CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 13IL

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

	PAR	Γ I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	SENCY	F	acility ID: 00933
MEDICARE/MEDICAID PROVIDER (L1) 245336	NO.	3. NAME AND ADD (L3) GOLDEN LI					4. TYPE OF ACTION: 1. Initial	7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 433 COUNT	Y ROAD 30				3. Termination	4. CHOW
(L2) 655371100		(L5) DELANO, M	IN		(L6)	55328	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 04/01/2006	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	RY 09 ESRD	<u>02</u> (L7)	22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other mplaint
. ,	8/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC	(210)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
2 AOA 3 Other								
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:				
From (a):		X A. In Complian	nce With		And/Or Approv	ved Waivers Of The	e Following Requirements:	
To (b):		Program Re			2. Tech	nnical Personnel	6. Scope of Service	ces Limit
· /		Compliance			3. 24 H		7. Medical Direct	
12. Total Facility Beds	54 (L18)	1. A	Acceptable POC			ay RN (Rural SNF) Safety Code		ize
		D. Not in Com	nlianaa yyith Draara		<u>A</u> 5. Life	Safety Code	9. Beds/Room	
13. Total Certified Beds	54 (L17)		pliance with Program ents and/or Applied		* Code:	A, 5	(L12)	
14. LTC CERTIFIED BED BREAKDOWN	N				15. FACILITY M	EETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1961 (i) (1):	(L15)	
	19 311	icr	ПД		1801 (e) (1) 01	1801 (J) (1).	(213)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR Facility's request for a continuing w	•		ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY AP	PROVAL	Date:
Brenda Fischer, U	Jnit Supervis	or	07/08/2015	(L19)	Kate Joh	nsTon, Pr	ogram Specialist	08/07/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR S	SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIGIBILIT	Y		IPLIANCE WITH (CIVIL			ial Solvency (HCFA-2572)	
_X 1. Facility is Eligible to Pa	rticipate	RIGI	HTS ACT:			Ownership/Control I Both of the Above:	Interest Disclosure Stmt (HCFA	1513)
2. Facility is not Eligible	•							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEM	ENT	26. TERMINAT	TION ACTION:	1)	30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Œ	VOLUNTARY	_00	INVOLUNT	ARY
07/01/1986					01-Merger, Closu	ire	05-Fail to Me	eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	n W/ Reimbursemen	nt 06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E CANCTIONS	(120)		03-Risk of Involu	ntary Termination	OTHER	
23. LICEATENSION DATE.	A. Suspension				04-Other Reason	for Withdrawal	<u>OTHER</u> 07-Provider	Status Change
	A. Suspension	or Admissions.	(L44)				00-Active	
(L27)	B. Rescind Sus	spension Date:	(2)					
			(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		00454						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION (OF APPROVAL DA	ATE .				
	(L32)	07/07/2015		(L33)	DETERMINA	ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245336 August 7, 2015

Ms. Shannon Donahue, Administrator Golden Livingcenter - Delano 433 County Road 30 Delano, Minnesota 55328

This notices redacts and replaces the letter dated July 21, 2015.

Dear Ms. Donahue:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective July 9, 2015 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

Your request for waiver of K067 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

Golden Livingcenter - Delano August 7, 2015 Page 2

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

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

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2015

Ms. Shannon Donahue, Administrator Golden Livingcenter - Delano 433 County Road 30 Delano, Minnesota 55328

RE: Project Number S5336024

Dear Ms. Donahue:

On June 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 20, 2015. This survey found the most serious deficiencies 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 July 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 20, 2015, effective July 9, 2015 and therefore remedies outlined in our letter to you dated June 4, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

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

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245336	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/8/2015	
Name	of Facility		Street Address, City, State, Zip Code		
GOLDEN LIVINGCENTER - DELANO			433 COUNTY ROAD 30		
			DELANO, MN 55328		

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

Correction Completed Com	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item	(Y5) I	Date
D Prefix F0166				Correction					Correction					Correction
Reg. # 483.19(h/2)				•										•
LSC				_06/29/2015					06/29/2015					06/29/2015
Correction Completed Com	•	483.10(f)(2)		-		ū	483.10(n)					483.15(e)(2)		_
Completed Comp				-	<u> </u>	LSC				<u> </u>	LSC			_
Completed Comp				Correction					Correction					Correction
ID Prefix F9315 06/29/2015 ID Prefix F9322 06/29/2015 ID Prefix F9431 06/29/2015 Reg. # 483.25(d) Reg. # 483.25(d) Reg. # 483.60(b), (d), (e)														
LSC	ID Prefix	F0315		•		ID Prefix	F0322				ID Prefix	F0431		•
Correction	Reg. #	483.25(d)				Reg. #	483.25(g)(2)				Reg. #	483.60(b), (d), (e))	
Correction	LSC			-		LSC					LSC			_
Completed Comp														
ID Prefix									Correction					Correction
Reg. # 483.65	ID Profix	E0441				ID Profix			Completed		ID Profix			Completed
LSC									-					_
Correction		483.65		-		-								_
Completed ID Prefix				-	-					┿-				_
Completed ID Prefix				Correction					Correction					Correction
Reg. # LSC														
LSC LSC LSC LSC LSC Correction Correction Completed ID Prefix ID Prefix Reg. # Reg. # LSC	ID Prefix			-		ID Prefix					ID Prefix			_
Correction Completed ID Prefix Reg. # LSC Reviewed By State Agency Reviewed By Reviewed By Signature of Surveyor: 07/21/2015 Signature of Surveyor: 07/08/2015 Date: Signature of Surveyor: Date: Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies. Was a Summary of Check for any Uncorrected Deficiencies.				_							Reg. #			_
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Reg. #	ID Prefix			Completed		ID Prefix			Completed		ID Prefix			
Reviewed By Reviewed By BF/KJ Date: Signature of Surveyor: 07/21/2015 10562 07/08/2015 Reviewed By Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO														
Reviewed By Reviewed By Date: Signature of Surveyor: Date: 07/08/2015 State Agency BF/KJ 07/21/2015 10562 07/08/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO	-										LSC			_
State Agency BF/KJ 07/21/2015 10562 07/08/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of										+-				
State Agency BF/KJ 07/21/2015 10562 07/08/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of														
State Agency BF/KJ 07/21/2015 10562 07/08/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies.	Reviewed By	,	Reviewed I	Ву	Da	te:	Signature o	f Surve	yor:	•			Date:	
CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of	State Agency	,	BF/F	ΚJ	0'	7/21/20				562			07/0	08/2015
Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of	Reviewed By	,	Reviewed I	Ву	Da	te:	Signature o	f Surve	yor:				Date:	<u> </u>
Uncompared Deficiencies (OMO 0507) Constant Facilities	CMS RO													
Haraman et al Definition size (CMO OFCT) Const. As the Facilities	Followup to	Survey Comple	eted on:				Check	for any	Uncorrected	Defic	encies. Was	a Summary of		
		5/20/	2015					•				-	YES	NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245336	(Y2) Multiple Construct A. Building B. Wing	I BUILDING 01	(Y3) Date of Revisit 7/10/2015
Name	of Facility		Street Address, City, State, Zip Code	
GO	OLDEN LIVINGCENTER - DELANO		433 COUNTY ROAD 30	
			DELANO MN 55328	

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

(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	l) Item		(Y5)	Date
			Correction					Correction					Correction
ID Dester			Completed		ID Desfer			Completed		ID Dester			Completed
ID Prefix			07/09/2015					07/09/2015					
•	NFPA 101 K0025				-	NFPA 101 K0067				Reg. #			_
	K0025	_		-		K0007			_				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
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			Correction					Correction					Correction
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ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			
Reviewed By					te:	Signature of	Surve	yor:				Date:	
State Agency	, PS	S/K	IJ	07	/21/201	.5		3476	4			07/	10/2015
Reviewed By	Review	ed E	Ву	Da	te:	Signature of	Surve	yor:				Date:	<u> </u>
CMS RO													
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of					a Summary of						
	5/19/2015					Unco	rrecte	d Deficiencies	(CI	MS-2567) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 13IL

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY	AGENCY		Facility ID: 00933
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245336 2.STATE VENDOR OR MEDICAID NO. (L2) 655371100).	3. NAME AND ADI (L3) GOLDEN LII (L4) 433 COUNTY (L5) DELANO, M	VINGCENTER A		(L6) 55328	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006 6. DATE OF SURVEY 05/20/		7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual	PLIER CATEGOR 05 HHA 06 PRTF	Y 09 ESRD 10 NF	02 13 PTIP 14 CORF	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC		Œ	FISCAL YEAR ENDIN	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	54 (L18) 54 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC	n	2. 3. 4.	pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements:	ector n Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 54 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILIT	Y MEETS or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS Facility's request for a continuing wai	•		ATION DATE):					
17. SURVEYOR SIGNATURE Tim Rhonemus,	HFE NE II	Date :	06/17/2015	(L19)		survey agency api nnsTon, Enfo	proval prcement Speci	Date: alist 07/02/2015
	PART II - TO	BE COMPLETEI	D BY HCFA R	_ ` /	OFFICE O	OR SINGLE STAT	E AGENCY	(L20)
DETERMINATION OF ELIGIBILITY	cipate (L21)		PLIANCE WITH C	CIVIL	21.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)	23. LTC AGREEME BEGINNING I (L41)		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTAF 01-Merger, C 02-Dissatisfa	Closure action W/ Reimbursemen	05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)			woluntary Termination ason for Withdrawal	OTHER 07-Provid 00-Active	er Status Change
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS		
	(L28)	00454		(L31)	AW	K67 sent to Roc	chi 07/06/2015 Co).
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION C	OF APPROVAL DA	TE	Posted	d 07/06/2015 Co).	
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1703 June 4, 2015

Ms. Shannon Donahue, Administrator Golden Livingcenter - Delano 433 County Road 30 Delano, Minnesota 55328

RE: Project Number S5336024

Dear Ms. Donahue:

On May 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Golden Livingcenter - Delano June 4, 2015 Page 2

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338

Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 29, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 29, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC 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 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. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Golden Livingcenter - Delano June 4, 2015 Page 4

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 20, 2015 (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 Golden Livingcenter - Delano June 4, 2015 Page 5

