 10/5/1 nedical diagnoses incles, morbid obesity, hedema, chronic respretention.	cluding				
	R183 had intact co symptoms of depre extensive assistance	MDS dated 8/3/17, identified with moderate ession. R183 required to complete all AD welling catheter and d	e I L's except				
	identified R183 req personal hygiene/g	care plan dated 7/28 uired personal assist rooming/dressing/und id not list intervention	ance with dressing.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 129 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOI DEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB			
	VALLET KEHABIEH	GOLDEN	VALLEY, MN	1 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 129	2 920			
	to maintain R183's needs.	hygiene and meet his bathing				
	resting on his bed, R183 was noted to of perspiration and urinary drainage babed frame, and tub observed under the dependent on staff can turn my light or will take them to cohe had called 911 v commode for 45 m responded within fir R183 stated his babe but had not yet receive a transported on a guwhile on the cart. R whore bath," when with a basin.	p.m. R183 was noted to be covered only with a sheet. have a strong, pungent odor other body odors. A straight g was noted attached to the ing from the bag was sheet. R183 stated he was for provision of care stating, " I n, but I don't know how long it me." R183 did acknowledged when he had been left on the inutes. He stated the staff we minutes after he called. It is scheduled for Mondays, eived one since admission to han two months ago. R183 shower he would need to be urney and assisted to shower 183 stated he has received "A he was assisted to wash up				
	stated he was goin not feel real clean. was about two wee dressed in a hospit	10/2/17, at 12:23 p.m. R183 ag to get dressed today but did R183 stated his last bed bath ks ago. R183 was noted to be al gown at this time and was crease of strong, pungent				
	body odor that had strong, pungent bod the room, and also of the R183's room get up for lunch, an to get back to bed, and had a history of interview, the bath st	been noted on 10/1/17. The dy odor was very prominent in notable in the hallway outside. R183 stated he chose not to d stated it would take too long would become uncomfortable f pressure ulcers. Following schedule was noted to be ation and identified R183				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 920	received his bath of During interview on stated he had recein R183 stated after higher up out of bed at to get up. R183 stated change linens follow have fresh linens. Further changed as request During interview on assistant (NA)-S stated assistance for a befelt he had provided care plan. NA-S stated replan. NA-S stated replan. NA-S stated replan. NA-S stated R1 went on to state if hassistance, he will a gold and within ten minutes, summon adequate for transfers. ADON concerns regarding expressed it was the washed up with modincluding washing carmpits, and applice in the stated responsible to the stated respon	n Tuesday evenings. 10/4/17, at 7:05 a.r ved a bed bath last e is bed bath he requend was asked why he ted he had to instruction wing his bath as he was astated his linented. 10/4/17, at 2:19 p.r ated he had provided bath for R183 and dicare according to Fated the resident can vant. NA-S stated he hygiene for R183. physician progress rates did not wish to bring, "I can't even gelp me shit. I won't b	n. R183 evening. ested to e wished t staff to vished to s were n. nursing stated he R183's also had notes of pursue et e n. the nt and mmediate er, or call d be provided e longer to st of two inaware of ints were ares, are, eodorant.	2 920			

Minnesota Department of Health

winneso	ta Department of He	eaim					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	BER:	A. BUILDING:		COMP	LETED
		00112		B. WING		10/0	5/2017
						1 10/0	0,2017
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOI DEN	VALLEY REHABILIT	ATION AND CARE		NTRY CLUE			
			GOLDEN '	VALLEY, MN	N 55427		
(X4) ID		TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	REGOLATOR OR E	OO IDEINTII TIINO IINI ONWAN	1011)	TAG	DEFICIENCY)	110/112	
2 920	Continued From pa	ge 131		2 920			
	washed on bath da	V.					
	•	,					
	Review of R183's re	esident care tracker fro	om				
	9/28/17 through 10/	/3/17, was done with A	DON-B.				
		racker had notations m					
		two bedbaths in one of					
		ted he would not of go					
		and felt the documenta					
	•	correctly. ADON-B indi					
		if R183 had received a					
	•	if short staff and unabl					
		er, the task would be p					
		shift to complete. The					
		ould be appropriate fo receive a bath at the ti					
	odor was noted.	receive a bain at the ti	me me				
	odor was noted.						
	A request for provis	sion of bathing process	was				
	also requested and		, mac				
	The facility policy A	ctivities of Daily Living	(ADL)				
		5, included: "Determin					
	resident has specifi	ic tasks and areas req	uiring				
	ADL assistance. Ba	athing, dressing and gr	ooming				
	•	erventions may include	, but are				
	not limited to:"						
		obtaining clothes					
	 Putting clothe 						
		tons and snaps					
		tems of clothing					
		moving braces and art	iticial				
	limbs						
	· Use of adaptiv						
		ersonal hygiene					
	i idilililig tile t						
	Callicing sup	phiies					
	Combing hairWashing face	and hands					
	· Washing race · Brushing teeth						
	Shaving if app						
	onaving it app	MOUDIC					1

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		00112	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 COL	DRESS, CITY, S JNTRY CLUE VALLEY, MI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
2 920	SUGGESTED MET The director of nurseducate responsible residents' dependa residents' compreh DON or designee of dependent resident hygiene needs are	lorant e-up if applicable s /e equipment THOD OF CORRECTION: sing and/or designee could e staff to provide care to nt on facility staff, based on ensively assessed needs. The ould conduct audits of cares to ensure their personal	2 920		
2 955	Eating - Risk of Che Subp. 3. Risk of che the comprehensive addressed in the cobeing at risk of chomust be continuou personnel when the timely emergency in necessary. This MN Requirements: Based on observation review, the facility for the comprehensive addressed on the comprehensive addressed on the comprehensive and the comprehensive addressed in the comprehensive ad	noking. A resident identified in resident assessment, and as omprehensive plan of care, as	2 955	Corrected	11/13/17

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 955	eating. A non-train member, Human R with feeding a resic aspiration pneumor problem. R19 was fed by HR-A. Even directly across the did not intervene ple constituted an imm for R19, with the poor death. The facility also fail were fed by a paid appropriately assess receive training through program for 2 of 2 observed to be fed swallowing problem with eating. The immediate jeon 8:12 a.m. when HR with eating, who haproblem and was hexecutive director ((DON), director of assistant ED-A and immediate jeopardy The IJ was remove but non-compliance and severity of (D)	appropriate assistance with ed paid feeding assistant/staff desources (HR)-A, assisted dent who had a history of nia and a complicated feeding observed coughing while being though nursing staff were table while this occurred, they acing R19 at risk. The findings ediate jeopardy (IJ) situation otential for serious harm, injury ed to ensure residents who feeding assistants (PFA) were seed to be fed by a PFA, and ough a state approved (R19, R97) residents who were by a PFA. R97 did not have ns but needed staff assistance pardy began on 10/04/17, at alpha acomplicated feeding aving difficulty swallowing. The ED), interim director of nursing clinical services (DOCS), I ED-B were informed of the yon 10/04/17, at 2:54 p.m., are remained at the lower scope isolated, with potential for harm that is not Immediate	2 955			
		onvious on 10/01/17 at 10:46				
		erview on 10/01/17, at 12:16 nstrator and the interim director				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 134 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		0.2011
GOLDEN	I VALLEY REHABILIT	TATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 955	of nursing (DON) be paid feeding assistance in the had dementia as swallowing). R19's dated 09/08/17, indicated 09/08/17, indicated of one was swallowing disorder Care Area Assessmindicated he require meals and had a neconsistency which The CAA further indicated from 1 Discharge Summan North Memorial Methospitalized from 1 Discharge Summan aspiration pneumon infiltrates (somethin lungs from the outsishow up in the other the infiltrate will method infection with editing). R19's Nutrition Risk indicated he receive thickened liquids and the dining room and the state of the	noth stated they did not ance program (PFA) ag. Decord undated indicated indicated dysphagia (difficulties Minimum Data Set (dicated he needed exwith eating and had not in the state of the set of t	to assist ated that lty (MDS) tensive o Status (13/17, eding at r altered esident. sufficient 2/16, from ed he was The had ateral to the ensity will Usually me sort n the 08/17, honey stance to imes.	2 955			
	needed total assist honey thickened lic	et card, undated, indi ance to be fed and re quids and a pureed di sing assistant care sl	eceived et. In				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 135 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
		00112	B. WING		40/	NE/2047
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/0	05/2017
	VALLEY REHABILIT	ATION AND CARE 7505 COU	NTRY CLUE	BDRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 955	undated, indicated consistency and he eating with a note, instruction." R19's speech thera indicated PT (patient of address dysphage to receive discharge followed up with nuprinted compensator reduce aspiration ridiscontinuation of sprogress due to decues. Nursing staff compensatory swalfor ongoing signs and A 24 Hour Status R"D/C [discontinue] find puree/honey thick lipatient's table to following: * Bite sizes should * Use spoon to give spoon size) *Allow patient to clegiving another bite * Do not put more find still chewing and the begins cough until coughing discounting observation nursing assistant (NR19 a drink of his justice)	his liquids were honey needed total assistance with see ST [speech therapy] spist note dated 8/02/17, and) seen for skilled ST services gia and complete final session e documentation. Therapist rsing staff regarding use of cry swallowing strategies to sk. A 24-hour log updated for services due to inability to mentia and inability to follow for implement use of clowing strategies and monitor and symptoms of aspiration. Seport dated 8/02/17, indicated: from ST today continue iquid diet. Printed strategies at clow during meals." The printed strategies are indicated be 1/2 spoonful of puree to honey thickened fluids (1/2) are mouth completely before cood in patient's mouth if he is sping, do not give more food	2 955			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 136 of 212

Minnesota Department of Health

Millinesc	Minnesota Department of Health					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00112	B. WING		10/0	5/2017
NAME OF		OTDEET AS	DDECC OITY	STATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	JNTRY CLUE			
		GOLDEN	VALLEY, MN	N 55427		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
17.0		,		DEFICIENCY)		
2 955	Continued From no	126	2 955			
2 300	•					
		him take three drinks and R19				
		nile drinking from the cup.				
		n he coughed waited for him to				
		nued to give him a teaspoon				
	•	and then a teaspoon of his				
		and he coughed again. At				
		him a level teaspoon full of his				
		nd he coughed again, then				
		l'It's ok" and gave him a drink cup. At 12:20 p.m. surveyor				
		ed NA-B if she was aware of				
		ing recommendations from the				
		athologist (SLP)-A and				
		tructions that were on the				
		ining room. NA-B stated she				
		NA-M instructed her that he				
		1/2 teaspoons of food and				
		A-B then took the teaspoon at				
	the table and place	d in his honey thickened juice				
	and proceeded to fe	eed him 1/2 teaspoons of his				
	food and beverages	s and his coughing had				
	decreased.					
		10/04/17, at 8:12 a.m. HR-A				
		e first floor dining room				
		eating. R19 had scrambled				
		age, oatmeal and honey				
	1	y juice. At the same table				
		n HR-A, sat assistant director B whom was assisting R134				
	with eating. HR-A gave R19 a level teaspoon full					
	of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first					
		wallow the spoonful of pureed				
		nediately giving a heaping				
		I to R19. R19 immediately				
		udly turning his head away				
		ght. HR-A stopped feeding				
		back and waited for him to				
		A then brought R19's glass of				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 137 of 212

