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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 13IL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00933

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245336**

2.STATE VENDOR OR MEDICAID NO.
(L2) **655371100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - DELANO**
(L4) **433 COUNTY ROAD 30**
(L5) **DELANO, MN** (L6) **55328**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **07/08/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving K67 is recommended.

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 07/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/07/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245336	A. Building B. Wing	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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/29/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	07/21/2015	10562	07/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245336	01 - MAIN BUILDING 01	7/10/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0025	Correction Completed **07/09/2015**	ID Prefix Reg. # **NFPA 101** LSC K0067	Correction Completed **07/09/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	07/21/2015	34764	07/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/19/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 13IL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00933

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245336**
2.STATE VENDOR OR MEDICAID NO.
(L2) **655371100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - DELANO**
(L4) **433 COUNTY ROAD 30**
(L5) **DELANO, MN** (L6) **55328**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **05/20/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving K67 is recommended

17. SURVEYOR SIGNATURE Date :
Tim Rhonemus, HFE NE II 06/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 07/02/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
AW K67 sent to Rochi 07/06/2015 Co.
Posted 07/06/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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 000	**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.**	
F 166 SS=D	483.10(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. 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	F 166	**F166** 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	

RECEIVED
JUN 16 2015
MN Dept of Health
St.Cloud

6/17/15 accepted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Donahue — TITLE: Executive Director — (X6) DATE: 6/15/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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F 166	Continued From page 1 which have a "dead horse smell" to them. R59 stated she voiced her concerns several times to the facility staff, but nothing had changed and staff still were still bringing the trash bins out in the hallway and leaving them set there for extended periods of time. Further, R59 stated she was bothered by having smelly trash cans in the hallway outside her room, "This is my home, and you don't have a trash can outside your room that smells like a dead horse." When interviewed on 5/18/15, at 1:36 p.m. 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 [about the trash bins] in the past though." During interview on 5/19/15, at 8:36 a.m., NA-B stated staff typically have the trash bins out in the hallway until 10:00 a.m., however they were told not to have equipment (including the trash bins) in the hallway during the State survey. Further, NA-B stated R59 had complained about the trash bins being in the hallway before, and added the bins should be kept in the closet "year round, not just when you guys [state surveyors] come." When interviewed on 5/19/15, at 8:45 a.m. the licensed social worker (LSW)-A stated she was not aware of any concern for R59 pertaining to the trash bins being kept in the hallway. Further, if staff were getting complaints about them, they should have reported this to management so a grievance resolution process could be started. A facility Grievance Process policy, dated 10/2009, identified, "All employees are	F 166		

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F 166	Continued From page 2 responsible for ensuring customer satisfaction within the LivingCenter." Further, the policy directed staff to complete a grievance policy and turn it in "for processing."	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehsive self administration medication assessment was completed to determine safe medication administration for 1 of 1 residents (R24) observed to receive medication through a nebulizer (breathing treatment) during the survey. Findings include: R24's significant change Minimum Data Set (MDS), dated 2/14/15, identified R24 had severe cognitive impairment. During observation on 5/17/15, at 6:10 p.m. R24 was laying in bed with her eyes closed, and the head of the bed elevated. R24 had a nebulizer mask on, but down around her neck while it was dispensing medication into the air. Registered Nurse (RN)-A entered the room at 6:11 p.m. and 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	F 176	**F176** 1. R24 was at end of life during survey and expired prior to completion of assessment to ensure she was safe to leave the nebulizer mask on her face while unattended. 2. All residents that self-administer medications have the potential to be affected, and will have assessments completed to ensure that they can do this safely and accurately. 3. Nursing staff and the IDT have been re-educated on guidelines for completion of Self-Administration assessments. 4. Monitoring for compliance will be completed by the DNS/Designee through weekly audits of self-administration assessments, care plans, orders and of residents who are self-administering for 6 weeks and then randomly; results will be reviewed at QAPI meetings. 5. Date of compliance 6/29/15	