> P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

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

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 06/04/2015 FORM APPROVED

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a voiced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who voiced this concern during survey. Findings include: R59's significant change Minimum Data Set (MDS) dated 2/19/15, identified R59 was cognitively intact. During interview on 5/17/15, at 7:45 p.m. R59 stated the hallways of the facility are often used for storage of equipment including trash bins			INCOIONID OLIVICES				OMB N	O. 0938-0391
MANG OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO DELANO, MN 53228 F 000 INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature the bottom of the first page of the CMS-267 form will be used as verification of compliance with your verification. Lyon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with your verification. F 186 83 10f(2)2 RICHITO PROMPTEFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a volced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who volced this concern during survey. Diring interview on 5/17/15, at 7.45 p.m. R59 stated the hallways of the facility are often used for storage of equipment including trash bins	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION		1		CONSTRUCTION		
GOLDEN LVINGCENTER - DELANO SUMMARY STATEMENT OF DETERBORES FOOD INITIAL COMMENTS The facility's plan of correction (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-2867 form will be used as verification of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2867 form will be used as verification of compliance. Upon receipt of an acceptance to validate that substantial compliances with the regulations has been attained in accordance with your verification. F166 48.3 1.0(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a voiced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who voiced this concern during survey. Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F166 1. Grievance was documented and trash collection bins may be reviewed daily Monday thur Friday. Grievances will be recurrented, addressed and filed according to the facility failed to the monthly Resident Council meeting minutes. Grievances will be documented, addressed and filed according to the facility will monitor compliance by a weekly review of the grievances to ensure appropriate follow up and documentation for a period of 6 weeks. Then random audits will be conducted and reviewed at QAPI, 5. Date of compliance. 6.29.15			245336	B. WING			0.5	3/20/2015
FREDIATORY OR ISC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 166 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a voiced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who voiced this concern during survey. Findings include: RECEIVED F 167 F 168 F 169 F 169 F 169 F 160 I Grievance was documented and trash collection bins are being stored in their appropriate areas. 2. All residents resident to be affected. 3. Grievances will be reviewed daily Monday thru Friday. Grievances will be added to the monthly Resident Council meeting minutes. Grievances will be documented, addressed and filed according to the facility grievance policy. Trash collection bins will be stored in their appropriate locations. 4. Facility will monitor compliance by a weekly review of the grievances to ensure appropriate follow up and documentation for a period of 6 weeks. Then random audits will be conducted and reviewed at QAPI, 5. Date of compliance: 6.29.15			0		433	COUNTY ROAD 30	1 00	12012013
The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 166 SS=D RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility falled to ensure a voiced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who voiced this concern during survey. Findings include: R59's significant change Minimum Data Set (MDS) dated 2/19/15, identified R59 was cognitively intact. During interview on 5/17/15, at 7-45 p.m. R59 stated the hallways of the facility rare often used for storage of equipment including trash bins	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF	1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a voiced grievance about trash collection bins in the hallway was acted upon timely for 1 of 1 residents (R59) who voiced this concern during survey. Findings include: R59's significant change Minimum Data Set (MDS) dated 2/19/15, identified R59 was cognitively intact. During interview on 5/17/15, at 7:45 p.m. R59 stated the hallways of the facility are often used for storage of equipment including trash bins F166 JUN 1 6 201 1. Grievance was documented and trash collection bins are being stored in their appropriate areas. 2. All residents residing in facility have the potential to be affected. 3. Grievances will be reviewed daily Monday thru Friday. Grievances will be added to the monthly Resident Council meeting minutes. Grievances will be documented, addressed and filed according to the facility grievance policy. Trash collection bins will be stored in their appropriate locations. 4. Facility will monitor compliance by a weekly review of the grievances to ensure appropriate follow up and documentation for a period of 6 weeks. Then random audits will be conducted and reviewed at QAPI. 5. Date of compliance: 6.29.15	F 000	The facility's plan of cas your allegation of concepts bottom of the first page be used as verification. Upon receipt of an acceptaint of your facility with the substantial complements been attained in a verification.	ompliance upon the nce. Your signature at the e of the CMS-2567 form will n of compliance. ceptable POC an on-site vill be conducted to validate cance with the regulations occordance with your	F	000	implementation of this Plan of Correction does not constitute a admission of or agreement with facts and conclusions set forth of survey report. Our Plan of Correction is prepared and exe as a means to continuously impute quality of care and to compall applicable state and federal	the on the cuted rove	RECEIVED
	SS=D	A resident has the right facility to resolve griev have, including those was of other residents. This REQUIREMENT by: Based on interview, an facility failed to ensure trash collection bins in upon timely for 1 of 1 nd this concern during surfindings include: R59's significant chang (MDS) dated 2/19/15, incognitively intact. During interview on 5/1 stated the hallways of the salve griever of the salve griever.	to prompt efforts by the ances the resident may with respect to the behavior is not met as evidenced and document review, the a voiced grievance about the hallway was acted esidents (R59) who voiced vey. de Minimum Data Set dentified R59 was 7/15, at 7:45 p.m. R59 he facility are often used		5	1. Grievance was documented trash collection bins are being stored in their appropriate area 2. All residents residing in facil have the potential to be affecte 3. Grievances will be reviewed Monday thru Friday. Grievance be added to the monthly Resid Council meeting minutes. Grievances will be documented addressed and filed according facility grievance policy. Trash collection bins will be stored in appropriate locations. 4. Facility will monitor compliar a weekly review of the grievance ensure appropriate follow up at documentation for a period of 6 weeks. Then random audits will conducted and reviewed at QA	as. ity ed. daily es will lent d, to the their nce by ces to nd ill be PI.	
BURALURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			_					

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

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D.	NO. 0938-039° ATE SURVEY DMPLETED
		245336	B. WING				05/00/0045
1	PROVIDER OR SUPPLIER LIVINGCENTER - DELAN	10		433	REET ADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 30 LANO, MN 55328		05/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	which have a "dead ho stated she voiced her the facility staff, but no staff still were still bring the hallway and leavin extended periods of tir she was bothered by his the hallway outside he and you don't have a tit that smells like a dead When interviewed on 5 nursing assistant (NA)-were stored in the closs morning cares. Further aware of any formal conditional added, "I guess I've here [about the trash bins] in the hallway until 10:00 a.m. not to have equipment (in the hallway during the NA-B stated R59 had cobins being in the hallway bins should be kept in the just when you guys [statement of the trash bins being kep the trash bins being kep the trash bins being kep	concerns several times to obthing had changed and ging the trash bins out in g them set there for me. Further, R59 stated having smelly trash cans in r room, "This is my home, rash can outside your room horse." 6/18/15, at 1:36 p.m. A stated the trash bins et, but brought out during r, NA-A stated she wasn't mplaints about them, but ard [R59] say something a the past though." 9/15, at 8:36 a.m., NA-B we the trash bins out in the close the trash bins) e State survey. Further, complained about the trash y before, and added the ne closet "year round, not the surveyors] come." 19/15, at 8:45 a.m. the LSW)-A stated she was m for R59 pertaining to t in the hallway. Further, plaints about them, they is to management so a cess could be started.	F	166			

PRINTED: 06/04/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245336 B. WING 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO** DELANO, MN 55328 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRFFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 166 Continued From page 2 F 166 responsible for ensuring customer satisfaction within the LivingCenter." Further, the policy directed staff to complete a grievance policy and turn it in "for processing." 483.10(n) RESIDENT SELF-ADMINISTER F 176 F 176 DRUGS IF DEEMED SAFE SS=D F176 An individual resident may self-administer drugs if the interdisciplinary team, as defined by 1. R24 was at end of life during §483.20(d)(2)(ii), has determined that this survey and expired prior to practice is safe. completion of assessment to ensure she was safe to leave the nebulizer mask on her face This REQUIREMENT is not met as evidenced while unattended. 2. All residents that self-administer Based on observation, interview, and document medications have the potential review, the facility failed to ensure a comprehsive to be affected, and will have self administration medication assessment was assessments completed to completed to determine safe medication ensure that they can do this administration for 1 of 1 residents (R24) observed safely and accurately. to receive medication through a nebulizer 3. Nursing staff and the IDT have (breathing treatment) during the survey. been re-educated on guidelines for completion of Self-Findings include: Administration assessments. 4. Monitoring for compliance will R24's significant change Minimum Data Set be completed by the (MDS), dated 2/14/15, identified R24 had severe DNS/Designee through weekly cognitive impairment. audits of self-administration During observation on 5/17/15, at 6:10 p.m. R24 assessments, care plans, orders was laying in bed with her eyes closed, and the and of residents who are selfhead of the bed elevated. R24 had a nebulizer administering for 6 weeks and mask on, but down around her neck while it was then randomly; results will be dispensing medication into the air. Registered reviewed at QAPI meetings. Nurse (RN)-A entered the room at 6:11 p.m. and 5. Date of compliance 6/29/15 re-applied R24's nebulizer mask around her nose and mouth with medication remaining in the vial attached to the mask. RN-A stated she thought

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245336	B. WING				05/20/2015
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	R24 was sleeping ar alone with the nebuli for a minute." Review of R24's Doo 5/13/15, identified an [medication used for disease (COPD)] 3 every 6 hours for Rephysician orders did administer her own not care plan, dated 2/16 "impaired cognition", "Administer medication plan did not identify Fadminister her own not was not indication the administration assess was safe to be left aloadministered the nebulizers. The DON assessment of R24 readminister her own not physician order allowing the DON stated R24 refor safety to self administered to do an assess A facility Self-Administer by the ID will be completed and	tor Order Sheet, dated order for "DuoNeb Solution choric obstructive pulmonary and individual indiv	F -	176			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245336	B. WING			5/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELA	NO		STREET ADDRESS, CITY, STATE, ZII 433 COUNTY ROAD 30 DELANO, MN 55328		SIZUZUIJ
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 247 SS=D	meds." Further, the porder is required for a medications." 483.15(e)(2) RIGHT ROOM/ROOMMATE A resident has the righthe resident's room ochanged. This REQUIREMENT by: Based on interview, a facility failed to ensure prior to receiving a roo (R70) who were review and discharge. Findings include: R70's quarterly MDS or R70 as moderately combined by the since she had a room admitted, but has since she has had roommate receiving any notices if come. R70 further state notified but "doesn't kr	e self administration of policy directed, "A physician's a resident to self-administer." TO NOTICE BEFORE CHANGE th to receive notice before a roommate in the facility is is not met as evidenced and document review, the exthat residents were notified commate for 1 of 2 residents wed for admission, transfer, and dated 2/09/15, identified gnitively impaired, with a grately impaired, with a grately impaired). 18/15 at 9:36 a.m., R70 and the when she was expected died. R70 indicated that the es since, but doesn't recall	F 2	176	documented e she receives a ling in a semi- ne potential to nentation of n assigned to orker. In her will be al Worker and n trained to they will be as soon as able mation of a new ng the notice led to document e resident's ee will conduct new admission eks, then e conducted PI.	
	8:42 a.m., R70 stated	that she had a couple of e, 2-3 months ago. One of her room when she				