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) PROVIDER OR SUPPLIER (X3) D112 STREET ADDRESS, CITY, STATE, ZIP CODE (ACA) D12 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG RESULATORY OR LSC IDENTIFYING INFORMATION) 2 955 Continued From page 1 37 honey thickened cranberry juice on as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pured sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was an ot following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scarambled eggs, pureed sausage, and half of his oatmeal and 34 of his honey thickened cranberry juice. ADON-B then said dwn to assist R134 across the same table R19 was sitting at. At approximately 82.5 a.m. SLP-A entered the dining room, and surveyor informed her of the above observation. HR-A was removing R19's clothing	Minneso	<u>ta Department of He</u>	ealth				
MAME OF PROVIDER OR SUPPLIER GOLDEN VALLEY REHABILITATION AND CARE (750 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 (741)D PREFEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (MS) PROVIDER'S PLAN OF CORRECTIVE AND OF CORRECTI							
C(A) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAME (EACH OFFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAME (EACH OFFICIENCY) (EACH OFFICIENCY) (EACH OFFICIENCY) 2 955 Continued From page 137 2 955 DEFICIENCY (INC.) (EACH OFFICIENCY) (EACH OFFICE			00112	B. WING		10/0	5/2017
CALLEY REHABILITATION AND CARE COLDEN VALLEY, MN 55427 CALLEY, MN 54427 CALLEY, MN 55427 CALLEY, MN 54427 CALLEY, M	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 955 Continued From page 137 honey thickened cranberry juice just below his chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his purede sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A waithle she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureds sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above	GOLDEN	I VALLEY REHABILIT	ATION AND CARE				
honey thickened cranberry juice just below his chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pureed sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureed sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
protector and SLP-A immediately walked up to the table and instructed HR-A she should have been following her recommendations of bite sizes which is 1/2 spoonful of liquids and food. HR-A then stated that NA-M had just informed her of the SLP instructions and she had stopped feeding R19.	2 955	honey thickened crachin and began spospoonfuls of thicker without first waiting HR-A fed R19 a full not a half teaspoon swallowing strategie R19 a heaping spospoon and R19 immediate stopped again and and HR-A then brouthickened cranberry began feeding R19 juice, and a level tedid not wait for R19 she gave him anoth cough loudly and his covered his mouth while he coughed. A across from HR-A was not strategies and R19 being fed. R19 had eggs, pureed sausa and 3/4 of his hone ADON-B left the sa R19 and NA-M ther across the same ta approximately 8:25 room, and surveyor observation. HR-A protector and SLP-A the table and instrubeen following her which is 1/2 spoonf then stated that NA the SLP instructions	anberry juice just below his con feeding R19 three ned juice, one after another for R19 to swallow each bite. I teaspoon of thickened juice, as identified by the ST es. HR-A proceeded to give onful of his pureed sausage ely began to cough. HR-A let him cough without waiting ught R19's glass of honey y juice to his chin and quickly three level teaspoonfuls of aspoon full of oatmeal. HR-A to swallow each bite, before her bite to eat. R19 began to is face turned red while HR-A with his clothing protector ADON-B whom was directly while she fed R19, made no R-A from feeding R19 even not following the ST swallowing continued to cough while deaten 100% of his scrambled age, and half of his oatmeal y thickened cranberry juice. The state of the above was removing R19's clothing A immediately walked up to cted HR-A she should have recommendations of bite sizes ful of liquids and food. HR-A -M had just informed her of				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FRIATE	DATE
2 955	During interview 10 stated she had bee 03/07/17, and beca certificate had expirenewed her certific with feeding when the also assisted anothe floor. HR-A stated is resident on fourth floes not spill her for herself. During interview on stated she knows the give small amouliquids to make the she does not know	/04/17, at 9:22 a.m. HR-A in working at the facility since ame a NA in 2005, her NA red in 2008, and she had not cate. HR-A stated she assists they are short staffed and had are resident (R97) on the fourth she does not need to feed the loor but just makes sure she bod while she is feeding 10/04/17, at 12:20 p.m. NA-K hat when feeding R19 they are nts of food and then give food go down. NA-K stated if there was any size amounts	2 955			
	cough while being to says instructions or should also be on house of the provided also told the interview of the provided also told the provided	is and he had a tendency to fed. She indicated his ticket in how he should be fed and it his care plan. 10/04/17, at 12:25 p.m. Turse (LPN)-D stated she was reding recommendations for What I don't know I can't tell 10/04/17, at 12:42 p.m. That written up the instructions reduced and had made these for R19 on 7/24/17, and resisted with feeding him. The left the feeding instructions at 9 ate and the instructions of she would make new cards ain at his table. SLP-A stated terim nurse manager during to longer works at the facility. P-A stated she wrote these				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 139 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				D. WING			
		00112		B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDE	N VALLEY REHABILIT	ATION AND CARE		NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 955	recommendations of board for all staff to stated R19 will courecommended a swith but did not think the her recommendation staff to follow throus since he was at sur was vital to follow the recommendations feed R19 1/2 teasp coughs much less aspiration. During interview on assistant director of don't know anything ADON-B added shiftoor at the facility for the SLP recommendations overheard a NA inspect food and the slowly and was not to just feed him slowly and was not to just feed him slowly and was not to just feed him slowly and was a certification of say anything to ADON-B added should not she was she contacted respectation and took with in normal limits.	on the 24 hour community see. The SLP-A furthing while eating and should be facility followed through. She relied heavily and the second on the second of th	ner ne le ago, agh on on the ndations ion and it en she iquids he of ated, "I luation." In the as prior d she N-B er that o she did g R19. A) was once she actions n were 3 stated	2 955			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 955	informing him of the SLP-A feeding instructions for feed during lunch today at the facility is they ke floors so they do not buring interview on stated R19 had couslow to eat, receive pureed food. NA-O glass to assist R19 while using the glas would use a spoon give a full teaspoon (approximately 3 m directions on the tal spoon for fluids but removed from the tal R19 as they did prespoon, and monitor	e facility not following uctions and had not ther, ADON-B stated ling were not at the tand a downfall they beep rotating staff from the know the residents of the face of fluid. Previously onths ago) there were the face of	heard d R19's rable have at m different s. h. NA-O ng, was and ur ounce coughing ughing, he uids and re written f to use a re to feed glass or was	2 955			
	stated an educator on R19's SLP-A red stated, "I told her as won't remember wh anything and had m	/04/17, at 3:42 p.m. from the facility instructions but so soon as you walk and you told me. She sign a paper saying len stated, "I had not so new diet."	ucted her she way I didn't say g I was				
	operations (DORO) by any managemen feeding and she ha feeding before; how	a.m. the director of stated HR-A was not team member to a d never done any type vever, DORO then stated	ot directed ssist with be of tated				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 955	facility staff member assistant. Although was no indication a checked with HR-A certification was curidentified HR-A connursing assistant. During interview 10 stated she received needed to check the feeding instruction at the black book wou cart. A nurse needed prior to staff serving started coughing or nurse. Interview on 10/5/1 practical nurse (LPI educated on the newho have special dwould have the instindicate to check the located on the beven in the dining room processed on the dining or choking with feeding resider. The immediate jeonates 12 a.m. was rep.m. when it could be document review, and educated dieta could and could not needed to be in the were eating, where guidelines were loc	rs she was a nursing DORO identified this ny management stafif her nursing assistancent, even though the nunicated to them should be detected on the ed to be in the dining gresident and if anyour choking they were to the place of the state of the should be located on the ed to be in the dining gresident and if anyour choking they were to the should be located on the ed to be in the dining gresident and if anyour choking they were to the process regarding iet. The ticket on the ructions and if needed to be black book which we are great any issues great only trained staff of the position of the process of the proces	s, there if had ant ley she was a A-Q the staff special aferred to beverage room one or alert the led would be eded to be upervise with can assist 10/4/17, t 2:54 ation, he facility taff of who a nurse esidents wallowing om, and	2 955			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 142 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, § INTRY CLUE	STATE, ZIP CODE R DRIVE		
GOLDEN	VALLEY REHABILIT	ΔΙΙΟΝ ΔΝΙ) (:ΔΚΙ		VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 955	Continued From pa	ge 142		2 955			
	eat.						
	pneumonia and was facility failed to follow instructions while feeding assistants waddition, ADON-B at the table while HR-and made no attempth this occurred. A policy was request recommendations to facility failed to follow the facility failed to follow the facility failed to fail the failed to fail the	a history of aspiration is at risk for aspirating the set risk for aspirating the law the SLP-A specific seeding R19, and ensure powere appropriately trained and NA-M were directly and Nas feeding R19 incorrupts to stop or intervene we sted for following SLP put was not provided.	paid d. In cross ectly, vhile				
	The director of nurse could review/revise for staff regarding to residents with meal addition, the DON at that appropriate concompleted on residappropriateness of feeding assistant. could conduct audit compliance.	them being fed by a paid The DON and/or designe s to ensure ongoing	ee ation st s). In sure ts are				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty	y-one				
21250	MN Rule 4658.0700 Director;PeriodicAd	O Subp. 2 F. Medical visement to DNS		21250			11/13/17
	conjunction with the director of nursing s for:	he medical director, in e administrator and the services, must be respon- isement to the director of					
	i . periodic adv	isement to the unector of					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

00112

B. WING __ 10/05/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7505 COUNTRY OLUB DRIVE

GOLDEN	OLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
21250	Continued From page 143	21250						
	nursing services to ensure a quality level of delegated medical care provided to residents; and							
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure on-going collaboration with the medical director to ensure identified quality concerns related to activities of daily living (ADLs) and insufficient staffing were adequately addressed and resolved. This had potential to affect all 94 residents in the facility.		Corrected					
	Findings include:							
	A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.							
	During the current recertification survey, the following examples of continued concern(s) were identified:							
	The facility did not provide cares as identified on the care plan for 2 resident who required staff assistance for repositioning; 1 resident whom							

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21250	required range of m monitoring not com stage 3 pressure ul living (ADL's) were who were depended F282 for additional. The facility did not presulted in resident unkept hair, and strodor for 3 residents staff for activities of information. The facility did not presulted in residents staff for activities of information. The facility did not presidents whom we ADL's, 2 residents with range who were not fed belimited staffing need residents and 14 stroncerns about the toprovide care and facility. Refer to F35. When interviewed of medical director (M facility on a regular MD-A stated he was concerns related to turn-over which had facility. MD-A state had been cited in the however, was not for care concerns (i.e.	notion. Pressure ulco pleted for 1 resident cer, and activities of not provided for 3 re nt upon staff for ADL	with a daily sidents is. See or nail characters, and body in the control of the c	21250			
	skin breakdown, an	nd bathing not being on found. MD-A state	done)				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 145 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	05/2017
NAME OF	PROVIDER OR SUPPLIER		<u>I</u>	STATE, ZIP CODE	1 10/0	13/2017
	N VALLEY REHABILIT	7505 COL	INTRY CLUB			
GOLDEI	T	GOLDEN	VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21250	facility administratic findings at a meetir the plans to address on the back burner again." MD-A state cares not being cor "certainly would be included on to help needs to be done," MD-A stated he wa immediate jeopardy current survey from and he would call the immediately. On 10/5/17, at 2:56 director (ED), assis (AED)-A, and regis (DOQ) were intervia, "huge support," treadily when questing DOQ stated MD-A deficiencies cited do survey, however, and is involvement with to address them. Is should have involved addressing the ider A facility Medical D 6/10/16, identified Medical director for listed objectives incoming in the monitoring of coordinating medic Further, the agreent in the agre	on had reviewed the cited SA and recently, however, some of as them must had been, "put," or, "we're never looked at and the continued concerns of empleted for residents, issues," which he should be develop a plan with, "what to correct them. Further, is unaware the facility had an any (IJ) determination on their in two days prior, on 10/3/17, the facility to discuss this in the current executive director the developing and available in the facility and available in the facility and available in the developing any action plans in the facility. The agreement dated MD-A more when intified concerns. In the current executive director of the developing any action plans in the facility. The agreement cluding to have the medical that residents at the Facility lical care," and, " assisting in resident care polices and all care in the Facility." In ent listed several me medical director including, and the medical director including the medical director including the medical director includin	21250			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 146 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN VALLEY REHABILITATION AND CARE			INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21250	Continued From pa	ge 146	21250			
	coordination of med "Be responsible for appropriate steps to inadequate medica reported to the Med SUGGESTED MET corporate owner(s) review their policy t industry standards involvement. The could have ongoing ensure ongoing cor areas of resident ca competency to ens consistently met. The this process as par of concerns and invithe facility.	dical care in the Facility," and, evaluating and taking correct situations of possible I care that is identified by or				
21330	Routine & Emerger Subp. 2. Annual de A. Within 90 da must be referred fo unless the resident examination within admission. B. After the ini nursing home must resident wants to se any necessary help at least an annual the		21330			11/13/17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		00112		B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21330	examination or with	ge 147 in one year from the ne within the six mor		21330			
	by: Based on interview facility failed to ens followed through to	ent is not met as evi and document revie ure a dental referral address dental cond 2) reviewed for dental	w, the was cerns for 1		Corrected		
	Findings include: R162's annual Minimum Data Set (MDS) dated 5/20/17, identified R162 had no cognitive impairment and required extensive assistance with personal hygiene. R162's Admission Record, undated, identified R162's payer source to be Medicaid. The Admission Record further indicated he had been admitted on 05/09/17.						
	08/16/17, identified swallowing problem During interview on stated he had lots of had a filling that had R162 stated he were and had all of his ternal had problems with R162 stated when I had requested to see	10/02/17, at 12:36 points of problems with cavid fallen out within the number of the tothe dentist last seth done, but since the cavities and a lost filling admitted to the fallogical fal	o.m. R162 ties and e last year. summer then has ling. cility he				
	on 05/12/17, he had	d requested a referra are Services for dent	al with				

6899

Minnesota Department of Health STATE FORM

PRINTED: 11/01/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00112 10/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7505 COUNTRY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21330 Continued From page 148 21330 treatment. A Golden Valley Rehab & Care Center Communication Result Report dated 05/23/17, at 1:57 p.m. indicated a referral was sent to Doorstep and confirmation of receiving the referral from Doorstep was received on 05/23/17, at 1:58 p.m.. During interview on 10/03/17, at 8:46 a.m. medical records director (MR)-A stated R162 makes his own decisions and he signed up for dental services when he admitted. MR-A then indicated a referral was faxed on 05/23/17, and

medical records director (MR)-A stated R162 makes his own decisions and he signed up for dental services when he admitted. MR-A then indicated a referral was faxed on 05/23/17, and that she had confirmation they received the fax. MR-A stated the dental service comes out monthly and did not know why he was not seen. In addtion, MR-A stated once the referral is sent to Doorstop they leave it up to them to schedule the appointment and that no one in the facility tracks if they are seen or not after the referral is sent.