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F 176	Continued From page 3 R24 was sleeping and it would be OK to leave her alone with the nebulizer on, "so I just stepped out for a minute." Review of R24's Doctor Order Sheet, dated 5/13/15, identified an order for "DuoNeb Solution [medication used for choric obstructive pulmonary disease (COPD)] ... 3 ml [milliliters] inhale orally every 6 hours for Respiratory congestion." R24's physician orders did not identify an order to self administer her own nebulizer medications. R24's care plan, dated 2/16/15, identified R24 had "impaired cognition", and instructed staff to, "Administer medication as ordered." R24's care plan did not identify R24 was safe to self administer her own nebulizer medication. There was no indication the facility had completed a self administration assessment, to determine if R24 was safe to be left alone when the nurses administered the nebulizer treatment. During interview on 5/17/15, at 6:20 p.m. the director of nursing (DON) reviewed R24's medical record and stated R24 was recently started on nebulizers. The DON was unable to identify any assessment of R24 regarding her ability to self administer her own nebulizer medications, or a physician order allowing her to do so. Further, the DON stated R24 should have been assessed for safety to self administer her own medications before being left alone with the nebulizer, "We need to do an assessment." A facility Self-Administration of Medications policy, dated 2/2007, identified, "If a resident desires to self-administer medications, an assessment by the IDT [inter-disciplinary team] will be completed and must show that the resident's cognitive, physical, and visual abilities	F 176		

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F 176	Continued From page 4 are conducive to safe self administration of meds." Further, the policy directed, "A physician's order is required for a resident to self-administer medications."	F 176		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This 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	F 247	**F247** 1. R70 will be given documented notification next time she receives a roommate. 2. All residents residing in a semi-private room have the potential to be affected. 3. Notice and documentation of roommates has been assigned to the facility Social Worker. In her absence a designee will be assigned. The Social Worker and designees have been trained to notify residents that they will be getting a roommate as soon as able after receiving confirmation of a new admission. After giving the notice they have been trained to document the notification in the resident's chart. 4. The ED or designee will conduct an audit after each new admission for a period of 6 weeks, then random audits will be conducted and reviewed at QAPI. 5. Date of compliance: 6.29.15	

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F 247	Continued From page 5 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 4/14/15 by the social service department. There was no mention of the previous roommates that R70 had. During an interview on 05/19/2015 8:38 a.m., the 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."	F 247		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	**F315** 1. R23 has had a bladder assessment completed. 2. All residents that have foley catheters removed have the potential to be affected and will have a bladder assessment completed when the catheter is removed.	

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F 315	Continued From page 6 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive bladder assessment was completed for 1 of 1 residents (R23) who was incontinent of urine following removal of an indwelling urinary catheter. Findings include: R23's minimum data set (MDS) dated 3/13/15 indicated R23 was continent of bladder with indwelling catheter, and required total assistance of two staff for transfers. R23's quarterly MDS dated 4/22/15 indicated R23 was frequently incontinent of bladder, had no bladder plan and required total assistance of two staff for transfers. During an observation of R23 on 5/17/15 at 4:08 p.m., resident's room had a strong urine odor and his bed sheets had been removed. An unidentified nursing assistant who was in the resident room at this time stated the sheets were wet and required changing. During an observation of R23's room on 5/18/15 at 8:30 a.m., R23's bed did not have any bed linens. Review of the facility Nursing Progress note, dated 3/18/15, indicated R23's urinary catheter was removed, a urinal was placed at his bedside and staff were also to check and changed R23 every 2 hours. Review of the facility Quarterly Interdisciplinary Resident Review dated 4/22/15 indicated R23 no	F 315	3. Nursing staff have been re-educated on the guidelines for completion of bladder assessments. 4. Monitoring for compliance will be completed by the DNS/Designee through audits on each resident who has a foley catheter removed over the next 3 months and then randomly to ensure residents with foley catheters removed have had a bladder assessment completed per guidelines. The results of these audits will be reviewed at QAPI meetings. 5. Date of compliance 6/29/15	