STATEMEN	NT OF DEFICIENCIES	(V4) PROMERONAL CONTRACTOR				OMB	NO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	1	OATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER		-	STI	REET ADDRESS, CITY, STATE, ZIP CODE		05/20/2015
GOLDE	N LIVINGCENTER - DELAN	10			COUNTY ROAD 30		
(X4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		UE	LANO, MN 55328		
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F 24	roommate the facility of she never came. In review of the facility 12/14 through 05/15 ic that the facility provide 4/14/15 by the social swas no mention of the R70 had. During an interview on licensed social worker started two months agwithin the electronic reresident of a potential r R70's records, LSW-A documentation on two shared a room with dur	did mention it to her, but 2 R70's progress notes from dentified only one notation de a notice to R70 on dervice department. There previous roommates that 05/19/2015 8:38 a.m., the (LSW)-A stated she do, and that she documents cord when she notifies a droommate. After review of twas unable to find troommates that R70	F	247			
	Resident Within the Fact CLIN1300-660 (effective under the procedure 9: affected by the transfer. 483.25(d) NO CATHETT RESTORE BLADDER Based on the resident's assessment, the facility resident who enters the indwelling catheter is no resident's clinical conditicatheterization was necesswho is incontinent of blat treatment and services to	e 1/26/2015) indicated "notify all roommates ." ER, PREVENT UTI, comprehensive must ensure that a facility without an it catheterized unless the ion demonstrates that essary; and a resident dder receives appropriate	F 31		 F315 1. R23 has had a bladder assessment completed. 2. All residents that have foley catheters removed have the potential to be affected and have a bladder assessment completed when the catheter removed. 	e will t	

LOTATELIES		I DIGITID GERVICEG				OMB	NO. 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		ATE SURVEY MPLETED
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	function as possible. This REQUIREMENT by: Based on observation review the facility failed comprehensive bladded completed for 1 of 1 reincontinent of urine foll indwelling urinary cath Findings include: R23's minimum data seindicated R23 was con indwelling catheter, and of two staff for transfers dated 4/22/15 indicated incontinent of bladder, required total assistance. During an observation of p.m., resident's room has bed sheets had bee unidentified nursing assistent room at this tim wet and required chang of R23's room on 5/18/1 did not have any bed lin. Review of the facility Nudated 3/18/15, indicated was removed, a urinal wand staff were also to chevery 2 hours. Review of the facility Querical staff were also to chevery 2 hours.	is not met as evidenced i, interview, and document d to ensure a er assessment was isidents (R23) who was owing removal of an eter. et (MDS) dated 3/13/15 tinent of bladder with d required total assistance s. R23's quarterly MDS d R23 was frequently had no bladder plan and e of two staff for transfers. of R23 on 5/17/15 at 4:08 ad a strong urine odor and n removed. An istant who was in the ne stated the sheets were ing. During an observation f at 8:30 a.m., R23's bed ens. ersing Progress note, I R23's urinary catheter vas placed at his bedside neck and changed R23	F		 Nursing staff have been educated on the guidelin completion of bladder assessments. Monitoring for compliance be completed by the DNS/Designee through a on each resident who has foley catheter removed or next 3 months and then randomly to ensure reside with foley catheters remove have had a bladder assess completed per guidelines. results of these audits will reviewed at QAPI meetin Date of compliance 6/29/1 	e will udits s a ver the ents ved ssment . The I be	

F 315 Continued From page 7 longer had an indwelling urinary catheter. There was no indication a bladder assessment was completed during this review period even though R23's indwelling catheter was removed. The facility Bladder Assessment Form initiated on 8/13/14 indicated R23's bladder status was reviewed and he was not appropriate for a toileting plan due to a CVA (cerebral vascular accident). The form was updated on 1/11/14 and 4/22/15 but the section designated for determining ability to participate in a bladder program was left blank for both reviews.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		NSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328 (IXA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 7 longer had an indwelling urinary catheter. There was no indication a bladder assessment was completed during this review period even though R23's indwelling catheter was removed. The facility Bladder Assessment Form initiated on 8/13/14 indicated R23's bladder status was reviewed and he was not appropriate for a toileting plan due to a CVA (cerebral vascular accident). The form was updated on 1/11/14 and 4/122/15 but the section designated for determining ability to participate in a bladder program was left blank for both reviews.			245336	B. WING				5/20/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 7 longer had an indwelling urinary catheter. There was no indication a bladder assessment was completed during this review period even though R23's indwelling catheter was removed. The facility Bladder Assessment Form initiated on 8/13/14 indicated R23's bladder status was reviewed and he was not appropriate for a toileting plan due to a CVA (cerebral vascular accident). The form was updated on 1/11/14 and 4/22/15 but the section designated for determining ability to participate in a bladder program was left blank for both reviews.			NO	•	433 C	OUNTY ROAD 30	***************************************	3.20.20.10
longer had an indwelling urinary catheter. There was no indication a bladder assessment was completed during this review period even though R23's indwelling catheter was removed. The facility Bladder Assessment Form initiated on 8/13/14 indicated R23's bladder status was reviewed and he was not appropriate for a toileting plan due to a CVA (cerebral vascular accident). The form was updated on 1/11/14 and 4/22/15 but the section designated for determining ability to participate in a bladder program was left blank for both reviews.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
R23's care plan last updated 4/2015, identified R23 required a mechanical lift for transfers with assistance of two staff, was frequently incontinent of bladder, had a history of spilling urinal, needed help with proper placement, and required assistance of one staff for toileting. The intervention directed staff to assist with urinal placement upon rising, before and after meals, at HS (hour of sleep) and PRN (as needed). An undated nursing assistant care sheet labeled: Group D, directed staff to "Offer use of urinal and commode. Wears briefs." During an interview on 05/18/2015 1:54 p.m., nursing assistant (NA)-A stated R23 was incontinent most of the time, but still has the urge to go and would occasionally use the urinal. She further stated R23 has no formal toileting plan and staff were to check and change him every 2 hours. NA-A stated, "[R23] does not use the toilet, due to being a total assist with a lift, he is on a two hour check and change program."		longer had an indwell was no indication a bicompleted during this R23's indwelling cathed. The facility Bladder As 8/13/14 indicated R23 reviewed and he was toileting plan due to a accident). The form was toileting plan due to a accident. The form was toileting plan due to a accident accident accident. The form was toileting plan due to a accident acci	ing urinary catheter. There ladder assessment was review period even though eter was removed. Sesessment Form initiated on 8's bladder status was not appropriate for a CVA (cerebral vascular was updated on 1/11/14 and n designated for participate in a bladder k for both reviews. Indical lift for transfers with for was frequently incontinent by of spilling urinal, needed ment, and required for toileting. The staff to assist with urinal to before and after meals, at the PRN (as needed). Sesistant care sheet labeled: for "Offer use of urinal and fis." O5/18/2015 1:54 p.m., A stated R23 was time, but still has the urge ionally use the urinal. She no formal toileting plan of and change him every 2 R23] does not use the toilet, sist with a lift, he is on a	FS	315			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245336	B. WING			04	5/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELAN	0		4	STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	have a toileting prograwas to be checked an She further stated R2: bed pan.	ontinent of bladder, did not am and his incontinent brief d changed every two hours. 3 does not use a toilet or a	F	315			
	licensed practical nurs incontinent of bladder	n 05/18/2015 3:27 p.m., se (LPN)-B stated R23 was and that occasionally he her stated R23 had no					
	director of nursing (DC director of nursing (AE "We do not technically residents are toileted e PRN [as needed]." The nurse did the assessmif a resident could beneprogram, and indicated toileting program would including: refusals, con preference. However, was not an appropriate resident was not capal bladder program. The	PON), the ADON stated, have toileting programs, every couple hours and to DON stated that the MDS tents and would determine efit from a toileting divarious reasons that a dinot be implemented fusion and resident the DON stated a CVA to reason to assess a pole to participate in a (DON) further stated, if a 3 day Bowel and Bladder					
	stated that bladder ass on admission, annually	B stated she was bing toileting programs lan of care. She further essments are completed and with a significant al of a indwelling urinary					·