Although R162 addressed concerns of his teeth the facility failed to follow thru to ensure he was seen by a dentist as he had requested upon admission on 05/23/17, almost five months later.

SUGGESTED METHOD OF CORRECTION: The director or nursing and/or designee could develop and or revise policies for provision of dental services and educate responsible staff to ensure follow up dental needs are scheduled and residents are assisted in arranging tranportation when residents request. The DON and/or designee could conduct audits of residents with dental needs to ensure residents recieve dental

Minnesota Department of Health

services consistently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	l'	ODATE SURVEY COMPLETED	
		00112	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 CO	DDRESS, CITY, UNTRY CLUI VALLEY, MI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	
21330	Continued From pa TIME PERIOD FOR (21) days.	ge 149 R CORRECTION: Twenty-one	21330		
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progredefined in part 465 procedures of resid the prevention and F. the development of the prevention and F. the development of the products, including defined in part 4656 G. a system for the products which affed disinfectants, antised incontinence products which affed disinfectants and ards of current standards of the control of the products which affed the products wh	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and			11/13/17
	by: Based on observati	on, interview and document ailed to implement a		Corrected	

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
711012711	OF CONTROL	IBENTI IOMITON NOMBER.	A. BUILDING:			LLTLD
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLDEN	LVALLEV DELIABILIT	7505 COU	INTRY CLUE	BDRIVE		
GOLDEN	I VALLEY REHABILIT	GOLDEN	VALLEY, MN	l 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	 ige 150	21390			
21000	comprehensive inferinclude consistent to infections to prever persons which had current residents, so The facility failed to water-management develop policy to provide the factor of th	ection control program to tracking, and analysis of at potential spread to other the potential to affect 94 staff and visitors to the facility. The ensure they had developed a tracking program to identify risks and revent Legionella exposure, I to affect all 94 current silty. Further, the facility failed unity-based glucometer was ance with manufacturer and cross contamination of gens for 2 of 2 residents (R31, ing their blood glucose and the potenital to affect 8 set floor with current blood orders. In addition, the facility and fine time to the facility of the facility of the facility of the facility and the potential to affect 8 set floor with current blood orders. In addition, the facility of the facility				
	Findings include:					
	INFECTION CONT	ROL PROGRAM:				
	director of nursing of three-ringed binder infection control modification included month divided there were docume	te afternoon, the assistant (ADON)-C provided a containing the facilty's pointoring program. The binder ider tabs, and upon inspection, ents filed only under August 17. Review of the materials ring:				
	Associated Infectio	ing Report/Monthly Healthcare n Incident Rate worksheet was 16) infection line listings, which				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		PLE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
	00112	B. WING		10/05/2017
NAME OF PROVIDER OR SUPPL	ER	STREET ADDRESS, CITY	STATE, ZIP CODE	
GOLDEN VALLEY REHAB	LITATION AND CARE	7505 COUNTRY CLU GOLDEN VALLEY, N		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		S ID FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
number, type of was done, type the infection was an overall for September is specific to site our urinary tract, ey Additionally und "infection Surve corresponded to contained the sadditional information regarding infection and the sadditional information infection	g other items: resident, r infection, onset date, if a of antibiotic and start dates acquired in house or nonfection rate (3.13.%) calcolor, however, but no rate rype of infection, for exect, respiratory or gastro-inger the September tab we illiance Worksheets" whice line items on the report, ame information. There we into a line items on the reports or ons in September 2017. Listing Report/Monthly Heation Incident Rate works (21) infection line line items on the report. In a calculated inder the August tab were curveillance Worksheets" of line items on the report. It was a final urine culture received worksheets for August diditional information or of ses regarding infections in the report. There were individual information or of the regarding infections in the responsibility. There were individual infections of the responsibility in the listing to track in allysis of infections compared to the responsibility.	a culture te, and if ot. There ilculated te cample intestinal. ere four ch c, and was no r analysis ealthcare sheet was istings. If for e sixteen " which c. In eport just 2017. other in or nuary al but there infection pleted , ible for		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 152 of 212

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21390	and infection rate. winter there were a director of nursing p director left, the res passed from one to done. ADON-C sta to me in August of 2 me" and stated she needed further edu the ICP. ADON-C a the monthly data, a stated going forwar analysis, and review addressed during th A facility policy, "Inf Program, revised J goal of the program risks of acquiring at among residents, e workers, volunteers policy indicated "A o established to redu epidemic Healthcar residents and HCW policy indicated the and surveillance co document all reside on monthly line listi line listing report to	tember infection percentages ADON-C stated since last number of changes at the position, and each time the ponsibility for the ICP was another, and did not get ted the ICP was formally given 2107, "it was just handed to still had questions and cation regarding how to run acknowledged current gaps in and lack of the current ICP, but d, there would be tracking and wof the findings would be	21390			
	assitant director of	MENT POLICY: on 10/3/17 at 2:298 p.m., the nursing (ADON)-C istated she ny program begun in regard to				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	ige 153	21390			
	Legionnaire's disea	ent for the prevention of use. ADON-C stated she was priefly looked at the CDC tool				
	director or maintenaregional directors of to set up a meeting management plan. company would confussessment of the water management aware of the need to plan in place becaustated we do not have	on 10/4/17 at 1:29 p.m., the ance, (M)-A stated one of the of the facility had contacted him to talk about the water. The M-A mentioned a local ming to help the facility begin water system as part of the taplan. The M-A stated he was to have a water management use, of "this Legionella" but have policy in place right now. had the (CDC) "toolkit" on his ing down on paper.				
	assistant executive currently she had a company to begin t management plan. the CDC toolkit, and conducting a facility AED-A stated so fadone in regards to policy to address.	on 10/5/17 at 2:26 p.m. the director, AED-A stated date scheduled for a local esting in regard to the water. The AED-A stated when had d the facilty would be y-wide assessment. The r, that was what had been creating a water management he Legionnaire's concern.				
	or procedure to add Legionnaire's disea	dress the potential of use in the facility.				
	LACK OF GLUCON	METER CLEANING:				
	System Quality Ass	n Blood Glucose Monitoring surance / Quality Control dated 12/14, identified a				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

Millinesc	ita Department of He	eaitri				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00112	B. WING		10/0	5/2017
		1	1		10/0	0,2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	UNTRY CLUE			
		GOLDEI	VALLEY, MI	N 55427		
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	TREGGE WORK ON E		TAG	DEFICIENCY)	147412	
04000	0 " 15	454	01000			
21390	Continued From pa	ige 154	21390			
	frequently asked qu	uestions (FAQ) section under				
	its cleaning procedu	ures which dictated, "Blood				
	glucose meters are	at high risk of becoming				
		blood borne pathogens such				
	as Hepatitis B Virus	s [HBV], Hepatitis C Virus				
		Immunodeficiency Virus [HIV	J.			
		ese viruses from resident to				
	resident has been of					
		d glucose devices. According				
	_	Disease Control and				
		g and disinfecting of meters				
	between resident u					
		se viruses through indirect				
	II The state of th	the manual directed staff to				
		er each use with an EPA				
		tection Agency) registered				
		lution of 1:10 concentration of				
	bleach.					
	During observation	on 10/4/17, at 6:54 a.m.				
		urse (LPN)-D removed a				
		ssure Platinum glucometer				
	1	ication cart on the first floor.				
		apped in a dried white cloth				
		een colored, handled container				
		s, device strips and alcohol				
		oved the dried white cloth and				
		to R31's room. LPN-D				
		using gloved hands, and				
		of blood using the glucometer	.			
	Afterwards, LPN-D	brought the device out of				
		l it back on the medication car	t			
		are R31's insulin for				
		N-D did not clean the				
		y wipes or chemicals after				
		m. LPN-D picked up the				
		r and stated she was, "going t	0			
		sugar," and began to walk				
		lication cart, and into R89's				
	room, with the devi-	ce in her hand before being				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 155 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	stopped by the surv When interviewed i stated staff clean th "supposed to be cle using a wipe which LPN-D then cleaned designated wipe an clean it for, "contain A provided, undated (checks) listing ider had current glucom first floor of the faci. During interview on assistant director of glucometer(s) need each resident, "for i case blood or bodily onto the device. F staff had just receiv recently. A facility Equipment Cleaning/Disinfectir 1/2017, identified the prevent resident cafrom becoming sou equipment, "will be applicable before us policy listed three consenior cannot be cleaned, dis according to manuf CDC guidelines."	mmediately following are device at night and caned in between peokilled bacteria and vide the device using a distated it was impornination," purposes. If 1st Floor Gluc(omentified eight different reter checks ordered lity. 10/4/17, at 12:34 p.m. finursing (ADON)-A stated to be cleaned inbenfection control issue of the facility, "will take are equipment and suppress of infection," and cleaned and disinfects with another reside ategories, including concritical, and listed expended in the policy did not spension of the policy did not spension control issue of the facility, "will take are equipment and suppress of infection," and cleaned and disinfects with another reside ategories, including concritical, and listed expension of the policy did not spension control issue of the policy did not spension of the policy did not	it was, ople," ruses. tant to ter) residents on the n. tated the etween es," in eferred ed nursing subject ated action to oplies d all used ted as ent." The eritical, examples e items, d tion and ecifically	21390			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B 14/11/0			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
001.051	LVALLEY DELLA DILLE	7505 COU	INTRY CLUE	3 DRIVE		
GOLDEN	I VALLEY REHABILIT	GOLDEN	VALLEY, MN	N 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 156	21390			
	TECHNIQUE DURI	FECTION CONTROL ING DRESSING CHANGE: as identified on physician's				
	Alzheimer's demen Minimum Data Set indicated R121 had	17, included early onset tia. A significant change (MDS) dated 8/18/17, I a stage 4 pressure ulcer depth involving bone, muscle				
	(open wound, with depth involving bone, muscle and supporting tissue). Physician's dated 8/30/17, directed staff to, "Cleanse wound, pat dry, Flagyl (antibiotic medication) 250 mg					
	to moist [wound page	olet) crushed into wound, wet ck] using Dakins Solution ser) BID (two times daily).				
	licensed practical n dressing change to assistant (NA)-A ar	on 10/2/17 at 12:24 p.m., urse (LPN)-C completed a R121's wound. Nursing nd NA-W helped to hold and				
	removal and placer Prior to the dressing bed side table in R	sition on the bed during the ment of the wound dressing. g change, LPN-C prepared the 121's room and gathered				
	needed supplies, among which included sterile, unopened 4" (inch) x (by) 4" gauze squares, and Dakins Solution (or DK solution, a type of solution made form diluted bleach, treated to reduce					
	of bacteria and viru discarded the outer	antiseptic that kills most forms ses). LPN-C removed and bandage and the packed				
	then cleansed the v After washing hand	sently in R121's wound, and wound and surrounding skin. Is and donning new gloves,				
	dressing package. by ripping a 3/4" str	ew, unopened 4" x 4" gauze LPN-C opened the package ip off across the top of the				
		the gloved hand, removed the the empty package wrapper				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 157 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	
			,			
		00112	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUE			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	- N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21390	Continued From pa	ge 157	21390			
	on top of the bed si the gauze 4 x 4 she empty package wra (milliliters) of DK so gauze was soaking wrapper, all on top then grasped the so squeezed out exces with the crushed moderate R121's wound with LPN-C placed a top pack, and the dres. When interviewed to explained R121's distated she opened the gauze 4 x 4, pla (on the outside of it DK solution into the gauze, soaked with the crushed Flagyl R121's wound. LPI procedure stated she changing of R121's changing of R121's	de table. Next, LPN-C placed is just removed on top of the apper, then poured about 30 ml plution on the gauze. The on top of the gauze package of the bed side table. LPN-C paked gauze, and lightly as DK solution. Then, along edication, LPN-C repacked the solution-saturated gauze. It is bandage on R121's wound sing change was completed. It is gauze package, removed aced it on top of the wrapper is package), then poured the gauze. LPN-C stated the it is packed into N-C did not question the ne considered this be be a serile technique" for the wound dressing.				
	registered nurse (R change for R121's v helped hold and ma	on 10/3/17 at 11:06 a.m., (N)-B completed a dressing wound. NA-B and NA-D aintain R121's position on the				
	RN-B washed his h table, then gathered placed them on the large gloves, which gloved hands, RN-E the packed, gauze and folded the would while he removed the	re. Prior to R121's treatment, ands, cleaned the bedside d supplies, medications and table. Next, RN-B donned he struggled to put on. With 3 removed the outer dressing, dressing from R121's wound, and packing into the gloves he gloves, then placed the es in the trash. Without first				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 158 of 212