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3)) DATE SURVEY COMPLETED
		245336	B. WING			05/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELAN	10		STREET ADDRESS, CITY, STATE, ZIP 433 COUNTY ROAD 30 DELANO, MN 55328	CODE	03/20/2013
(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 BE THE APPROPRIATE	(X5) COMPLETION DATE
	483.25(g)(2) NG TRE RESTORE EATING S Based on the compre resident, the facility m (1) A resident who ha alone or with assistant tube unless the reside demonstrates that use unavoidable; and (2) A resident who is figastrostomy tube received treatment and service pneumonia, diarrhea, metabolic abnormalitie ulcers and to restore, skills. This REQUIREMENT by: Based on observation review, the facility failed checked placement of (g-tube) prior to infusir for 1 of 1 resident (R3) feeding during the sum Findings include: R37's admission Minim	ATMENT/SERVICES - SKILLS hensive assessment of a flust ensure that s been able to eat enough ce is not fed by naso gastric ent's clinical condition of a naso gastric tube was fed by a naso-gastric or elives the appropriate is to prevent aspiration vomiting, dehydration, es, and nasal-pharyngeal if possible, normal eating if possible, normal eating is not met as evidenced a gastrostomy tube and medication and formula for observed to have a tube vey.	F 32 F 32		hecked prior to medications, repersolved prior to medications, repersolved pastrostomy otential to be expected been copriate strostromy or guidelines, resident with a monitoring libe rough random astrostomy checked prior of ula and water, audits will be meetings.	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DAT	E SURVEY IPLETED
	245336	B. WING			0.5	5/20/2015
	0		43	33 COUNTY ROAD 30		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	1	x			(X5) COMPLETION DATE
calories through the fer R37 was observed du 5/18/2015 9:00 a.m, li (LPN)-A obtained R37 shirt and laid it on a clathen flushed the g-tub without first checking programmed gastrostomy tube. LPN P37's medications via with water administered medication. Once LPN medications, she then feeding through his gas In interview on 5/18/15 that she had forgotten should of before the in In review of the facility Administration of Enter 11/13/14) step 16 - "Puplacement of the G-tub on the resident's abdorcentimeters] of air via the supplement of the supplement of the grant of the centimeters] of air via the supplement of the supplement of the grant of the gran	ring the medication pass on censed practical nurse 's g-tube from under his ean white washcloth. LPN-A e with 120 cc of water, placement of the N-A proceeded to place the g-tube, one at a time of between each l-A had finished R37's started R37's enteral strostomy tube. If at 9:15 a.m., LPN-A stated to check placement, and itial water flush. If policy, entitled: If all Feeding (last reviewed it on gloves - verify correct is by placing a stethoscope men, inject 10-15 cc [cubic he 60 cc syringe, listen for	F				
director of nursing (DO the facility is to check p anything via the g-tube 483.60(b), (d), (e) DRU LABEL/STORE DRUGS. The facility must emplo a licensed pharmacist v	N) stated that the policy of lacement before giving G RECORDS, S & BIOLOGICALS y or obtain the services of who establishes a system	F 4:	31			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page calories through the fe R37 was observed du 5/18/2015 9:00 a.m, li (LPN)-A obtained R37 shirt and laid it on a cle then flushed the g-tube without first checking p gastrostomy tube. LPN P37's medications via with water administere medication. Once LPN medications, she then feeding through his ga In interview on 5/18/15 that she had forgotten should of before the in In review of the facility Administration of Enter 11/13/14) step 16 - "Pu placement of the G-tub on the resident's abdor centimeters] of air via t a "whooshing" sound, t gastric contents". During interview on 5/1 director of nursing (DO the facility is to check p anything via the g-tube. 483.60(b), (d), (e) DRU LABEL/STORE DRUGS The facility must employ a licensed pharmacist v	PROVIDER OR SUPPLIER **ILIVINGCENTER - DELANO** **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)* **Continued From page 10** calories through the feeding tube. R37 was observed during the medication pass on 5/18/2015 9:00 a.m, licensed practical nurse (LPN)-A obtained R37's g-tube from under his shirt and laid it on a clean white washcloth. LPN-A then flushed the g-tube with 120 cc of water, without first checking placement of the gastrostomy tube. LPN-A proceeded to place P37's medications via the g-tube, one at a time with water administered between each medication. Once LPN-A had finished R37's medications, she then started R37's enteral feeding through his gastrostomy tube. In interview on 5/18/15 at 9:15 a.m., LPN-A stated that she had forgotten to check placement, and should of before the initial water flush. In review of the facility policy, entitled: Administration of Enteral Feeding (last reviewed 11/13/14) step 16 - "Put on gloves - verify correct placement of the G-tube by placing a stethoscope on the resident's abdomen, inject 10-15 cc [cubic centimeters] of air via the 60 cc syringe, listen for a "whooshing" sound, the slowly draw back	PROVIDER OR SUPPLIER **ILIVINGCENTER - DELANO** **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)* **Continued From page 10* calories through the feeding tube. **R37 was observed during the medication pass on 5/18/2015 9:00 a.m., licensed practical nurse (LPN)-A obtained R37's g-tube from under his shirt and laid it on a clean white washcloth. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 5528 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE RECEDED 98 YILL REGULATORY OR LISC IDENTIFYING INFORMATION) CARON BERGIEVEN WING THE RECEDED SY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) CONTINUED FROM THE RESULT OF DEFICIENCIES TAG FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY F 322 Continued From page 10 calories through the feeding tube. R37 was observed during the medication pass on 5/18/2015 9:00 a.m, licensed practical nurse (LPN)-A obtained R37's g-tube from under his shirt and laid it on a clean white washcloth. LPN-A then flushed the g-tube with 120 c of water, without first checking placement of the gastrostomy tube. LPN-A proceeded to place P37's medications via the g-tube, one at a time with water administered between each medication. 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R37 was observed during the medication pass on 5/18/2015 9:00 a.m., licensed practical nurse (LPN)-A obtained R37's g-tube from under his shirt and laid it on a clean white washcloth. LPN-A then flushed the g-tube with 120 cc of water, without first checking placement of the gastrostomy tube. LPN-A proceeded to place P37's medications via the g-tube, one at a time with water administered between each medication. Once LPN-A had finished R37's medications, she then started R37's enteral feeding through his gastrostomy tube. In interview on 5/18/15 at 9:15 a.m., LPN-A stated that she had forgotten to check placement, and should of before the initial water flush. 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NAME OF PROMOBER OR SUPPLIER 245336 NAME OF PROMOBER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO SUMMARY STATEMENT OF DEFICIENCIES (PRESENT OF STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 65228 SUMMARY STATEMENT OF DEFICIENCIES (PRESENT OF STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 65228 F 431 Controlled from page 11 controlled drugs in sufficient detail to enable an accurate reconcilision; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and Include the appropriate accessory and cautionary instructions, and the supprison date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate destruction of Fentary (a narrotic medication) and controlled rugs with the review of completed by 16 page 17 page 18	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION		O. 0938-0391
MANE OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO DIAL DIAL DIAL DIAL DIAL DIAL DIAL DIAL	AND PLAN O	F CORRECTION		1				
STREET ADDRESS, CITY, STATE JIP CODE 433 COUNTY ROAD 39 DELANO, MN 55328 PROVIDER'S PLAN OF CORRECTION (PAPER TAG) FREFIX TAG FREFIX TAG Continued From page 11 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controlle, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. SIMPLE ADMESS, CITY, STATE_ZIP CODE PREFIX TAG PREFIX T			245336	B. WING			05	5/20/2015
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 11 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate	GOLDEN	LIVINGCENTER - DELAN			433	COUNTY ROAD 30 LANO, MN 55328		
controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
duragesic patches to prevent possible theft and/or diversion. This had potential to affect 1 of 1 residents (R52) currently prescribed duragesic		controlled drugs in su accurate reconciliation records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. In accordance with Stafacility must store all doloked compartments controls, and permit on have access to the key. The facility must provide permanently affixed controlled drugs listed Comprehensive Drug of Control Act of 1976 and abuse, except when the package drug distributing quantity stored is minimized readily detected. This REQUIREMENT by: Based on observation, review, the facility failed destruction of Fentanyl duragesic patches to pand/or diversion. This	fficient detail to enable an an; and determines that drug and that an account of all aintained and periodically used in the facility must be with currently accepted and cautionary expiration date when ate and Federal laws, the largs and biologicals in under proper temperature and authorized personnel to authorized personnel to a separately locked, compartments for storage of an Schedule II of the Abuse Prevention and dother drugs subject to be facility uses single unit ion systems in which the anal and a missing dose can ais not met as evidenced a interview, and document do to ensure the appropriate (a narcotic medication) revent possible theft had potential to affect 1 of	F	431	 Used Fentanyl patches removed from R37 are bein flushed down the sewer system. All residents receiving controlled medication patch have the potential to be affected. Nursing staff have been reeducated on appropriate disposal of controlled medication patches and disposal in the sewer system. Monitoring for compliance who be completed by DNS/Designee through weekly audits of disposal of remove controlled medication patches in the sewer system for 6 weeks and then randomly. Results of these audits will reviewed QAPI meetings. 	m. vill ed hes	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			·	OMB	NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		245336	B. WING				05/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELAN	10		433	REET ADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 30 LANO, MN 55328		03/20/2013
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	failed to ensure only litresident medication. Findings include: R52's Order Summary identified an order for, 25 MCG/HR Apply 25 skin] every 72 hours for The facility's single me observed with licensed on 5/17/15, at 1:32 p.r with a key, and a covelabeled "Hazardous W counter with a yellow preading, "Coumadin [a medication], Warfarin [No Fentanyl Patche from the container, and Fentanyl duragesic pathers of the person have keys to the Further, the used Fent should not have been prather flushed down the the Utility Room as used	Furthermore, the facility icensed staff had access to A Report, dated 5/5/15, "FentaNYL Patch 72 Hour mcg transdermally [on the part of Pain." Redication room was depractical nurse (LPN)-C mandle of practical	F	431			
	theft or diversion, "The When interviewed on 5 facility staffing coordina	potential is always there." 5/17/15, at 3:08 p.m. the ator (SC) verified she had a s to the medication room.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245336	B. WING				05/20/2015
	PROVIDER OR SUPPLIER	10		433 (EET ADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 30 ANO, MN 55328	·	30.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	assistant director of n should be removing the sticking it to a tissue, drain. The ADON stallicensed nurse, and a been putting used Fer the container on the croom. At 5:44 p.m. the facility policy for mediastated, "What we have dispensing pharmacy." Fentanyl duragesic particles of the container on the croom. At 5:44 p.m. the facility policy for mediastated, "What we have dispensing pharmacy." Fentanyl duragesic particles of the facility deficiency of the facility Medication Drug Administration (Foused patches in half at the avoid theft and diversity of the facility Medication Drug Administration of the flushed of the facility Medication Drug Medication Drug is the package insertion of the flushed of th	/17/15, at 4:05 p.m. the ursing (ADON) stated staff he patch from the resident, and flushing it down the ted the SC was not a dded staff should not have notanyl duragesic patches in ounter in the medication e ADON provided the cation destruction, and been told by Alixa [the is to flush them [used stches]." 5/18/15, at 10:50 a.m. the toler (DP) stated the Food and EDA) recommends to fold and flush them down to drain resion of the narcotic. estruction policy, dated truction methods comply laws and regulations", and ch included, "Medications down the toilet or drain sert specifically instructs anyl patches) [refer to state (Fentanyl Transdermal tidentified, "The high	F	431			
	particular target for abu Further, the insert iden disposal of the patches	tified a process for which included bolded d Duragesic down the toilet ragesic patch may be					

	to . OIT MILLOTOTALL C.	TINEDIONID GENVICES			OMR	10. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DAT	TE SURVEY MPLETED
•		245336	B. WING _		0	5/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELAN	10		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		<u> </u>
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441 SS=F	children, pets, and ad prescribed"	e 14 lults who have not been CONTROL, PREVENT	F 4	F441		
	safe, sanitary and conto help prevent the de of disease and infection. (a) Infection Control P The facility must estate Program under which (1) Investigates, control in the facility; (2) Decides what processhould be applied to a (3) Maintains a record actions related to infect (b) Preventing Spread (1) When the Infection determines that a resident the spread of its isolate the resident. (2) The facility must procommunicable disease from direct contact will trans (3) The facility must rechands after each direct hand washing is indicate professional practice. (c) Linens Personnel must handle	ram designed to provide a infortable environment and velopment and transmission on. rogram olish an Infection Control it - ols, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective ctions. of Infection Control Program dent needs isolation to infection, the facility must ohibit employees with a error infected skin lesions in residents or their food, if smit the disease. quire staff to wash their tresident contact for which ted by accepted		 The infection control price has been updated to in consistent tracking, treand analysis and develor action plans to improsinfection control throug facility. All residents, staff and have the potential to be affected. Licensed nursing staff have the educated on the requirement to identify a document date of onset of potential infections, cagents, treatments presidevelop appropriate car and interventions to min risk potential for transmi others. The facility systet tracking, trending and an of infections has been reand revised as indicated. Line listing of infections of tracking, trending and ar will be audited weekly for weeks and then random Results will be presented QAPI for review and actiplanning as needed. Date of compliance 6/29/ 	actude anding, opment ove hout the visitors and of S/SX ausative cribed, e plans imize ssion to m for nalysis eviewed with nalysis r 6 y. d at on	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING			05/20/2015	
	ROVIDER OR SUPPLIER	ANO		STREET ADDRESS, CI 433 COUNTY ROAD : DELANO, MN 5532	30	03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉT	
F 441	Continued From painfection.	ige 15	F	141			
	by: Based on interview facility failed to imp program that includ collected data, and identified trends in the facility. This ha	NT is not met as evidenced If, and document review, the lement an infection control ed consistent analysis of provide staff education with order to reduce infections in ad potential to affect all 38 lity, staff, and visitors.					
	sheet from March the The sheet identified	g of Resident Infections flow aru May 2015 was reviewed. the following information lected by the infection control					
·	(Community Acquire The facility Line List sheet, dated March in the facility had exp Four of the five resident	ssociated Infection) or CAI					

	to . Git MEDIONICE G	WEDIOAID OLIVIOLS				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245336	B. WING_			05/20/2015
	PROVIDER OR SUPPLIER LIVINGCENTER - DELA	NO		STREET ADDRESS, CITY 433 COUNTY ROAD 30 DELANO, MN 55328	, STATE, ZIP CODE	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	
	residents had their ro only two of the five refacility they resided of identified four of the fantibiotic treatment for the five residents identified infection (HAI) or come (CAI). Further, their wof the data to determine infections, screen for similar symptom, or a infections of the same. The facility Line Listing sheet, dated April 201 residents in the facility infections. Four of the of infection identified, their rooms, unit, symptom, or infections. Further infections. Further trending of the data to of the infections, screen a similar symptom, or further infections of the The facility Line Listing sheet, dated May 2018 had experienced infections. Each resident, Each resident,	iffied; three of the five om number identified, and isidents had which unit of the in identified. The sheet ive residents required or their infections. None of nitified on the sheet had stion was a hospital acquired imunity 'acquired infection was no analysis or trending ne possible causes of the possible spreading of a ction plans to reduce further type in the facility. If of Resident Infections flow 5, identified five different or had experienced possible in four of the five identified in the facility of the five identified in the facility of the five identified in the facility. If of Resident Infections flow of the five identified is a faction plans to reduce the facility. If of Resident Infections flow of the facility of the facility of the facility. If of Resident Infections flow of the facility of the facilit	F 4	41		
	> R27 experienced, "1 emesis X [times] 2 " ar > R50 experienced, "u	ıd;				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT	E SURVEY
		0.45000					
NAME OF P	ROVIDER OR SUPPLIER	245336	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	0	5/20/2015
	LIVINGCENTER - DELAN	10		433	3 COUNTY ROAD 30 ELANO, MN 55328		
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	and all three of the ide the North unit of the fa analysis / urinary cultus the residents, and R50 as having e-coli (a bar responsible for the information required antibiotic mere symptoms. None of the were identified has haw as left uncompleted, lacked analysis or trendetermine possible cascreen for possible sp symptom, or action plainfections of the same. When interviewed aborogram on 5/18/15, and nursing (DON) stated a facility program, and donursing progress notes 24 hour report sheets. Control data is typically patterns during the face Performance Improver it had not been complemenths, "It's been a litt of months." Further, the education was schedu in the past couple of nidentification and trendeters.	ethargy, glazed look". entified to share a room, entified residents resided on acility. A UA/UC (urinary ure) was obtained for all of 0 and R48 were identified octeria) as the organism ection. R50 and R48 dication to treat their ne residents on the form ving an HAI or CAI as it and the sheet further ading of the data to uses of the infections, reading of a similar ans to reduce further type in the facility. But the infection control at 3:45 p.m., the director of she was responsible for the ata is collected by review of so, physician orders, and the The collected infection or reviewed for trends and illity Quality Assurance and ment (QAPI) meetings, but set of or the past few the weaker the past couple ne DON stated no staff led or had been completed nonths" because of the of e-coli urinary tract North unit of the facility hat we do is informal."	F	441			

		MEDICAID SERVICES				OMB	NO. 0938-0391
AND PLAN O	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
		245336	B. WING				05/00/0045
	ROVIDER OR SUPPLIER	0		43	TREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 ELANO, MN 55328	05/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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
	failed to consistently of for trends and patterns the infections were ori implement actions plain the facility. R27, R5 the same unit of the fa symptoms of a UTI, two with a UTI from the same failed to research the cordevelop actions plain transmission to other many control program incorp.	ed infections, the facility collected data was reviewed in order to analyze where ginating from, and ins to reduce the infections 60, and R48 all resided on cility and presented with to of them being diagnosed me bacteria, and the facility cause of these infections, ins to reduce the risk of esidents in the facility. In Infection Control 1/9/15, identified several ction prevention and orates", including, process and outcome	F	441			

PRINTED: 06/04/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245336 B WING 05/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) POCOK W/AW for K67 6-25-15 K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Livingcenter Delano Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to:

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

Health Care Fire Inspections

State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145.

Executive Director

N DEPT. OF PUBLIC SAFET

(X6) DATE

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

วทุกสา

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
			245336	B. WING	NG		05/19/2015		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO					4	STREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 DELANO, MN 55328			
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		Continued From page By email to: Marian.Whitney@state THE PLAN OF CORRIDEFICIENCY MUST II FOLLOWING INFORM 1. A description of what to correct the deficience 2. The actual, or propo 3. The name and/or title responsible for correcti prevent a reoccurrence This facility will be survibuildings: Golden Livingcenter Definition of the constructed at 3 dispuilding was constructed at 3 dispuilding was constructed determined to be of Typ 1988 a single story add the South Wing and det (000) construction. The facility has a fire ala	ECTION FOR EACH NCLUDE ALL OF THE IATION: It has been, or will be, done y. Sed, completion date. It of the person on and monitoring to the deficiency. It is eyed as two separate the sean Main building is a basement. The building fferent times. The original din 1967 and was the II (000) construction. In the ition was constructed to the ermined to be of Type II It is arm system with smoke is and spaces open to the		0000		VIE	DATE	
		census of 38 at the time	ity of 54 beds and had a of the survey. FR, Subpart 483.70(a) is						
	1	NOT MET as evidenced	by:						

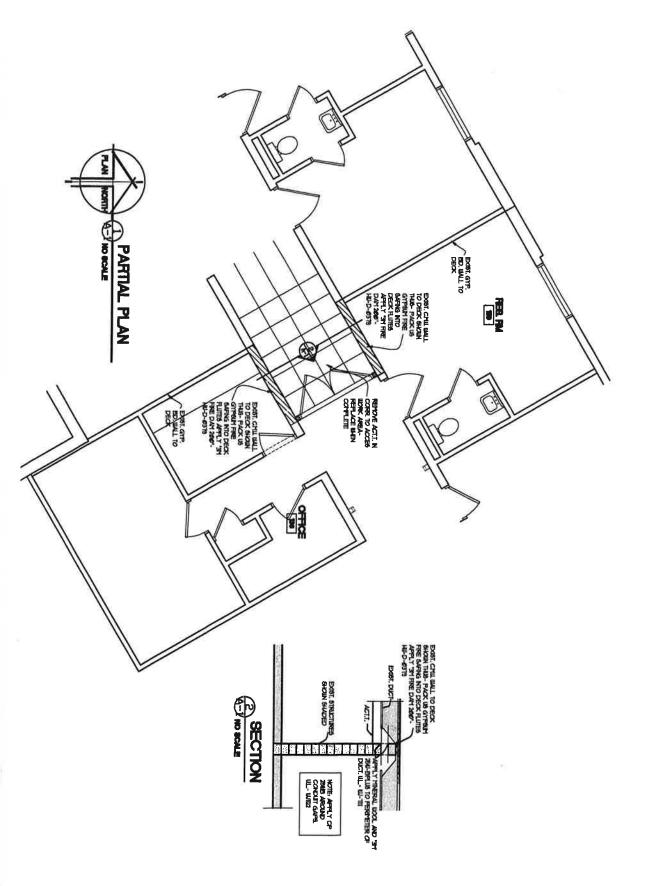
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245336	B. WNG		NAME DOLDING VI		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO				STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328			/19/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 025 SS=F	Smoke barriers are coleast a one half hour faccordance with 8.3. terminate at an atrium protected by fire-rated panels and steel frame separate compartmen floor. Dampers are not penetrations of smoke heating, ventilating, ar 19.3.7.3, 19.3.7.5, 19. This STANDARD is not Observations revealed barriers is not in according to the residents, staff a effected in the event of smoke to pass from on other. Findings include: Observations during the 2015, between 8:00 and that the southview wing various penetrations the sealed.	enstructed to provide at ite resistance rating in Smoke barriers may wall. Windows are glazing or by wired glass es. A minimum of two its are provided on each a required in duct barriers in fully ducted and air conditioning systems. 1.6.3, 19.1.6.4 The that southview smoke dance with NFPA 101 "The 0 edition) section 19.3.7.3. could negatively affect all and visitors of the wings a fire by allowing fire and the side of the barrier to the effective facility tour on May 19, and 11:00 am, revealed a smoke barrier wall has rough the wall that are not effort (RW) verified these		025	K025 1. The penetrations in the smoke barrier wall will be sealed using Gypsum Fire Safing and applying '3M Fire Dam 200'. See attached TAG 25 plan of correction." 2. The proposed completion date will be within 30 days of approval this plan. 3. Richard Wozniak, Maintenance Director, will be responsible for monitoring and prevention of reoccurrence of the deficiency.	"K-	15
	NFPA 101 LIFE SAFET	Y CODE STANDARD	K 06	37			

		MEDIONID OLIVIOLS				OMB N	O. 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	
NAME OF B		245336	B. WING			05/19/2015		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DELANO				43	TREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 ELANO, MN 55328			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE	
	with the provisions of in accordance with the specifications. 19.5 19.5.2.2 This STANDARD is not be a seed on observation revealed that the facility part of the air distribution make-up air for the sleen exhaust, throughout the accordance with NFPA practice could allow the to travel far from the fir affect all 38 residents, restricting their means situation Findings include: On facility tour between 11:00 AM on 05/19/201 that the heating, ventile systems for the building system as part of the a make-up air for the bat does not meet Exceptice edition), Section 2-3.11 over-pressurized corrid	and air conditioning comply section 9.2 and are installed a manufacturer's .2.1, 9.2, NFPA 90A, ot met as evidenced by: is and an interview, it was by is using the corridors as on system to provide reping rooms' bathroom e building which is not in 90A. This deficient e products of combustion re origin and negatively staff and visitors by of egress in a fire on the hours of 8:00AM and 15, observations revealed ation, and air conditioning g is using the corridor in distribution system for hrooms exhaust. This is on 2 of NFPA 90A (1999 .1 that allows ors.	K	067	K067 See attached waiver reques	t.		
/ 1	This deficient practice v facility Maintenance Dir discovery.	vas confirmed by the ector (RW) at the time of						

	NO TOTA WEBIOAILE				OMB NO. 0938-0391			
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
NAME OF		245336	B. WING		-	05/19/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - DELAN	o		433 COUNTY RO				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA	E ATE	(X5) COMPLETION DATE		
				ŀ				
				P				

K-TAG~25 PLAN OF CORRECTION

GOLDEN LIVING DELANO DELAND, MN.