Minneso	<u>ita Department of He</u>	ealth					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NU	IMBER:	A. BUILDING:		COMP	LETED
		00440	l	B. WING		40/0	E/0047
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				INTRY CLUB			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE					
			GOLDEN	VALLEY, MN	1 55421		
(X4) ID		ATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG		00 10 211111 1 0 0	111011,	IAG	DEFICIENCY)	1 W 11 E	
21390	Continued From pa	ige 158		21390			
	···aching or cloopsis	bio bondo DN D (dannad				
		ng his hands, RN-B o					
		es, grasped a new g					
		ped a strip across the					
		en it, and with the glo					
		e. With the gauze in					
		e around the outside					
		gauze in half and ma					
		d the wound edges.					
		oves and disposed of					
		loves. RN-B donned					
	pair of gloves, with	out washing or sanitiz	ze his				
	hands, opened and	other package of 4 x 4	4 gauze.				
		d hold of a liquid spra					
		s was a "liquid wound					
		an to spray R121's wo					
		mediately the spray n					
		ound, then drained a					
		t of the wound, as w					
		in dripping onto the to					
		e gauze in hand, RN-					
		nd, soaking up the dr					
		rainage. While clean					
		ottle came in contact					
		ascaded down onto t					
		21's bed; the bottle v					
		ved his soilded glove					
		d gauze by folding the					
		disposal into the tras					
		vound, RN-B remove					
	donned another pa	ir of gloves, tore ope	n an new				
	gauze 4x4, and pag	cked R121's wound.	RN-B				
	applied a top banda	age to cover the pack	ĸed				
	wound, and comple	eted the treatment.					
	·						
	When interviewed	on 10/3/17 at 4:32 p.i	m. RN-B				
		ressing change he tri					
		nnique, and thought h					
		open the gauze pac					
		s not aware the outsi					
		tle came in contact w					
l	, spray olcarisci bott	ic carrie in contact w	iui uic				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 159 of 212 X11C11

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	NTRY CLUB			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21390	Continued From pa	ge 159	21390			
	drainage from clear stated he thought the "too bad." RN-B die but only after the er completed. When interviewed of assistant director of when opening a dresshe would expect the asto expose the interviewed of the solution on top outside wrapper was "its filthy" ADON-C for staff to follow appetechnique during drechnique during dreded for the nurs	nsing R121's wound. RN-B ne dressing change didn't go d state he washed his hands, ntire dressing change was on 10/4/17 at 9:01 a.m., the f nursing (ADON)-C stated essing package, like gauze, ne package to be opened so side of the package, then pour of that. ADON-C stated the as considered contaminated, also stated it was important opropriate hand washing ressing changes, and added egarding infection control was sees. ADON-C stated this issue g because we have other				
	A facility policy, Har 2017, indicated Har important procedur acquired infections staff was to wash h immediately after rerequired staff to use organic material and SUGGESTED MET. The director of nurs review/revise policies urvelliance, infecti wound dressing character all staff on director of nursing a policies for Legione.	ndwashing, dated January indwashing is the most a for preventing healthcare. The policy directed when ands, and indicated amoving gloves. The policy a hand hygiene to remove dirt, distribution transient microorganisms. THOD OF CORRECTION: Sing and/or designee could as for infection control on control practices with anges, use of glucometers and these policies. Also, the and/or designee could develop alla. The DON and /or acate all responsible staff on				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	these policies and control practices for use of glucometers designee could con survelliance and impolicies to ensure control process.	conduct audits of infer wound dressing cha . In addition, the DOI duct audits of facility plementation of Legi	anges, N and/or onella	21390			
21540	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is not the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician does not the order and if the change the order, the consulting pharmal directly to the QAA.	g. A nursing home ment's drug regimen for usage, based on the disage, based on the disage, based on the port any irregularity to physician. If the attendence of the pharmacist must all director for review not the attending physician he matter must be regy Assurance and Assequired by part 4658 dician is the medical dimacist shall refer the	nust or nursing e to the ending ing rovide ist eing t refer the rif the rattending ication for does not eferred for sessment .0070. If lirector, e matter	21540			11/13/17

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ige 161	21540			
	facility failed to reco needed (PRN) antip appropriate monitor	and document review, the ord indications for use with as psychotic medication to ensure ring for 1 of 5 residents (R6) essary medication use.		Corrected		
	Findings include:					
	Findings include: R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs) and displayed rejection of care and verbal symptoms on a less than daily basis. R6's most recent signed physician orders dated 9/6/17, listed R6's current medications including order(s) for: - Zoloft (an antidepressant medication) 200 mg (milligrams) by mouth every bedtime for depression; - Risperdal (an antipsychotic medication) 3 mg by mouth every bedtime for a listed diagnosis of, "anxiety" and; - Risperdal 0.5 mg, "by mouth twice daily as needed for depression." The PRN dosing had a listed start date of 6/14/17.					
	were reviewed. In any of the PRN Ris R6 received the PR twice on 9/17/17, or 9/27/17, for a total oback side of the Malabeled, "Comment provided directions medications had be medications are given Medication Notes."	Iministration record(s) (MAR) August 2017, R6 did not take perdal. In September 2017, RN Risperdal once on 9/16/17, nce on 9/21/17, and once on of five administrations. On the AR, a column listing was ss/Nursing Observations," and for staff to identify why any een withheld and, "When PRN yen, explain in Nurse's However, the entire column nk and uncompleted.				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 162 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, ST JNTRY CLUB VALLEY, MN	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21540	R6's Psychiatric Presidentified R6 had a disorder, bipolar type, "seemingly state was documented a keeping positive," of however, listed an a "There have been mursing staff." Furthote, it does appeat his Risperdal p.r.n. provider reminded if needed to target thinking." R6's Behavior Charton the dates the PF Further, R6's progrationale for the PR When interviewed on ursing assistant (Non-compliant," at the have equipment to cares. NA-G stated having any hallucin thinking, and furthed displayed would be charted. During interview on practical nurse (LP PRN Risperdal for would ask for it whe staff. LPN-F stated	ogress Note dated 9 history of schizoaffe be with staff reporting ole and doing well over schizoaffe, "more difficult to poor wound hassessment section no concerns reported her, dictation is listed on a few occasions him that this is available depression, anxiety, or to Detail Report date R6 had no recorded RN Risperdal was press note(s) dated 8/y recorded indication RN Risperdal being pon 10/4/17, at 9:32 and 10/4/17, at 9:3	ective g him to verall." R6 culty ealing, with, d by d of, "Of asking for since this able to him or unclear d 8/5/17 to behaviors rovided. '5/17 to as or provided. a.m. s particular staff didn't uld refuse of R6 sional ors R6 ses and m. licensed ived the netimes ing at the actice was	21540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION		E SURVEY PLETED	
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	MAR, to have docu PRN Risperdal had However; after revi surveyor added it w be there."	mentation to support I been given in Septe ewing R6's record wi vas not and, "its supp	ember. th the cosed to	21540			
	and assistant direct interviewed. ADON documenting, "the ineeded medication or in the progress rimportant to documneeded medication	a.m. registered nursitor of nursing (ADON A-A stated staff shoul indication," for giving on the back side of notes. ADON-A statement rationale for giving, "so you can determed medication," and to	I)-A were d be as the MAR d it was ng as ine the				
	staff failed to docur indication when the periodic assessmen	rders for PRN Risper ment the reasoning a ry administered it to a nt and evaluation to d as being effective an	nd allow determine				
	1/2016, directed sta medication use as and CareTracker st completed a review use when applicabl	rive Medication policy aff to document, "PR applicable," on the caystem, and staff wou of psychoactive mede and during the RAI applications in the medent Instrument) process.	N are plan Id dication				
	The director of nurs review/revise policie psychotropic medic for the use of those and/or designee co these policies and of the se policies and of the second seco	THOD OF CORRECT sing and/or designee es regarding monitor cations for ongoing just medications. The Double educate licensed conduct audits of psyensure ongoing justifications.	could ing of stification ON staff on vchotropic				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 164		21540			
	the use of psychotr	opic medications.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Tw	enty-one				
21565	MN Rule 4658.1329 Medications Self Ad	5 Subp. 4 Administra dmin	tion of	21565			11/13/17
	self-administer med resident assessment care as required in 4658.0405 indicate	inistration. A resider dications if the compr nt and comprehensiv parts 4658.0400 and this practice is safe om the attending phy	rehensive re plan of d and there				
	by: Based on observati review, the facility fassess for the safe medications for 1 o observed to have m	ent is not met as evi ion, interview and do ailed to comprehensi ty of self administrati f 1 resident (R48) wh nedications at bedsid red oral medications.	cument ively on of no was e and		Corrected		
	Findings include:						
	R48's quarterly Min indicated R48 was	imum Data Set dated cognitively intact.	d 6/17/17,				
		on 10/1/17, at 9:57 a glycerin 0.4 milligran e.					
	Assessment dated to administer all me	tion Data Collection a 1/10/17, indicated nu edications as the resi f- administer medica	ırsing was dent was				
	R48's physician ord	ler dated 7/11/17, ind	licated it				

Minnesota Department of Health

STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPL IDENTIFICATION N		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00112		B. WING		10/0	05/2017
NAME OF PROVIDER O	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN VALLEY	REHABILIT	TATION AND CARE		INTRY CLUE Valley, MN			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCII Y MUST BE PRECEDED B' .SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
was oka to treat of nursing a ensure F nitroglyco. During of registered medicati poured to proceed medicati administ was also of the was also	chest pain) failed to co R48 was sa erin on her bservation ed nurse (F ons in a cl he pills on ed to chect ons were to trating ther onoted on hterview or he did not a fons becau the bedsid a hospice /17, at 10:2 fons could was a nurs ian's order N-A stated hent indica erin at the ons for he collow- up in -E stated to the bedsid nent indica erin at the ons for he collow- up in -E stated to the stated to th	R48's nitroglycerin (in at the bedside. Hower personner is a session of the total o	yever, ent to 9 a.m. er morning room. R48 and glycerin .m. RN-E take her leave as because s bedside and wing R48's current o have es to leave after set-up. at 10:48 had been were: ageal ety) 0.5 two gr, two pressure, ers) 180	21565			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 166 of 212

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				7.1. 20122.1.10.			
		00112		B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	TATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21565	Continued From pa	age 166		21565			
	60 mg, and two cap nerve pain) 400 mg	psules of gabapentin J.	(treat				
		self- administration o equested and was no					
	The director of nurs review/revise polici administration of m responsible license DON and/or design medication adminis	THOD OF CORREC'sing and/or designed es for resident self dedication, and educated staff on those polinee could conduct austration for residents administer are safe to	e could ate the cies. The idits of to ensure				
	TIME PERIOD FOI (14) days.	R CORRECTION: Fo	ourteen				
21580	MN Rule 4658.132 Medications; Requi	5 Subp. 7 Administra irements	ation of	21580			11/13/17
	administration of m complete procedur record, transferring medication from the	tration requirements redications must include of checking the responding the responding the resident's prescription of the medication of t	ude the sident's the tion				
	by: Based on observat review, the facility f administered in acc	ent is not met as ev ion, interview and do failed to ensure insul cordance with manuf ure complete dosing	cument in was acturer		Corrected		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 167 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
21580	residents (R31) obsaddition, the facility insulin's were dated potential administratesidents (R200, Rinsulin available for medication cart(s). Findings include: INSULIN ADMINIST R31's signed physicidentified an order facting insulin used and directed staff to [subcutaneous; und management of his increased blood sugnanagement of his increas	served to receive ins failed to ensure oped when opened to protein after expiration (B4) observed to have administration in the TRATION: cian orders dated 9/2 for a Lantus Solostar to reduce blood sugar, "Inject 71 units der the skin] twice day diabetes (disease of	ned event for 2 of 2 e undated event for a long for a using for a vent for a vent for a vent for a high for	21580			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 168 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21580	(used to determine showed the surveyor medication administ began to walk over medication. LPN-D and questioned aborimed. LPN-D staneedle with insulin needle was conside administered the insun-primed needle to Immediately following was interviewed and need to prime the nadministration, as the insulin pen. LPN-D instructions including the surveyor, and so when interviewed cassistant director of insulin pen needles being used to remo "make sure they're dosage." During interview on consulting pharmaca attached to an insular, "two unit air shot patient. A facility Insulin Injeit identified a subject and listed a procedinsulin vial with syridirections or p	the dose) up to 71 up. LPN-D then clost tration record (MAR to R31 to administed was stopped by the put if the insulin pented, "you do not printed, "you do not printed sterile. LPN-D sulin using the pented to the control of the con	ed R31's) and r the e surveyor had been ne," the n as the then with an n, LPN-D re was no de the needle edle with did." a.m. stated efore fle to, ne correct m. needle med with on a /2015, insulin / using an d any when	21580			

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILITA	ΔΤΙΟΝ ΔΝΟ CARE	INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21580	Continued From pa	ge 169	21580			
	South medication of practical nurse (LPI cart was opened wivials of insulin insidicating insulin, good opened) was approlacked any labeling been using it, or whan additional vial of was approximately writing on the vial to been opened or whe LPN-H reviewed bounaware how long to which resident receipust be tossed." A vial of Novolin N (was labeled for R20 the insulin remaining spacing on a yellow "date opened," and however, both of the There was no recording the was, "not sure," addition, two separatives are stored in the care was no recording the property of the care was the care was a support of the care was no recording the was, "not sure," addition, two separatives are stored in the care was no recording the care was not care was no recording the care was no recording the care was no recording the care was not care was no	0 a.m. the Second Floor art was reviewed with licensed N)-H. The top drawer of the th four opened, uncapped e. One vial of Novolin R (short for only 42 days after being ximately 3/4 full, however, to identify which resident had ten it was opened. Further, Novolog (short acting insulin) 1/2 full and had no label or demonstrate when it had ich resident was using it. In the vials and stated she was they had been opened for, nor sived them adding, "these can (an intermediate acting insulin) 00 with approximately 1/2 of the ginside. The label had of colored sticker to record the, "exp. [expiration] date," these spaces were left blank. The ded, visible date on the vial to been opened. LPN-H stated when they were opened. In the ate opened Lantus flexpen(s) cart and also labeled for R200. The pens and stated, "nothings"				
	were inside and lab was dated when it h	nal separate Lantus flexpens eled for R84. One of the pens nad been opened, however, ted and lacked any markings				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 170 of 212

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21580	Continued From pa	age 170	21580			
	the refrigerate and "need to be thrown recording dates on opened as, "they ex When interviewed assistant director or insulin, "needs to brinsulin expired after During interview on consulting pharmac containers should be follow recommended staff, "know how lost A facility Storage at Medications, Biology policy dated 10/16, manufacturer/supp dates for opened marecord the date open	on 10/4/17, at 11:30 a.m. f nursing (ADON)-A stated e dated," when opened as r a set period of time. 10/5/17, at 12:07 p.m. cist (CP)-A stated insulin be dated when opened to ed storage guidelines and so righter good for." Ind Expiration Dating of gicals, Syringes and Needles directed staff to follow lier guidelines for expiration medications including to, " ened on the medication medication has a shortened				
	The director of nurs review/revise polici expiration of medic responsible license DON and/or design resident medication medications, to ensure medications (such provide medication	THOD OF CORRECTION: sing and/or designee could es for storage of medications, ations, and educate all ed staff on those policies. The nee could conduct audits of ns, storage of those sure that date vials of as insulin) are opened, and to s according to manufacturer when using of insulin pens is				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00112		B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21580	Continued From page 171 TIME PERIOD FOR CORRECTION: Seven (7) days.			21580			
21630	Subp. 2. Destruction A. Unused port remaining in the nur discharge of a residual prescribed, or any of discontinued permain manner recomment or the consultant purpharmacist must fur instructions and for kept on file in the number of the prescribed or drugs remaining in death or discharge were prescribed or discontinued permain according to part 6 be returned to the person destruction listing the medication, prescripperson destroying the witness to the destruction. This MN Requirements	on of medications. ions of controlled sul rsing home after dea dent for whom they w controlled substance anently must be destr ded by the Board of I narmacist. The board rnish the necessary ms, a copy of which is ursing home for two y itions of other prescrip the nursing home aft of the resident for wh	ostances th or ere royed in a Pharmacy d or the must be years. otion er the nom they royed or must to part me of ure of the ure of the rded on denced	21630	Corrected		11/13/17
	review, the facility fa procedures to ensu patches were dispo	ailed to implement po re transdermal narco sed of in methods to This practice had pot	olicies and otic help		Consoled		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21630	affect 2 of 2 resider orders for transderr Further, the facility reconciliation was opolicies and proced of potential diversio (4th Floor, 3rd Floothe survey. This have residents with curresubstances on these Findings include: A facility Destruction dated 7/2015, direct transdermal patchen narcotic medication resident with, "Two the destruction of the resident's Medication [MAR]." Further, the transdermal patched unless it was prohibe cutting the patches a, "drug buster" system An undated Fentan which identified R16 orders for Fentanyl facility. On 10/1/17, at 10:5 South medication operactical nurse (LPI second metal contakey. The container narcotic medication including several optransdermal patched	nts (R188, R161) with mal patches in the far failed to ensure narch completed in accordatures to ensure rapid an on 3 of 3 medication, 2nd Floor) reviewed potential to affect and potential to affect and orders for control are affected floors. In of Controlled Druggeted staff to destroy use (i.e. Fentanyl [a point of the patch on the point of the patch on the point of the patch on the policy identified fluss was the, "preferred pited, then staff shoulin half and placing the policy in half and placing the patch on the policy identified fluss was the preferred pited, then staff shoulin half and placing the policy identified fluss was the placing the patch of t	cility. cotic ance with detection on carts ed during 38 of 38 led s policy ised otent from a st sign for cord shing d," method ld be nem into provided rrent s in the cloor h licensed ained a I with a veral e anyl the	21630			

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 173 of 212

PRINTED: 11/01/2017

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETI DATE
21630	Continued From page 173 transdermal patches, stating staff were supposed to, "have somebody watch," when used patches are removed and disposed of. LPN-H stated when she removed patches, she placed them, "in the sharps container [attached to medication cart, able to be accessed using scissors and cutting]." Further, LPN-H stated she had changed a patch for R188 that morning (10/1/17), however, added she did not have anyone else watch it as nobody was available at the time. R188's 10/2017 MAR was reviewed with LPN-H. The MAR identified an order for Fentanyl 50 mcg/hr (micrograms per hour) to be applied every 72 hours. Further, the MAR had directions of, "Fold and flush patch down toilet following removal / Two nurses must witness," and provided spacing for two nurses to record their initials when completed. However, these spaces were left blank with no initials recorded. When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated used transdermal patches should be removed with two nurses present and disposed to, "via sewer." ADON-A stated removing patches without two staff and disposing of them in a sharps container was, "not acceptable," and the nurse, "needs education." During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated the facility policy was for two nurses to witness and destroy the used transdermal patches via sewer as there was, "left over drug on the patch." CP-A stated the nurse disposing of the patch in the sharps container and removing on her own, "didn't follow the policy."	21630	DEFICIENCY)	

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COL DEA	I VALLEY REHABILIT	ATION AND CARE 7505 COU	INTRY CLUE	DRIVE		
GOLDEN	VALLET REHABILIT	GOLDEN	VALLEY, MN	I 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 174	21630			
	NARCOTIC RECO					
	A facility Controlled identified a directive have procedures in ordering, receipt, as destruction of controlled Drugs as staff to document a including schedule counted by the off-trained medication Further, an addition Dating of Medicatic Needles policy date labeled, "Controlled directed, "Facility si	Drugs policy dated 7/2016, eto, "assure that all Centers place to safeguard the dministration, storage and colled drugs." The policy of, "Ongoing Inventory of a Each Shift," and directed all controlled medications, II, III, IV, and V, had been going and on-coming nurse or aide (TMA). The policy of the po				
	medication cart wan practical nurse (LP) with a physical key compartment inside medications. LPN-compartment and sout a few," of the naturing her 8 a.m. mot complete a nare before signing them LPN-G and the surfinside the metallic of R123 should have aloud, however, on middle of the packat LPN-G stated she,	a.m. the South 4th Floor is reviewed with licensed N)-G. The cart was locked with an additional metal is which contained oral narcotic is opened the locked metallic stated she, "[had] not signed arcotics she gave this morning inedication pass. LPN-G would cotic count with the surveyor in out. When completed, weyor counted the narcotics compartment. LPN-G stated 59 remaining oxycodone pills is e had been removed from the age and only 58 pills remained. "did not notice that," when if-going nurse that morning				

winnesc	ota Department of He	aith					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	S	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		NTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (CROSS-REFERENCE)	ILD BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 175		21630			
	and added, "I don't further narcotic coumedication cart. L counting the medicand stated the nurse count on a flowsheet reach nurse signing signatures were recand provide evidence been counted. The September 2017: 9/1/17 - three of the 9/2/17 - all six space 9/3/17 - all six space 9/3/17 - one of the 9/10/17 - three of the 9/11/17 - three of the 9/15/17 - three of the 9/15/17 - three of the 9/15/17 - two of the 9/15/17 - three of the 9/20/17 - two of the 9/21/17 - four of the 9/21/17 - one of the 9/21/17 - one of the 9/21/17 - three of the 9/25/17 - one of the 9/26/17 - three of the 9/28/17 - three of the 9/29/17 - three	know what happened." nts were incorrect on the PN-G reviewed for production carts with the surves sign off each time the contained in a binder onsisted of six column off for each shift. A total quired to satisfy the flowage the medication cart is following was identified as six spaces were left blank, six spaces were left blank is spaces were left blank is spaces were left blank, ces were left blank, ces were left blank, ces were left blank, it is spaces were left blank it is spaces were left	he cess for veyor, hey r. s with tal of six wsheet had ed: blank, blank, blank, lank, lank, lank, lank, lank, blank, blank				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB			
()(1) ID	SHIMMADV STA		VALLEY, MN		ON.	(УЕ)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21630	Continued From pa	nge 176	21630			
	had not been docur an entire day. Whe following this review unsure if the cart had had just not been d right." LPN-G state the medication cart might be missing."	d five instances when the cart mented as being counted for en interviewed immediately w, LPN-G stated she was ad not been counted, or if it locumented adding, "it is not ed it was important to count is each shift as, "medication				
	The narcotic count flowsheets were provided for the remaining medication cart(s) on the 4th Floor and identified the following:					
	9/1/17 - two of the s 9/3/17 - two of the s 9/4/17 - two of the s 9/5/17 - two of the s 9/10/17 - three of th 9/11/17 - three of th 9/13/17 - two of the 9/18/17 - two of the 9/21/17 - two of the 9/22/17 - two of the 9/27/17 - three of th 9/28/17 - three of th 9/29/17 - three of th 9/29/17 - three of th 9/29/17 - three of th	for September 2017: six spaces were left blank, he six spaces were left blank				
	9/2/17 - four of the 9/3/17 - four of the 9/4/17 - one of the 9/5/17 - three of the	or September 2017: six spaces was left blank, six spaces were left blank, six spaces were left blank, six spaces was left blank, e six spaces were left blank, e six spaces were left blank,				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 177 of 212

	ta Department of He			1		Т	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		. ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	IDENTIFICATION NO	JIVIDLIN.	A. BUILDING:			LLILD
		00112		B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				INTRY CLUE			
GOLDEN	I VALLEY REHABILIT	ATION AND CARE		VALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORM	ATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					BEHOLINOTY		
21630	Continued From pa	ge 177		21630			
	9/7/17 - five of the s	six spaces were left	hlank				
		e six spaces were let					
		six spaces were left					
		six spaces were lef					
		ie six spaces were le					
	9/12/17 - all six spa		,				
	•	ne six spaces were l	eft blank,				
	9/14/17 - two of the	six spaces were lef	t blank,				
	9/15/17 - five of the six spaces were left blank,						
	9/16/17 - three of the six spaces were left blank,						
		six spaces were lef					
		six spaces were lef					
		e six spaces were let					
		ne six spaces were l ne six spaces were l					
		six spaces were it					
		six spaces was left					
		six spaces were lef					
		six spaces were lef					
		six spaces were lef					
	and;	·					
	9/30/17 - three of th	ne six spaces were l	eft blank.				
	·	3 a.m. the 3rd Floor					
		s reviewed with LPN					
		ss for counting and is. LPN-B stated na					
		is. LPN-B stated ha ing shift change," an					
		eets kept in a binder					
		viewed and consiste					
		on the 4th Floor cart					
	identified the follow		(S) and				
		-					
	September 2017:						
		spaces was left blan					
		spaces was left blan					
		spaces was left blan					
		spaces was left bla					
		spaces was left bla					
	9/19/17 - one of six	spaces was left bla	nk,				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 178 of 212 X11C11