Sheehan, Pat (DPS)

Sheehan, Pat (DPS)

Thursday, June 25, 2015 1:12 PM

rochi_lsc@cms.hhs.gov

<u>...</u> Sent: From:

င္ပ Swenson, Kimberly (DPS); 'shannon.donahue@goldenliving.com'; Dehler, Robert; Dietrich, Shellae (MDH); 'Fiske-Downing,

Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)

Subject: Golden Living Center Delano (235336) K67 Annual Waiver Request - Previously Approve - No change

This is to inform you that GLC Delano is a again requesting an annual waiver for K67, corridors as a plenum. The exit date was5-20-15.

I am recommending that CMS approve this waiver request.

Patrick Sheekan, Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416

Health Care & Corrections Fire Inspections

Minnesota State Fire Marshal Division Est. 1905

445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525

Web: fire.state.mn.us

Name of Facility	272	Delano		2000 CODE
	PART IV RI	ECOMMENDATION FOR WAIVER OF	PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS	
	For each iten number and applied, woul provisions will required, atta	For each item of the Life Safety code recommender number and state the reason for the conclusion tha applied, would result in unreasonable hardship on t provisions will not adversely affect the health and some required, attach additional sheet(s).	For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).	
PROVISION NUMBER(S)			JUSTIFICATION	
K 067	An am	An annual/continuing waiver is being requested for K067.	d for K067.	and the second of the second o
	A) Comp	mpliance with this provision will cause ase:	 A) Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: 	180C
	A	A bid to complete the required work to November 29, 2011. The 2011 bid she estimate of \$2500 in roofing work and materials to comply with K067. An up	A bid to complete the required work to comply with K067 was completed by Able Onsite on November 29, 2011. The 2011 bid showed \$177,323 in labor and material costs, with an additional estimate of \$2500 in roofing work and \$45,000 in electrical work, for a total of \$244,823 in labor and materials to comply with K067. An updated bid was obtained in 2015 and the total cost to complete	al : and ete
			ure project is now big at \$2/4,225. There are concerns that penetration of load bearing walls on both wings would sacrifice the structural integrity of the facility.	tural
	A		Construction of this project would create a hardship for the residents of this facility. There are two distinct wings in this building. Construction on each wing would require that residents are relocated off that wing, and there is no other place in the facility for them to reside. This would create an unreasonable hardship for the residents, their family members, and facility staff trying to relocate the residents in the construction is complete. The increase in noise and chimilation from the	vo ted the
			construction would also create an unreasonable hardship for those residents that suffer from dementia and related illnesses.	entia
	A A A		Given the total costs of the project as well as the numerous other financial obligations, it will take over 20 years for the facility to recoup the costs of construction. The construction of this project would be paid for in full upon completion of the project. The huilding was nurchased by Reverly Healthcare in 1967. It was acquired via merger by Golden.	e over
	•		Living in 2006. Estimates of usable remaining life are 15 years after the merger, or until 2021.	
Surveyor (Signature)		Title	Office	o o
Fire Authority Official (Signature)	re)	Title	Office Date	6-75-15
Form CMS-2786R\03/04) Previous	Previous Versions Obsolete	a o		Page 26

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

Name of Facility

number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly For each item of the Life Safety code recommended for waiver, list the survey report form item applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is 'equired, attach additional sheet(s).

PROVISION NUMBER(S)

K 067

JUSTIFICATION

- B) There will be no adverse effect on the building occupants safety in accordance with SOM 2480B because:
 - The facility is equipped with an automatic corridor smoke detection system.
- The building has automatic shutdown of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system.
 - Annual services and maintenance contracts exist to service all the facility fire protection systems, including fire alarm, sprinkler system, and fire extinguishers. The fire alarm system is continuously monitored to provide automatic fire department notification.
 - Fire safety training is provided for all employees quarterly and during orientation for all newly hired staff.
- Fire drills are conducted at least quarterly for all shifts. AA
- The facility is protected by a supervised automatic sprinkler system.

Date	Date
Office	Office
Trtle	Title
Surveyor (Signature)	Fire Authority Official (Signature)

Form CMS-2786F (03/04) Previous Versions Obsolete

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

F5336033

PRINTED: 06/04/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 2 - 2008 ADDITION		E SURVEY MPLETED
		245336	B. WING			0.	5/19/2015
	ROVIDER OR SUPPLIER Livingcenter - Delan	0		43	TREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 ELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
	Minnesota Department Fire Marshal Division. Golden Livingcenter Difound in substantial correquirements for partic Medicare/Medicaid at 483.70(a), Life Safety edition of National Fire (NFPA) Standard 101, Chapter 18 New Health This facility will be sunbuildings: Golden Livingcenter Diffusion 1-story addition with new as constructed in 200 be Type II (000) to the The addition is fully spontant the facility with smoke detection in open to the corridors the automatic fire department at 42 MET as evidenced by:	sipation in 42 CFR, Subpart from Fire, and the 2000 e Protection Association Life Safety Code (LSC), h Care. /eyed as two separate elano building # 2 is a b basement. An addition 08 and was determined to East Wing. rinkler protected has a fire alarm system in the corridors and spaces hat is monitored for ent notification. city of 54 beds and had a e of the survey. CFR, Subpart 483.70(a) is			A 6 25/15		
BORATORY DI	RECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1703 June 4, 2015

Ms. Shannon Donahue, Administrator Golden Livingcenter - Delano 433 County Road 30 Delano, Minnesota 55328

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5336024

Dear Ms. Donahue:

The above facility was surveyed on May 17, 2015 through May 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Golden Livingcenter - Delano June 4, 2015 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

When all orders are corrected, the order form should be signed and returned to Brenda Fischer at Minnesota Department of Health, 3333 W Division, #212 St Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

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

Enclosure (s)

cc: Licensing and Certification File

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 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **433 COUNTY ROAD 30 GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 RECEIVED *****ATTENTION****** IUN 17 2015 NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section MN Dept of Health 144A.10, this correction order has been issued St.Cloud pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** On May 17-20, 2015 surveyors of this Minnesota Department of Health is Department's staff visited the above provider and documenting the State Licensing the following licensing orders were issued. When Correction Orders using federal software. corrections are completed, please sign and date Tag numbers have been assigned to on the bottom of the first page in the line marked Minnesota state statutes/rules for Nursing with "Laboratory Director's or Provider/Supplier Homes. Representative's signature." Make a copy of

Minnesota Department of Health

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

Manner Faryle

Executive Director

(X6) DATE

f continuation sheet 1 of 24

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: 00933 B. WING 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 000 Continued From page 1 2 000 these orders for your records and return the The assigned tag number appears in the original to the address below: far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is Minnesota Department of Health listed in the "Summary Statement of 3333 West Divison Street, Suite 212 Deficiencies" column and replaces the "To St. Cloud, MN 56301 Comply" portion of the correction order. c/o Brenda Fischer, Unit Supervisor This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. 2 435 MN Rule 4658.0210 Subp. 2 A.B. Room 2 435 Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints. including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint

Minnesota Department of Health

and its resolution.

PRINTED: 06/04/2015 **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: _ 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 435 Continued From page 2 2 435 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure that residents were notified prior to receiving a roommate for 1 of 2 residents (R70) who were reviewed for admission, transfer, and discharge. Findings include: R70's quarterly MDS dated 2/09/15, identified R70 as moderately cognitively impaired, with a BIMs score of 8 (moderately impaired). During interview on 5/18/15 at 9:36 a.m., R70 stated she had a roommate when she was admitted, but has since died. R70 indicated that she has had roommates since, but doesn't recall receiving any notices before her roommates come. R70 further stated it would be nice to be notified but "doesn't know if it would do much good." In a subsequent interview on 5/19/15 at 8:42 a.m., R70 stated that she had a couple of residents for roommate, 2-3 months ago. One of the roommates was in her room when she returned from supper one day. Her last roommate the facility did mention it to her, but she never came. In review of the facility R70's progress notes from 12/14 through 05/15 identified only one notation that the facility provided a notice to R70 on

During an interview on 05/19/2015 8:38 a.m., the Minnesota Department of Health

R70 had.