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21630	9/22/17 - one of six 9/23/17 - one of six 9/24/17 - one of six 9/27/17 - one of six 9/29/17 - one of the 9/3/17 - one of the 9/17/17 - two of the 9/18/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/19/19 - one of the 9/21/17 - one of the 9/21/17 - one of the 9/19/19 -	age 178 a spaces was left blank, a spaces was left blank, a spaces was left blank, a spaces was left blank and; a spaces was left blank and; a spaces was left blank. Immediately following this ad staff must had, "forgot to unts being completed adding,] should be filled in." LPN-B tant to count and document each shift as, "that's how we correct," and nothing was LPN-B and the surveyor of the narcotics in the d found it to be correct. So a.m. the 2nd Floor South as reviewed with LPN-H who as for counting and reconciling as. LPN-H stated the narcotics een each shift exchange, and a sign the narcotic counting and in a binder on the cart. were provided and identified six spaces were left blank, six spaces was left blank, six spaces was left blank, six spaces were left blank, esix spaces was left blank, a six spaces was left blank	21630	DEFICIENC!)		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 179 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
21630	Continued From pa	nge 179	21630			
	When interviewed i review, LPN-H stat had not signed the	e six spaces was left blank. Immediately following this ed she was unsure why nurses flowsheet to demonstrate they arcotics adding, "people maybe				
	forgot to sign." Fu important to count nurses coming on a	rther, LPN-H stated it was and sign the flowsheet as are, "taking credit the count is ald be tracked who had access				
		flowsheets were provided for ication cart(s) on the 2nd Floor bllowing:				
	9/2/17 - one of the 9/5/17 - one of the 9/6/17 - one of the 9/7/17 - one of the 9/8/17 - two of the 9/9/17 - one of the 9/10/17 - one of the 9/11/17 - five of the 9/12/17 - four of the 9/13/17 - two of the 9/14/17 - three of the 9/20/17 - one of the 9/21/17 - five of the 9/21/17 - two of the 9/23/17 - one of the 9/23/17 - one of the 9/29/17 -	art" for September 2017: six spaces was left blank, six spaces were left blank, six spaces was left blank, six spaces was left blank, e six spaces were left blank, e six spaces was left blank				
		Month End Operations Report stiffed 38 different residents				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 180 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21630	had controlled substhree reviewed med When interviewed of assistant director of medication cart nar between each shift flowsheet(s) so, "your responsible for the missing." During interview on consulting pharmacy completes audits or "periodically," and responsible for the missing. The machine completes audits or "periodically," and responsistently. CP-A audit, which had be month ago, she ago with the narcotic counts were consistently. CP-A audit, which had be month ago, she ago with the narcotic counts are interim director and also placed in a website, however, a responsibility to revistated staff should,	stances stored amon dication carts. on 10/4/17, at 11:30 at finite fini	a.m. stated the inted the is of thing go m. the ets, 2017, the recent nan a issues'' ded. ewed with the time, y on their lity's CP-A and	21630			
	The director of nursing develop and/or revidestruction of unsefentanyl patches rewhom they were prodesignee could eduand conduct audits	THOD OF CORRECTION of the property of the prop	could oper ding as for and or oolicies tices in				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 181 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
		00112	B. WING		10/0	10/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
21630	Continued From page 181		21630				
	medications, fentanyl patches are being consistently implemented.						
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen					
21665	MN Rule 4658.1400 Physical Environment		21665			11/13/17	
	A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.						
	by: Based on observation review, the facility for in an acceptable material affecting 2 residents room. A ceiling tile working not in safe working were also not maintain R111. Wall mounted room 106 affecting room's (DR) ceiling	ons, interview and document ailed to manage facility odors anner on the 4th floor, s (R84 and R2) residing in that was missing in room 329, R113, electric outlets were order, room tiles, and window tained in room 104, affecting d fans were not cleaned in R66, and the 1st floor dining and wall mounted fans were ng 13 resident whom ate their or DR.		Corrected			
	2:25 p.m., the followith the facility staff maintenance technicarpenter/engineer housekeeping directions.	nental tour, held on 10/3/17 at ving issues were reviewed					

Minnesota Department of Health

Millinesc	ita Department of He	eaim	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
		7505 CO	UNTRY CLUE	BDRIVE		
GOLDEN VALLEY REHABILITATION AND CARE GOLDEN			VALLEY, MI			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 NC	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
0.4005	0 11 15		04005			
21665	Continued From pa	ige 182	21665			
	director (AED-A).					
		, pungent urine odor in a				
		re R82 and R2 resided. The the hallway, and was				
		at the door into their room.				
		oom, R84 was observed				
		nair (WC) looking out the				
		had only a fitted sheet with a				
		sed to absorb urine for residen	t			
		nt), as well as, a vinyl recliner				
		ker pad. When approached, ungent odor of concentrated				
		om his person. The floor of the				
		ausing surveyor and staff's				
	footsteps to be hea					
		884 will not wear any				
		s, while he states they are for ly has replaced R84's recliner				
		2 years due to being saturated				
		sked about odor control, they				
		ers and have this room and 5				
		6 times a day - everyday				
		but the odors still persists.				
		have tried a urea-neutralizing				
		reakdown urine salts and ated that they have not. AED- <i>l</i>				
		why this product has not been	`			
		Restated that type of product				
		contract for use within this				
	facility.					
	On 10/2/17 at 2:24	n m _ maintananaa taahnisiss				
		p.m., maintenance technician ssues are noted the floor staff,				
	` '	ed to contact maintenance and				
		ere is an issue(s) that needs				
		n, MT indicated they can call				
	on the walkie-talkie	s, or call on the phone. They				
	can also leave writt	en information at the nursing				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 183 of 212

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
	GOLDEN VALLEY REHABILITATION AND CARE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	stations, which wou maintenance and he the building each do the building each do the building each do the building each do the suspended ceiling tiles. The area above section of ceiling tiles. The area above section of ceiling tiles. The area above section of ceiling tiles and both house should of been between the wall are tiles and both house should report this to department. At 2:57 p.m. in room R111), noted a 4-outher mopboard, that between the wall are hanging at a 45 degintact. The outlet we electric Hi-Lo bed, were aware of this staff lowered the Hidislodging it from the tright away. The threand bedroom was a measuring approximation in width. A pirroom measuring approximation in the bedroom winder stripping which allower incomment approximation.	p.m., the bathroom in room The bathroom had a with 2 foot (ft) x 3 ft ceiling we the toilet was missing a e, that was approximately 6 ft the support bar missing that ween the 2-3 ft sections. MT e was unaware of the missing ekeeping and/or floor staff to the maintenance m 104-1 (first bed in room - utlet electrical box just above was pulled off the wall and residents bed, and was gree angle, with the wires as being used to run R111's Neither M-A, MT or HSKP issue. MT stated it appeared i-Lo bed onto the outlet box are wall. This would be repaired eshold between the bathroom cracked with tile missing mately 18 inches in length and arece of title was missing in the exproximately four inches by inches. The CCE, identified ared, and the area did not from the room to the other. ow had missing weather wed an opening to the ximately 1/2 inch wide by the window. The CCE stated this	21665			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SO COMPLETE.	
00112 B. WING 10/05	5/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN VALLEY REHABILITATION AND CARE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
In Room 106 at 3:11 p.m., the oscillating wall fan next to the bathroom, had a heavy build up of gray dust, that occluded the fan cage. There were strings of dust (approximately 2-3 inches) blowing out from the fan cage. The blades of the fan also had a heavy buildup of dust and black debris on the edges. HSKP stated the fans should be cleaned on monthly basis. In reviewing of the 1st floor dining room, at 3:24 p.m., a white ceiling fan, appeared gray with a heavy accumulation of gray dust. The on/off fan switch was broken off, and the fan could only be cleaned by turning the ceiling lights off. M-A stated they would have to fix the ceiling fan controls so that the housekeeping staff could clean the fan and fan blades. A oscillating wall fan, also located in the 1st Floor dining room, had a heavy build up with mats of gray dust on the fan cage. HSKP stated the housekeeper would not of been able to clean the ceiling fan, because it could not be turned off unless the light was off. She stated housekeeping staff have noticed the wall fan, and should be cleaning this on a monthly basis. Licensed practical nurse (LPN)-B whom was in the dining room at this time, stated approximately 13 residents ate in the dining room. In review of the facility policy, entitled: Maintenance and Repair: To Prevent Spread of Infection (revised January 2017), pertained more to "Personnel Health" (personal protection was to be used) and Preventative maintenance rather than what should be reported to maintenance / housekeeping for repairs. On page 3 of the same policy, in a section entitled: Pluming Supply and Drainage Systems , the policy indicated that the facility was to have "scheduled regular preventive	

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 185 of 212

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING: COMPLET				
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	<u></u>
GOLDEN	I VALLEY REHABILITA	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pare fixtures" and the "wassues. A second facility man Physical Environment indicated that the facomfortable, and horesident" and "all electrical, and resident maintained in safe of the center 'Preventa' The policy further in and housekeeping weekly rounds to in common areas, office policy indicated that concerns found and rounds, providing the weeks. Request for the last findings and complete however wer not recommended. The separate policity from Healthcare Sethousekeeping In-S. The first, entitled: Condicted the purpose that each resident ramonthly basis. The	ge 185 ater supply system." ddress electrical or ceiling tile aintenance policy, entitled: ent (effective July 2015), ceility "provides a safe, clean, ome like environment for each essential mechanical, ent care equipment is operating condition through ative Maintenance Program'." adicated that the maintenance manager would be performing clude "resident rooms (10), ces, gym and laundry." This at the facility would correct at keep results of the weekly mem to quality assurance every at 3 months of weekly rounds, etion records were requested, ceived. The service of the policy was: "[insures] oom is discharge-cleaned on is policy made no mention of	21665			
	second policy, entitl Room Cleaning, als should do when not	mentioned above. The led: 5-Step Daily Patient so did not mention what staff ing missing ceiling tiles, dirt her environmental concerns, aning.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY	
		00112	B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	7505 COL	DRESS, CITY, S	STATE, ZIP CODE B DRIVE		
GOLDEN	I VALLEY REHABILIT	ALION AND CARE	VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	HSKP was asked for rooms designated a day" and fan cleani However, on 10/5/1 stated that neither I supporting docume the fans noted were to during environments	or cleaning logs for the 6 as "to be cleaned six times a ng for the last 3 months. 7 at 12:43 p.m., the AED-A HSKP nor the facility had ntation that these 6 rooms and be being completed, as referred ental tour by HSKP.	21665			
	staff regarding the ifunctional and hom administrator or demaintenance and hiperiodic audits of all ensure a safe, clea environment is maintenance.	or designee, could educate importance of a safe, clean, elike environment. The signee, could coordinate with ousekeeping staff to conduct reas residents frequent to in, functional and homelike intained to the extent possible. R CORRECTION: Twenty-one				
21730	Subp. 11. Insect ar condition on the site conducive to the hard insects, rodents, or eliminated immedia control program mupersonnel. This MN Requirement	5 Subp. 11 Plant eration, & Maintenance nd rodent control. Any e or in the nursing home urborage or breeding of other vermin must be ttely. A continuous pest ast be maintained by qualified ent is not met as evidenced	21730			11/13/17
	review, the facility facontrol was maintain	on, interview and document ailed to ensure adequate pest ned for flying insects ity, which was mainly identified		Corrected		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 187 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				I \ /	E SURVEY PLETED	
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE (MUST BE PRECEDED BY SC IDENTIFYING INFORM)	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21730	throughout the 1st deficient practice have residents (R31, R16 facility. Findings include: R31 was interviewed stated the facility has the water fountain cand the unused bat flies come from the R31 further indicate coughing and hack Monday I told admabout the fly proble was done about it". "there are often severays, and if you twi. During interview on stated there were sed dining room. When come out, and the fand go to the food. practical nurse (LPI but did not know who buring interview 10 stated he had been and the "This place"	Ige 187 Ifloor and dining room ad the potential to af 62, R130, R35) resided on 10/01/2017, at as problems with several as problems with several as problems with several as the flies are everal flies in the stated in the flies in the conditional flies are eating they reflies are eating they reflies are eating they reflies came out of the At 12:02 p.m. licens N)-E stated she had here they came from 1/01/17, at 10:06 a.m. at the facility for five sucks"! In addition er flies in his room as	9:53 a.m. ver flies, rusted, he sewer rywhere." " Last thing nything tated ment fly out." 1., R31 floor eally dry drains ed seen flies, . R162 months R162	21730	DELIGITION OF THE PROPERTY OF		
	stated he had been The food is cold I d the same thing eve stated he eat's in hi	/01/2017, at 10:10 a at the facility about on't eat breakfast be ry day. In addition R is room because of t flies in the dinning ro	a year. cause its 130 he bugs				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 188 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE			
			VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21730	Continued From page 188		21730			
	observed a small b in her room. An ad observed of a fly in completed lunch transport to the complete lunch transport transport to the complete lunch transport tran	10/02/2017, at 12:51 p.m. lack fly over R35's lunch tray lditional observation was R35's room flying over R35's ay again at 12:59 p.m. lion on 10/02/2017 at 1:25 were seen flying around the 1st At 1:42 p.m. four flies were ge bag, and six flies on the of the 3rd floor conference 7 at 8:08 a.m., multiple small ag around the room. lecord review at the 1st floor 10/3/17 from 8:41 a.m 11:28 were observe flying around the residents areas on the first				
	and at 9:00 a.m. at	on 10/03/2017, at 8:43 a.m. the first floor nurses station flying around the desk.				
	p.m., maintenance was aware of the "f dining room which week. He stated the the housekeepers was in the dining room, resolved. When M-kitchenette of the 1 black flies emanate	tal tour, on 10/3/17 at 2:25 director (M)-A stated that he flies" being in the 1st floor was continuing for the past two ney were "fruit flies." He had washing out all the garbage nd making sure food is not left and thought the problem was A tapped the sink on the st floor dining room, smalled from the sink area. M-A II a pest control company that				