4/14/15 by the social service department. There was no mention of the previous roommates that

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: 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 435 Continued From page 3 2 435 licensed social worker (LSW)-A stated she started two months ago, and that she documents within the electronic record when she notifies a resident of a potential roommate. After review of R70's records, LSW-A was unable to find documentation on two roommates that R70 shared a room with during the time frame of 12/04/14 through 1/01/15 and 1/21/15 through 2/19/15. In review of the facility policy entitled: Transfer of Resident Within the Facility Procedure # CLIN1300-660 (effective 1/26/2015) indicated under the procedure 9: "notify all roommates affected by the transfer." SUGGESTED METHOD OF CORRECTION: The administrator and/or their designee could develop an system that assures documentation of room changes / roommate changes would be evident and requested in a timely manor. TIME PERIOD FOR CORRECTION: Fourteen (14) days. 2 910 MN Rule 4658.0525 Subp. 5 A.B Rehab -2 9 1 0 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

Minnesota Department of Health

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		DELANO	, MN 55328	T		
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2 910	Continued From page	4	2 910			
	receives appropriate t prevent urinary tract i much normal bladder	reatment and services to nfections and to restore as function as possible.				
	by: Based on observation review the facility faile comprehensive bladde	er assessment was esidents (R23) who was lowing removal of an				
	Findings include:					
	indicated R23 was cor indwelling catheter, an of two staff for transfer dated 4/22/15 indicated incontinent of bladder,	d required total assistance s. R23's quarterly MDS				
	p.m., resident's room h his bed sheets had bee unidentified nursing as resident room at this tir wet and required chang of R23's room on 5/18/ did not have any bed lin	sistant who was in the me stated the sheets were ging. During an observation 15 at 8:30 a.m., R23's bed nens.				
	was removed, a urinal	ursing Progress note, d R23's urinary catheter was placed at his bedside heck and changed R23				

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: 00933 B. WING 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 910 Continued From page 5 2 9 1 0 Review of the facility Quarterly Interdisciplinary Resident Review dated 4/22/15 indicated R23 no longer had an indwelling urinary catheter. There was no indication a bladder assessment was completed during this review period even though R23's indwelling catheter was removed. The facility Bladder Assessment Form initiated on 8/13/14 indicated R23's bladder status was reviewed and he was not appropriate for a toileting plan due to a CVA (cerebral vascular accident). The form was updated on 1/11/14 and 4/22/15 but the section designated for determining ability to participate in a bladder program was left blank for both reviews. R23's care plan last updated 4/2015, identified R23 required a mechanical lift for transfers with assistance of two staff, was frequently incontinent of bladder, had a history of spilling urinal, needed help with proper placement, and required assistance of one staff for toileting. The intervention directed staff to assist with urinal placement upon rising, before and after meals, at HS (hour of sleep) and PRN (as needed). An undated nursing assistant care sheet labeled: Group D, directed staff to "Offer use of urinal and commode. Wears briefs." During an interview on 05/18/2015 1:54 p.m., nursing assistant (NA)-A stated R23 was incontinent most of the time, but still has the urge to go and would occasionally use the urinal. She further stated R23 has no formal toileting plan and staff were to check and change him every 2 hours. NA-A stated, "[R23] does not use the toilet,

due to being a total assist with a lift, he is on a two hour check and change program."

PRINTED: 06/04/2015 **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: _ 00933 B. WING 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **433 COUNTY ROAD 30 GOLDEN LIVINGCENTER - DELANO** DELANO, MN 55328 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 2 9 1 0 Continued From page 6 2 9 1 0 In an interview on 05/18/2015 3:25 p.m., NA-C stated R23 could be continent of bladder, did not have a toileting program and his incontinent brief was to be checked and changed every two hours. She further stated R23 does not use a toilet or a bed pan. During an interview on 05/18/2015 3:27 p.m., licensed practical nurse (LPN)-B stated R23 was incontinent of bladder and that occasionally he used a urinal. She further stated R23 had no specific toileting plan. In an interview on 05/18/2015 3:33 p.m. with the

director of nursing (DON) and the assistant director of nursing (ADON), the ADON stated, "We do not technically have toileting programs, residents are toileted every couple hours and PRN [as needed]." The DON stated that the MDS nurse did the assessments and would determine if a resident could benefit from a toileting program, and indicated various reasons that a toileting program would not be implemented including: refusals, confusion and resident preference. However, the DON stated a CVA was not an appropriate reason to assess a resident was not capable to participate in a bladder program. The (DON) further stated, if a catheter is removed, a 3 day Bowel and Bladder Assessment should be completed.

In an interview on 05/19/2015 11:59 a.m., registered nurse (RN)-B stated she was responsible for developing toileting programs when completing the plan of care. She further stated that bladder assessments are completed on admission, annually and with a significant change such as removal of a indwelling urinary catheter, which was not completed for R23.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	
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2 910	Continued From page	7	2 910			
2 930	director of nursing and review the facility's po educate the facility sta comprehensive asses incontenance.	onent for urinary ORRECTION: Twenty-one ubp. 7 B. Rehab -	2 930			
	and feeding syringes. Based on the assessment, a nursing B. a resident who gastrostomy tube or fe	abnormalities, and as and to restore, if				
	by: Based on observation, review, the facility faile checked placement of (g-tube) prior to infusin	g medication and formula) observed to have a tube				

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: _ 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **433 COUNTY ROAD 30 GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 2 930 Continued From page 8 2 930 Findings include: R37's admission Minimum Data Set (MDS), dated 3/23/15, identified R37 was cognitively intact, and received "51 percent (%) or more" of his total calories through the feeding tube. R37 was observed during the medication pass on 5/18/2015 9:00 a.m, licensed practical nurse (LPN)-A obtained R37's g-tube from under his shirt and laid it on a clean white washcloth. LPN-A then flushed the g-tube with 120 cc of water, without first checking placement of the gastrostomy tube. LPN-A proceeded to place P37's medications via the g-tube, one at a time with water administered between each medication. Once LPN-A had finished R37's medications, she then started R37's enteral feeding through his gastrostomy tube. In interview on 5/18/15 at 9:15 a.m., LPN-A stated that she had forgotten to check placement, and should of before the initial water flush. In review of the facility policy, entitled: Administration of Enteral Feeding (last reviewed 11/13/14) step 16 - "Put on gloves - verify correct placement of the G-tube by placing a stethoscope on the resident's abdomen, inject 10-15 cc [cubic centimeters] of air via the 60 cc syringe, listen for a "whooshing" sound, the slowly draw back gastric contents...". During interview on 5/19/2015 12:59 p.m., the director of nursing (DON) stated that the policy of

the facility is to check placement before giving

anything via the g-tube.

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
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2 930	Continued From page	9	2 930		
	director of nursing and	ose residents with			
	TIME PERIOD FOR C (21) days.	CORRECTION: Twenty-one			
21390	MN Rule 4658.0800 S	ubp. 4 A-I Infection Control	21390		
	control program must procedures which provations A. surveillance ba collection to identify no residents; B. a system for decontrol of outbreaks of C. isolation and preduce risk of transmist D. in-service eductor prevention and control E. a resident health immunization program defined in part 4658.0 procedures of resident the prevention and treater. The development employee health policipractices, including a telefined in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident resident in part 4658.0 G. a system for resident residen	vide for the following: sed on systematic data assocomial infections in election, investigation, and infectious diseases; recautions systems to sision of infectious agents; ration in infection ; th program including an , a tuberculosis program as 810, and policies and care practices to assist in atment of infections; at and implementation of es and infection control uberculosis program as 815; viewing antibiotic use; view and evaluation of infection control, such as cs, gloves, and			

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: 00933 B. WING 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 21390 Continued From page 10 21390 I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to implement an infection control program that included consistent analysis of collected data, and provide staff education with identified trends in order to reduce infections in the facility. This had potential to affect all 38 residents in the facility, staff, and visitors. Findings include: A facility Line Listing of Resident Infections flow sheet from March thru May 2015 was reviewed. The sheet identified the following information which was to be collected by the infection control coordinator: > Room > Unit > Resident Name > Admission Date > Type of Infection > Symptoms/Date > Cultures > Treatment > Other Actions (if needed) > HAI (Healthcare Associated Infection) or CAI (Community Acquired Infection) The facility Line Listing of Resident Infections flow sheet, dated March 2015, identified five residents in the facility had experienced possible infections. Four of the five residents had actual symptoms (i.e. foul urine odor, crackles in the lungs) and the type of infection identified; three of the five

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	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	SURVEY
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0(0)), MN 55328			
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213	Continued From page	e 11	21390			
	residents had their ro	oom number identified, and				
	only two of the five re	esidents had which unit of the				
	facility they resided a	n identified. The about				
	identified four of the	n identified. The sheet				
	aptiblistic treatment for	ive residents required				
	the five residents idea	or their infections. None of				
		ntified on the sheet had				
	indication if their infec	ction was a hospital acquired				
	infection (HAI) or com	nmunity `acquired infection				
	(CAI). Further, their	was no analysis or trending				
	of the data to determi	ne possible causes of the				
	infections, screen for	possible spreading of a				
	similar symptom, or a	ction plans to reduce further				
	infections of the same	type in the facility.				
	The facility Line Listin	g of Resident Infections flow				
	sheet, dated April 201	15, identified five different				
	residents in the facility	y had experienced possible				
	infections. Four of the	e five residents had a type				
	of infection identified,	and all of the residents had				
	their rooms, unit, sym	ptoms, cultures, and				
	treatment identified.	Four of the five identified				
		tibiotic medication to treat				
	their infections. Furth	er, there was no analysis or				
	trending of the data to	determine possible causes				
	of the infections scree	en for possible spreading of				
	a similar symptom or	action plans to reduce				
	further infections of the	e same type in the facility.				
		e same type in the facility.				
	The facility Line Lieting	g of Resident Infections flow				
	sheet dated May 201	5, identified three residents				
	had experienced infec	tions so for during the				
	month Fach resident	, room and their unit were				
	identified on the flow of	hoot Pooldont committee				
	were identified as the	sheet. Resident symptoms				
	were identified as the	ioliowing:				
	> P27 over aniana a 1 114	00.511				
	> R27 experienced, "1	00.5 [temperature]				
	emesis X [times] 2 " ar	na;			ĺ	
	> R50 experienced, "u	rgency, pain, difficulty				
	voiding" and;					
	> R48 experienced, "le	ethargy, glazed look".				