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21730	with M-A and the corpest Control, Inc.) previewed the facility the "glueboards" (seach light were insponted: > On the 4th floor, the light, was noted to lapproximately 5 homultiple black-eyed fungus gnats. This floor dining area. > On the 3rd floor be dining area, now ut area. The light's glueboard, and the kitchen on the 2 house flies, black-eyed fungus gnats. > On the 2nd floor of flies, black-eyed frugus gnats. > On the 2nd floor of flies, black-eyed frugus gnats. During reached under the pulled from the floor matter, with food do and the pulled from the floor glueboard, was four of black-eyed fruit for the puring an interview stated that black-eyellies, are much larger.	a.m., on a environmentracted company's pest control technicia best control technicia by "bug lights" wall sociated. The following the glueboard within have trapped the followse flies, one ground fruit flies and nume light was located in the bug lig	(Adam's an (PCT), onces and uside of grass was the bug owing: drawing he 4th in the old ral storage etle, herous of house mats. The rance of everal s and when, PCT and poist red fruit flies and	21730	BENGLING		
	in high moisture loc	cations, which can be ugh cleaning of bree)				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 190 of 212

Minneso	Minnesota Department of Health							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00112	B. WING		10/05/2017			
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE				
GOLDEN VALLEY REHABILITATION AND CARE			DUNTRY CLUE N VALLEY, MI					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE			
21730	Continued From pa	age 190	21730					
	such as drain traps PCT stated, like all months of the year, these areas. PCT s (especially floor drapower-washed, whi drain grates and cle The PCT suggester flushed with 3-5 gadrains are free flow fruit flies. PCT furth floor coverings (incomposed by the floor coverings (incomposed by the floor coverings) for the inspected for craare dark and collect to be deep cleansed that the fungus gnashould dramatically for the other flies (holds), warm moist of continue breeding to denied the presence areas where they we sealed and intact (holds) from the indicated: "The center residents, staff and pests by controlling with outside pest could attempt to contain a routine basis (holds).	s and garbage collection areas flies, during the warmer, staff need to routinely clean states areas such as drains ains) may need to be ich included removing the floceaning the undersides as welled to M-A that all drains be allons of water, to assure the ving, to help control all forms oner suggested to M-A that all cluding vinyl and ceramic tiles) acks and potential areas that at moisture. These areas need ats, once it freezes outside by decrease in numbers, but as a nouse, fruit and black-eyed fruit and bl	er ser se					
	as suggested by the SUGGESTED MET	THOD OF CORRECTION:						
	The administrator,	maintenance supervisor, or						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		LETED		
		00112		B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILITA	ATION AND CARE		INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21730	designee could ens program was develond facility could educate perform routine envensure adequate per report these finding performance improving further recommend compliance. TIME PERIOD FOR (21) days.	ge 191 sure a preventative peroped and implement te staff on these policy ironmental rounds/a est control. The facilities to the quality assurvement (QAPI) compations to ensure ong R CORRECTION: Two.651 Subd. 5 Patients	ed. The cies and udits to ty could rance mittee for oing	21730			11/13/17
21000	Residents of HC Fa Subd. 5. Courteouresidents have the a courtesy and respe- employees of or pe health care facility.		ts and th ty by ce in a	21000			11/13/17
	review, the facility facility facility facility were donned exposed skin for 1 of addition, the facility hygiene was mainta 2 of 5 residents (R5 Findings include: R10's Face Sheet in (stroke), neuromusc bladder, and hemip	on, interview and docailed to ensure resident and covered resident (R10). failed to ensure personned in a dignified most, R2) reviewed for coular dysfunction of the quarterly Minimum D	ent's lents In sonal anner for dignity. of CVA he the left		Corrected		

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN VALLEY REHABILITATION AND CARE			INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 192	21805			
	cognitively intact, a	17, indicated R10 was nd required extensive ff for dressing and grooming.				
	a.m. R10 was sitting leaning to the right apron. The smoking and resident's shirt stomach and urostd attached to the abd was observed to lea	g in the entrance of the facility wearing a soiled smoking g apron hung to R10's right, pulled up exposing his omy (device to collect urine, omen). At 10:03 a.m., R10 ave the facility to visit with a de, stomach and urostomy still				
	sitting in the facility facing the door. R1 which was hiked up urostomy fully expohim that his stomac but his clothes are transferred from be lift, the cloth on the shirt up as he is low that if his urostomy	a.m. R10 was observed again main entrance. R10 was 0 was wearing a red polo shirt of to just below his chest, with used. R10 stated it bothered the and urostomy are exposed, tight. R10 further stated, when the to wheel chair (WC) with the WC seat back pulls R10's wered into WC. R10 indicated is tucked into his pants, the the ostomy wafer will peel off.				
	nursing assistant (NR10 this morning a	on 10/4/17, at 12:36 p.m. NA)-E stated she had assisted nd added, "Yes, his belly sticks hirt down, but it does not elly."				
	sheet (undated), an 9/11/17), lacked do	up 3 nursing assistant care and R10's care plan (last signed cumentation of instructions to solutions covered his bag.				

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/05/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	worker (SS)-A state clothing was discus during R10's quarte September. SS-A s clothes from donatineither the family/g to wear "other peopwas informed the fabuying new clothes ever occurred. SS-with laundry service have been educate when his stomach a During an interview verified that he was refused. R10 stated going to be buying On the same day, a checking with laundry purchased only 2-3 In review of a facilit (effective July 2015 efforts between the party to ensure clot	do/4/17, 12:53 p.m. social and that the purchase of new seed with family/guardians arly care conference in stated that the facility offered ons to the facility, however, uardians nor R10 wanted R10 oles" clothes. SS-A stated he amily/guardians would be but was unaware if this had A stated that he would check as. SS-A stated that floor staff d to adjust R10's clothing and ostomy are exposed. To on 10/4/17, at 12:58 p.m. R10 offered donated clothes, but d his family/guardians were him new clothing items. At 1:15 p.m. SS-A stated after dry, family/guardians had pairs of pants. To policy, entitled: Clothing in pairs of pants. To policy and in the procurement of needed	21805			
	had moderate cognextensive assistant hygiene. The MDS (seven or more epi- but at least one epi-	S dated 9/1/17, indicated R55 nitive impairment and needed be with dressing and personal identified R55 was frequently sodes of urinary incontinence, sode of continent voiding) Diagnoses included				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 194 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	dementia and depression of the control of the contr	a.m. R55 was seated borway to her room. Tas noted to be under ght hand. on 10/1/17, at 11:10 wheelchair by the elector and strongly esaturated in the area. a.m. R55 was seated elevator and nursing a shower the night face remained under ght hand. 10/4/17, at 8:20 a.m. of the clean her nails and and her feel "dirty." 10/4/17, at 8:37 a.m. of nursing (ADON)- A strong the clean her nails and the clean hand of the clean her soiled clother and the clean her so	A dark r her long a.m. R55 vators of urine ea of her ea of her ed in her g desk. before. A her a. R55 d it a. R55 d it a. R55 d it a. Stated ils and hing. d clothing ed R2 moisture uded was ed on	21805			
	o/b/17, indicated R2	2 would be neat, clea	an and				

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	
		00442	B. WING		40/0	E/2047
		00112			10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21805	well groomed daily, assist with persona and undressing with care plan indicated and ADLs and at tincare plan lacked ap R2's Urinary Contin 8/4/17, indicated R2 refuses to wear incoccasionally soils swould lie in bed and the bed and refused however, the care pstaff should handle encourage him to compare the strong urine smell, saturated with urine as the right lower si uncombed and stick Multiple staff were I desk and staff did room and assist wit comb his hair. At 3: lying on his right sick were saturated with strong odor of urine in the hallway. On 10/3/17, at 10:1 hallway in front of the were untied, his hair up in multiple place the back of the collaboration.	The care plan directed staff to I hygiene, grooming, dressing a physical assistance. The R2 was resistant to therapy nes refused shaving. The opposite proaches to refusal of cares, ence care plan, last reviewed 2 was incontinent and resident continent products and elf. A behavior indicated R2 durinate soiling himself and d to be changed was noted, plan did not address how the the behavior, other than to	21805	DELIGIENCI)		

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 196 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	7		DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILITA	ATION AND CARE		VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21805	5 Continued From page 196			21805			
	shoes, however AD back to his room ar comb his hair. On 10/4/17, at 6:51 dining room watchir uncombed and was His gray t-shirt had front. R2 was in the when he walked do and laid in bed. Sta offer to change his this time.	ON-A did not offer to tand help him change his a.m. R2 was sitting in a television. His hair was sticking up in multiple a quarter sized hole in dining room until 9:06 who the hall towards his ff did not approach R2 shirt or comb his hair, of 10/4/17, at 8:47 a.m. s	the vas places. the a.m. room and during				
	During interview on 10/4/17, at 8:47 a.m. social services assistant (SS)-A stated R2 had a brother that he had contacted in the past about getting new shoes and the brother bought him a new pair. SS-A stated he had not noticed the holes in R2's clothing and had not notified R2's brother, for help in obtaining new clothing. SS-A stated it was a resident's right to wear what they wanted, however, R2 would never complain about having holes in his clothing unless they were really large. During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled, and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and wasn't sure who did. NA-G stated he was fairly independent but needed hands on assistance frequently and did allow staff to comb his hair and assist with changing his clothes, it just depended on how						

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 197 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	NTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From page 197		21805			
	staff approached hi	m.				
	ADON-A stated it w to walk around in u added urine odor, sholes and messy had the facility policy R indicated: "The cento a dignified existe communication with services inside and must protect and presidentDignity/Se Participation. You h from the facility in a environment that president and presidentDignity/Se Participation.	10/5/17, at 9:39 a.m. vas unacceptable for a person rine soiled clothing. ADON-A soiled clothing, clothes with air were undignified. desident Rights dated 7/15, ter promotes the resident right ence, self determination, and outside the center. The center romote the rights of each elf Determination and ave the right to receive care a manner and in an romotes, maintains, or and respect in full recognition of				
	The director of nurs review/revise policic staff on those policic could conduct audit residents with expo and assisted to apskin and to ensure maintained.	THOD OF CORRECTION: sing and/or designee could es on dignity and educate all les. The DON and/or designee ts of resident cares to ensure used body parts, are offered propriately cover their exposed personal hygeine is				
	TIME PERIOD FOR	R CORRECTION: one (1) day.				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			11/13/17
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | A. BUILDING: | COMPLETED |

00112 | B. WING | 10/05/2017

NAME OF F	PROVIDER OR SUPPLIER STREET	ADDRESS, CITY,	STATE, ZIP CODE	
GOLDEN	VALLEY REHABILITATION AND CARE 7505 C	OUNTRY CLUE	3 DRIVE	
GOLDLIN	GOLDE	N VALLEY, MI	N 55427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 198	21830		
	(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment an alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative oboth. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated writing by the resident as the person to contact if an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has pecified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident in the possession of the facility; (2) examining the medical records of the resident in the possession of the facility;	d ree		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING	10/05/2017	
00112 B. WING	10/05/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
7505 COUNTRY CLUB DRIVE		
GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AND	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE	ETE
21830 Continued From page 199 21830		
family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for		

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21830	Continued From page 200 the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.		21830			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor medication time choices for 1 or 4 residents (R48). In addition, the facility failed to honor food choices for 1 of 4 residents (R162) reviewed for choices.			Corrected		
	Findings include: R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and					
	included diagnoses of anxiety and depression. During interview on 10/1/17, at 3:45 p.m. R48 stated she wanted her evening medications given at 7:00 p.m. but they were scheduled for 8:00 p.m. and sometimes it took a really long time to receive her medications. R48 stated the nurses were aware and was told she had to come ask for them earlier.					
	was seated in her v	on 10/2/17, at 7:52 p.m. R48 wheelchair next to the iting for her evening				
	R48's Medication Adminsitration Records (MAR) indicated the following:					
		nilligram (mg) 2 capsules by aily, scheduled for 8:00 a.m.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED			
		00112		B. WING		10/	05/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	ADDRESS, CITY, STATE, ZIP CODE OUNTRY CLUB DRIVE EN VALLEY, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21830	- melatonin 3 mg 1 for 8:00 p.mativan 0.5 mg 2 tal - morphine soluble scheduled for 9:00 - morphine sulfate evening, scheduled - MAPAP rapid relethree times daily, sp.m. and 8:00 p.m. September 2017 gabapentin 400 mmouth (po) twice dand 8:00 p.m melatonin 3 mg 1 for 8:00 p.m melatonin 3 mg 2 tal - morphine soluble scheduled for 9:00 - morphine sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled - MAPAP (acetamin 500 mg 2 tabs po to the sulfate evening, scheduled	tab po at bedtime, so po at 8:00 pm. tab 5 mg 2 tabs po at p.m. ER 15 mg 2 tabs po at for 8:00 p.m. asse gelcap 500 mg acheduled for 8:00 a.m. asse gelcap 500 mg acheduled for 8:00 a.m. asse po at 8:00 pm. tab 5 mg 2 tabs po at p.m. ER 15 mg 2 tabs po at p.m. and 8:00 p.m. and 8:	every 2 tabs po m., 12:00 sules by 00 a.m. cheduled at bedtime, every e gelcap heduled for n. evening m. and d for 7:00 esting the e to two e patient on times references	21830				
		i 10/5/17, at 10:14 a. f nursing (ADON)-A						