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00933	B. WING		05/20/2015
	ROVIDER OR SUPPLIER LIVINGCENTER - DELAN	10 433 COL	DDRESS, CITY, STA INTY ROAD 30 D, MN 55328	TE, ZIP CODE	
(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 APPROPE DEFICIENCY)	BE COMPLETE
21390	Continued From page	: 12	21390		
	and all three of the ide the North unit of the fa analysis / urinary culture the residents, and R5 as having e-coli (a bar responsible for the infrequired antibiotic me symptoms. None of the were identified has have as left uncompleted, lacked analysis or trendetermine possible cascreen for possible sp symptom, or action plainfections of the same. When interviewed abor program on 5/18/15, anursing (DON) stated facility program, and donursing progress note 24 hour report sheets. control data is typically patterns during the facility program. Further, the ducation was schedulin the past couple of ridentification and trendinfections (UTI) on the adding, "So much of well-as a series of the same o	dication to treat their the residents on the form riving an HAI or CAI as it and the sheet further anding of the data to uses of the infections, reading of a similar ans to reduce further type in the facility. but the infection control at 3:45 p.m., the director of she was responsible for the lata is collected by review of s, physician orders, and the The collected infection by reviewed for trends and cility Quality Assurance and ment (QAPI) meetings, but eted for the past few the weaker the past couple the DON stated no staff alled or had been completed months" because of the difference of the facility and the post informal."			
	failed to consistently of	ad been collecting data ed infections, the facility ollected data was reviewed s in order to analyze where			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00933	B. WING		05/20/2015
	ROVIDER OR SUPPLIER	O 433 COU	DDRESS, CITY, ST. NTY ROAD 30 , MN 55328	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPR DEFICIENCY)	BE COMPLETE
21390	Continued From page the infections were or		21390		
	implement actions pla in the facility. R27, R9 the same unit of the fa symptoms of a UTI, to with a UTI from the sa failed to research the or develop actions pla transmission to other of A facility Elements of a Program policy, dated items an "effective infe- control program incorp	ns to reduce the infections 50, and R48 all resided on acility and presented with wo of them being diagnosed ame bacteria, and the facility cause of these infections, ns to reduce the risk of residents in the facility. an Infection Control 1/9/15, identified several ection prevention and porates", including, g process and outcome			
	director of nursing and review the facility's pol monitoring, tracking, tr infections treated within	ending and analyzing			
21426	MN St. Statute 144A.0 Prevention And Control		21426		
	maintain a comprehens infection control progra current tuberculosis inf issued by the United S Control and Prevention	om according to the most fection control guidelines tates Centers for Disease			

PRINTED: 06/04/2015 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 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **433 COUNTY ROAD 30 GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 21426 Continued From page 14 21426 Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced Based on interview, and document review, the facility failed to ensure a tuberculosis (TB) symptom screening was completed upon admission for 1 of 5 residents (R37) reviewed for TB compliance during the survey. Findings include: R37's admission Minimum Data Set (MDS), dated 3/23/15, identified R37 was cognitively intact. R37's Baseline TB Screening Tool for Residents, dated 5/5/15, was reviewed. A section identified

Minnesota Department of Health

When interviewed on 5/18/15, at 3:20 p.m. the assistant director of nursing (ADON) stated R37 had dismissed the facility recently, and returned

as "Resident History and Risk Factors" contained screening questions which are used to determine potential exposure to TB along with a "Y" or "N" and directions to "circle response". However, this section was left blank and not completed.

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		00933	B. WING		05	5/20/2015
	PROVIDER OR SUPPLIER N LIVINGCENTER - DELAN	NO 433 COUI	DDRESS, CITY, STATE UNTY ROAD 30 D, MN 55328	;, ZIP CODE		
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21426	to his home in the cor should have had a ne when he admitted to the A facility Tuberculosis dated 1/6/15, identified facility to screen patient and other persons at intervals outlined by Control], state required prevalence." SUGGESTED METHO director of nursing and the facility's policy and the facility staff responsible to the sacility sta	ew TB symptom screening the facility. s Exposure Control Plan, ed, "It is the policy of this ents/residents, associates, for M. tuberculosis infection by CDC [Centers for Disease ements, or facility HOD OF CORRECTION: The ad/or designee could review and procedures and educate possible for the provision of TB	21426			
21565	Medications Self Adm Subp. 4. Self-admini self-administer medica resident assessment a care as required in pa 4658.0405 indicate the is a written order from This MN Requirement by: Based on observation review, the facility faile self administration me completed to determine	distration. A resident may cations if the comprehensive and comprehensive plan of earts 4658.0400 and his practice is safe and there in the attending physician. In the is not met as evidenced his interview, and document led to ensure a comprehsive edication assessment was	21565			

6899

	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		00933	B. WING		05/2	20/2015
NAME	OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
GOL	DEN LIVINGCENTER - DELAI	OV	NTY ROAD 30 , MN 55328			
(X4) PRE TA	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2	(MDS), dated 2/14/15 cognitive impairment. During observation of was laying in bed with head of the bed eleval mask on, but down and dispensing medication. Nurse (RN)-A entered re-applied R24's nebulant and mouth with medicationed to the mask. R24 was sleeping and alone with the nebulization of the mask. R24 was sleeping and alone with the nebulization used for a minute." Review of R24's Doct 5/13/15, identified an [medication used for a disease (COPD)] 3 every 6 hours for Resphysician orders did radminister her own necare plan, dated 2/16, "impaired cognition", a "Administer medication plan did not identify Radminister her own newas no indication the administration assess was safe to be left alonalministered the nebulance of the service of	in through a nebulizer during the survey. Inge Minimum Data Set is, identified R24 had severe in 5/17/15, at 6:10 p.m. R24 in her eyes closed, and the sted. R24 had a nebulizer round her neck while it was in into the air. Registered if the room at 6:11 p.m. and ulizer mask around her nose cation remaining in the vial RN-A stated she thought if would be OK to leave her ter on, "so I just stepped out or Order Sheet, dated order for "DuoNeb Solution choric obstructive pulmonary mI [milliliters] inhale orally piratory congestion." R24's not identify an order to self ebulizer medications. R24's f15, identified R24 had and instructed staff to, in as ordered." R24's care 24 was safe to self ebulizer medication. There facility had completed a self ment, to determine if R24 ne when the nurses	21565			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00933	B. WING		05/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DELAN	O	ITY ROAD 30 MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21565	director of nursing (DO record and stated R24 nebulizers. The DON assessment of R24 re administer her own ne physician order allowing the DON stated R24 sfor safety to self administer before being left alone need to do an assessment of the DON stated R24 sfor safety to self administration of the DON stated R24 sfor safety to self administration of the DON stated R24 sfor safety to self-administration of the DON stated R2/2007, it desires to self-administration of the DON stated R2/2007, it desires to self-administration of self administration of self administration of the DON stated R2/2007, it desires to self-administration of self administration of self-administration of self-ad	DN) reviewed R24's medical was recently started on was unable to identify any garding her ability to self abulizer medications, or any her to do so. Further, hould have been assessed hister her own medications with the nebulizer, "We ment." Tration of Medications dentified, "If a resident ster medications, an T [inter-disciplinary team] must show that the hysical, and visual abilities self administration of Dicy directed, "A physician's resident to self-administer DD OF CORRECTION: The for their designee should icy and procedures and	21565			
21630	MN Rule 4658.1350 S Medications; Destruction	ubp. 2 A.B. Disposition of on	21630	-		
	Subp. 2. Destruction of A. Unused portion remaining in the nursing discharge of a resident prescribed, or any con-	s of controlled substances g home after death or for whom they were				

PRINTED: 06/04/2015 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 00933 05/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 **GOLDEN LIVINGCENTER - DELANO DELANO, MN 55328** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 21630 Continued From page 18 21630 discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate destruction of Fentanyl (a narcotic medication) duragesic patches to prevent possible theft and/or diversion. This had potential to affect 1 of 1 residents (R52) currently prescribed duragesic

Minnesota Department of Health

patches in the facility. Furthermore, the facility failed to ensure only licensed staff had access to

R52's Order Summary Report, dated 5/5/15, identified an order for, "FentaNYL Patch 72 Hour 25 MCG/HR Apply 25 mcg transdermally [on the

skin] every 72 hours for Pain."

resident medication.

Findings include:

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Minnesota Department of Health STATE FORM

been putting used Fentanyl duragesic patches in the container on the counter in the medication room. At 5:44 p.m. the ADON provided the facility policy for medication destruction, and stated, "What we have been told by Alixa [the

6899

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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NAME OF F		00933	B. WING		05/20/2015	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DELAN	IO 433 COUN DELANO, I	TY ROAD 30 MN 55328			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21630	Continued From page	20	21630			
	dispensing pharmacy] is to flush them [used Fentanyl duragesic patches]."					
	dispensing pharmacis Drug Administration (F	5/18/15, at 10:50 a.m. the st (DP) stated the Food and FDA) recommends to fold and flush them down to drain ersion of the narcotic.				
	05/12, identified, "Des with federal and state listed a procedure whi should not be flushed unless the package in	Destruction policy, dated struction methods comply laws and regulations", and ich included, "Medications down the toilet or drain sert specifically instructs tanyl patches) [refer to state"				
	System) package inse content of Fentanyl in particular target for about Further, the insert ider disposal of the patches print of, "Flush the use right away. A used Dudangerous for or even	ntified a process for is which included bolded ed Duragesic down the toilet				
	director of nursing and	DD OF CORRECTION: The designee should licy and procedures and lift responsible for the list.				
	TIME PERIOD FOR C	ORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00933		00933	B. WING		05	05/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	-		
GOLDEN LIVINGCENTER - DELANO 433 COUN			NTY ROAD 30 MN 55328				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.		21880				
	facility employing more provides outpatient me have a written interna at a minimum, sets for followed; specifies time limits for facility respor or resident to have the advocate; requires a w grievances; and provid an impartial decision motherwise resolved. Coresidential programs a 253C.01 which are hos treatment programs, at centers with section 14	s defined in section ute care facility, and every e than two people that ental health services shall I grievance procedure that, th the process to be e limits, including time use; provides for the patient e assistance of an written response to written es for a timely decision by maker if the grievance is not compliance by hospitals, us defined in section epital-based primary and outpatient surgery 4.691 and compliance by ganizations with section					

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Minnesota Department of Health STATE FORM

nursing assistant (NA)-A stated the trash bins were stored in the closet, but brought out during morning cares. Further, NA-A stated she wasn't aware of any formal complaints about them, but added, "I guess I've heard [R59] say something

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00933	B. WING		0.	5/20/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE			
GOLDEN	LIVINGCENTER - DELAN	O 433 COUN DELANO,	TY ROAD 30 MN 55328				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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	(X5) COMPLETE DATE		
	stated staff typically hallway until 10:00 a.r. not to have equipmen in the hallway during t NA-B stated R59 had bins being in the hallw bins should be kept in just when you guys [st When interviewed on sticensed social worker not aware of any concent the trash bins being keif staff were getting conshould have reported to grievance resolution possible for ensuring within the LivingCenter directed staff to completurn it in "for processin SUGGESTED METHO director of nursing and review the facility's poleducate the facility star following up on grievar	in the past though." 19/15, at 8:36 a.m., NA-B ave the trash bins out in the m., however they were told to (including the trash bins) he State survey. Further, complained about the trash way before, and added the the closet "year round, not tate surveyors] come." 5/19/15, at 8:45 a.m. the complaints about them, they this to management so a rocess could be started. 10 coess policy, dated a grievance policy and g." 10 DOF CORRECTION: The complaints and procedures and ff responsible for the	21880	DEFICIENCY			