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 202 of 212

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	VALLEY REHABILIT	ATION AND CARE	INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	was not aware R48 medications sched 8:00 or 9:00 p.m. A scheduled for twice changed by the nur that are scheduled to be communicate The facility policy R indicated: "The cenright to a quality of confidentiality, inde and decision makin and Federal regula fully informed in ad and of any changes may affect your we planning care and the and treatment, unle incompetent or four state law." R162's quarterly M he was cognitively appetite or over ear Care Plan dated 05 regular diet with lar R162's Nutrition Ris Assessment dated received regular diet with lar ceived regular diet with lar large observed to bring Fone brat, 1/2 corn cand one ice cream ordered two brats as	s wanted her evening uled for 7:00 p.m. rather than DON-A stated medications adaily or at bedtime could be sing staff. The medications for a certain time would need do to hospice for changes. Resident Rights dated 7/15, the recognizes the resident's life that supports privacy, pendent expression, choice, ag, consistent with State law tion You have the right to be vance about care, treatment, in the care or treatment that II-being and to participate in treatment or changes in care less you have been adjudged and to be incapacitated under DS dated 08/17/17, indicated intact and did not have a poor ting. R162's Nutrition Risk 5/17, indicated he received a	21830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21830	order and that was he was supposed to what I had on my m I wanted." R162 the had on my Fing came here [the faci In follow up intervie R162 stated he new brat or ice cream as on 10/02/17. During phone intervient the facility's restated she did not he her but thought R16 meat diet so he shoportion at lunch on to talk to the facility' During interview on manager (DM)-A stalarge portion diet ar should have checked upset and that he s	not on his diet and the have. R162 stated heal ticket and that is en stated, "This is not ticket and I never should had receive a dould had received a transport of the second of the second had received a transport of the second had received had receive	, "I know not what it what I build have 00 a.m. econd g lunch 12:17 O)-A front of louble wo meat mended m. dietary regular assistant e became to have	21830			
	Social Service and/ develop /revise poli educate all facility s DON and/or design interviews to ensure	THOD OF CORRECT or their designee cou cies for resident clos taff on those policies ee could conduct res eresident choses are edication administration	uld es and s. The sident e being				
	TIME PERIOD FOR	R CORRECTION: Fo	urteen				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00112		B. WING		10/05/2017	
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	Continued From page 204			21830			
	(14) days.						
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness.			21855			11/13/17
	residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 6 residents (R121) during observations of personal cares.			Corrected			
	Finding include:						
	orders dated 9/28/1 Alzheimer's dement Minimum Data Set indicated R121 was required the physical bed mobility, eating personal hygiene. had a stage 4 press depth involving bon tissue).	as identified on phys 7, included early ons tia. A significant cha (MDS) dated 8/18/17 stotally dependent up all assistance of two stotally dependent up and all assistance of the muscle and support and all assistance of the muscle and support assistance of two stotal assistance	set inge 7, pon and staff for and ited R121 ind, with orting				
	During observation	on 10/3/17, at 11:06	a.m.				

6899

Minnesota Department of Health								
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		00112	B. WING		10/05/2017			
NAME OF F	NOTICE DEFICIENCIES OF CORRECTION (X1) PROVIDERS UPPLIER (X3) DATE SURVEY COMPLETED (X4) MULTIPLE CONSTRUCTION A BUILDING: B. WING 10/05/2017 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 205 nursing assistant (NA)-B was in R121's room, and pulled the window drapes shut to begin cares when registered nurse (RN)-B entered the room. RN-B began to gather supplies for a dressing change to R121's wound as NA-D also entered the room, and closed the door behind her. At 11:12 a.m., working on the exit side the bed, NA-D moved R121's incontinent brief, rolling the front not itself, and tucked it between R121's legs. NA-B stood on the opposite side of the bed, while NA-D rolled R121 first toward the exit side of bed to remove the solied brief, than back to the window side. NA-B held R121 as he faced the will be NA-D gathered R121's gown on his stomach, then pulled down the bed sheet, and cleansed R121's bottom with a cloth. Next, NA-D rolled R121 on its back, then cleaned R121's genital area. NA-D left R121's bedside to dispose of the wash cloths and get additional bedding and clothing, while NA-B stood next to R121's pentals now fully exposed. At 11:15 a.m., while RN-B finished gathering and setting up supplies for the dressing change, R121							
GOLDEN	I VALLEY REHABILIT	TATION AND CARE						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE			
21855	nursing assistant (Nand pulled the wind when registered nursing RN-B began to gath change to R121's with the room, and closed 11:12 a.m., working NA-D moved R121's heet, and untied R the front onto itself, R121's legs. NA-B the bed, while NA-E exit side of bed to reback to the window faced the wall, while on his stomach, the and cleansed R121 NA-D rolled R121 or R121's genital area dispose of the wash bedding and clothin R121 in bed, his general in bed, his general in back, his were uncovered and passed. NA-B remand made no attern waited for RN-B. A dressing change, and nhis left side, faciliar	NA)-B was in R121's room, dow drapes shut to begin cares urse (RN)-B entered the room, her supplies for a dressing wound as NA-D also entered ed the door behind her. At gon the exit side the bed, 's gown, pulled down the bed R121's incontinent brief, rolling, and tucked it between a stood on the opposite side of D rolled R121 first toward the remove the soiled brief, than a side. NA-B held R121 as he e NA-D gathered R121's gown en pulled down the bed sheet, the bottom with a cloth. Next, on his back, then cleaned a. NA-D left R121's bedside to h cloths and get additional and, while NA-B stood next to enitals now fully exposed. At the RN-B finished gathering and	21855	DEFICIENCY				
	R121's genitals rem made no attempt to exposed body area application of a top from the bed and F genitals still fully ex	mained exposed, and NA-B provide cover for R121's provide cover for R121 was rolled on his back, provided to R121 was provided by the cover for R121's provided cover for R121's p						

Minnesota Department of Health

at 11:24 a.m., nine minutes after the dressing

STATE FORM 6899 If continuation sheet 206 of 212 X11C11

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00112	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE 7505 C	ADDRESS, CITY, S OUNTRY CLUE EN VALLEY, MN	B DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21855	change began. For a full minute be following R121's drewing R121's private body though a bed sheet accessible to use a When interviewed of stated to help guard have to shut the do sheet to cover [R12 during cares and drewing the help with the better." During an interview assistant director of residents should be possible during the ADON stated she codignity and privacy residents. A facility policy, Cor July 2015, directed:	fore, then during, and essing change, staff allowed y area to be exposed, even gown, and other towels we	-B a t ft			
	The director of nurs review/revise policion the appropriate propersonal care. The conduct audits of respective personal care.	THOD OF CORRECTION: sing and/or designee could es and re-educate all staff or vision of privacy during DON and/or designee could esident cares to ensure maintained and needs are m				

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112		B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	05 COU	DRESS, CITY, S INTRY CLUE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21855	TIME PERIOD FOR (14) days.	R CORRECTION: Fourte		21855			
21870	Residents of HC Fa Subd. 18. Respor residents shall have reasonable respons requests. This MN Requirements by: Based on interview facility failed to ensi- concerns presented to the residents. The R10, R11, R12, R13, R43, R44, R50, R5, R106, R116, R127,	651 Subd. 18 Patients & ic.Bill of Rights asive service. Patients are the right to a prompt are to their questions and ent is not met as eviden and document review, the tree they had followed up at resident council meetis affected 24 residents as affected 24 residents as R14, R21, R31, R34, R3, R65, R66, R73, R79, R135, R179) who have esident council meetings	ced ne on etings (R6, R39,	21870	Corrected		11/13/17
	During interview on resident council repare not getting anyw stated there have be closure of the reside facility, slow responsime of medication afrom 7:30 a.m. and extended period of were incontinent residence. R31 also stated per filed on 4/7/17, 4/14	10/1/17, at 10:14 a.m. the resentative, R31 stated where with anything." R3 een concerns regarding ent store, understaffing a se to call lights, variance administration in the more 11:30 a.m., and there we time before residents who ceived care by the facility as onal grievances had be 1/17 and 9/11/7, related to no f cares. He stated he	, "We 31 at the e of rning as an no y staff.				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00112		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	ATION AND CARE	7505 COL	DRESS, CITY, S JNTRY CLUB VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21870	not yet received res grievances filed, eit R31 stated he has demonstrate the co submitted. A review of the resi from 3/2/17 to 9/7/1 -3/2/17, resident co time it took to have failure to provide ca answered. The mir from the Ombudsm have the facilty follo complaint is filed ar completed. The me attended by the follo R50, R58, R65, R7 -4/6/17, information regarding the plans that will be built out doors. The meeting concerns identified The meeting was n following residents: R66, R79, R106. -5/4/17, concerns re not receiving medic Previous concerns identified were not a minutes. The meeti	sponses in follow up ther in writing or by a kept the documents incerns that had been dent council meeting 7 identified the following resident rights were notes also identified an of the resident rights with an investigation we teting was noted to howing resdient's: R6	my staff. to n g minutes wing: e length of , and an update ght to if a //as lave been , R21, sidents g patio double ect 3/2/17. by the , R58, a staff and me. utions eting the	21870			
		and requests were mess for the resumption					

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00112	B. WING		10/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I VALLEY REHABILIT	ATION AND CARE	INTRY CLUB			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	VALLEY, MN	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21870	Continued From pa	ige 209	21870			
	council meetings. T previous concerns identified. The mee following residents: R44, R65, R66, R7 -7/6/17, concerns we resumption of the re-	refreshment desired for the The minutes did not address or resolution to concerns eting was attended by the R10, R11, R12, R21, R31, 3, R106, R135. Were identified related to esident store. The meeting as previous concerns or				
	resolution to conce	rns identified. The meeting R11, R12, R21, R31, R43,				
	requested all nursing routed to the direct through. The minutinquired whether lessue the facility to in available. The minumanagement staff line staff (nurses, a Resident attendance)	lent Council president ng related complaints be or of nursing for follow es also reflected the residents gal services were available to nplement nurses/aides being utes identified concerns should be cut instead of front ides). be was not outlined in the oreflect members present.				
	to the concerns pre "new business" hea speaking with state aide care/staff aide attendance was no	id not address any responses eviously identified. There was a ading included potentially legislators to change laws for to resident ratio. Resident to outlined in the meeting which members were present.				
	director of social se been acting as the since July of 2017. there continued to l	10/5/17, at 10:48 a.m. the ervices (DSS) stated he had liaison of the resident council In this role, the DSS stated be discussion regarding the ne resident store, however, at				

Minnesota Department of Health

STATE FORM 6899 X11C11 If continuation sheet 210 of 212

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0112

| Manual Content of Health | (X2) Multiple Construction | (X3) DATE SURVEY | (X3) DATE SURVEY | (X4) DENTIFICATION NUMBER: | (X5) Multiple Construction | (X6) DATE SURVEY | (X6) DATE SURVEY | (X7) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
GOLDEN	N VALLEY REHABILITATION AND CARE	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE			
21870	this time there are no plans in place. The stated there were multiple concerns idea regarding grievances related to nursing staffing concerns. These concerns were the executive director (ED) to review and through. The DSS stated staffing was feaddressed but there has been no resoling staffing concerns, and these residents able to file written grievances and noted expressed lack of follow through regard concerns. During interview on 10/5/17, at 2:35 pustated the facility had identified the need follow through on resident council conchowever, stated there was not a plan for as to how this would be done. The ED grievances which had been filed were fon, however, stated prior to her appoint ED approximately one month ago, there been a formalized process for follow upstated she was aware of residents concregarding staffing and provision of care were still working on these concerns. A policy, effective July 2015, titled, Res Council identified under Procedure: but four the council will report concerns/griethe ED and/or responsible party who wis subsequently prepare a response to an concerns/grievances from the council. response is to be provided in writing by by completing the Resident Concern Resident Concerns, there was indication the facility had completed followed these concerns, and promptly responderesident council members.	entified g and re routed to a follow requently ution of were also d R31 had ding written m. the ED red for reerns, ormalized stated followed up tenent as re had not be the ED retrieves and they revances to ill revances to ill revent a facility report.	21870					

6899

PRINTED: 11/01/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00112 10/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7505 COUNTRY CLUB DRIVE GOLDEN VALLEY REHABILITATION AND CARE GOLDEN VALLEY, MN 55427** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21870 21870 Continued From page 211 SUGGESTED METHOD OF CORRECTION: The admininstrator and/or designee could educate facility staff involved with resident council, to assure concerns are not only heard but are responded to in an apporpriate time frame and manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days.