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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. 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." In an interview on 05/18/2015 3:25 p.m., NA-C	F 315		

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F 315	Continued From page 8 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.	F 315		

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F 322 F 322 SS=D	Continued From page 9 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (g-tube) prior to infusing medication and formula for 1 of 1 resident (R37) observed to have a tube feeding during the survey. 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	F 322 F 322	**F322** 1. Resident #37's gastrostomy tube was been checked prior to administration of medications, formula and water per guidelines until his discharge date of 5/24/15. 2. All residents with gastrostomy tubes have the potential to be affected. 3. Nursing staff have been educated on appropriate assessment of gastrostomy tube placement per guidelines. 4. When we have a resident with a gastrostomy tube, monitoring for compliance will be completed by the DNS/Designee through random audits to ensure gastrostomy tube placement is checked prior to administration of medications, formula and water. Rresults of these audits will be reviewed at QAPI meetings. 5. Date of compliance 6/29/15	

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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 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.	F 322		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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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 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	F 431	**F431** 1. Used Fentanyl patches removed from R37 are being flushed down the sewer system. 2. All residents receiving controlled medication patches have the potential to be affected. 3. Nursing staff have been re-educated on appropriate disposal of controlled medication patches and disposal in the sewer system. 4. Monitoring for compliance will be completed by DNS/ Designee through weekly audits of disposal of removed controlled medication patches in the sewer system for 6 weeks and then randomly. Results of these audits will be reviewed QAPI meetings. 5. Date of compliance 6/29/15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 patches in the facility. Furthermore, the facility failed to ensure only licensed staff had access to resident medication. Findings include: 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." The facility's single medication room was observed with licensed practical nurse (LPN)-C on 5/17/15, at 1:32 p.m.. The room was opened with a key, and a covered plastic container labeled "Hazardous Waste" was sitting on the counter with a yellow post-it note taped to the lid reading, "Coumadin [an anti-coagulant medication], Warfarin [Coumadin], Nicotine ONLY ... No Fentanyl Patches." The lid was removed from the container, and inside the following used Fentanyl duragesic patches were found: Four - 50 mcg [micrograms]/hr [hour] and; Three - 25 mcg/hr patches. LPN-C stated all of the nurses, and the staffing person have keys to the medication room door. Further, the used Fentanyl duragesic patches should not have been placed in the container, but rather flushed down the hopper [wash basin] in the Utility Room as used patches still contained some Fentanyl medication, and were at risk for theft or diversion, "The potential is always there." When interviewed on 5/17/15, at 3:08 p.m. the facility staffing coordinator (SC) verified she had a key that allowed access to the medication room. Further, she had the key for "maybe a year."	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 During interview on 5/17/15, at 4:05 p.m. the assistant director of nursing (ADON) stated staff should be removing the patch from the resident, sticking it to a tissue, and flushing it down the drain. The ADON stated the SC was not a licensed nurse, and added staff should not have 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 dispensing pharmacy] is to flush them [used Fentanyl duragesic patches]." When interviewed on 5/18/15, at 10:50 a.m. the dispensing pharmacist (DP) stated the Food and Drug Administration (FDA) recommends to fold used patches in half and flush them down to drain to avoid theft and diversion of the narcotic. A facility Medication Destruction policy, dated 05/12, identified, "Destruction methods comply with federal and state laws and regulations", and listed a procedure which included, "Medications should not be flushed down the toilet or drain unless the package insert specifically instructs you to do so (i.e. Fentanyl patches) [refer to state laws and regulations]." An undated Duragesic (Fentanyl Transdermal System) package insert identified, "The high content of Fentanyl in the patches ... may be a particular target for abuse and diversion." Further, the insert identified a process for disposal of the patches which included bolded print of, "Flush the used Duragesic down the toilet right away. A used Duragesic patch may be dangerous for or even lead to death in babies,	F 431		

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F 431	Continued From page 14 children, pets, and adults who have not been prescribed ..."	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	**F441** 1. The infection control program has been updated to include consistent tracking, trending, and analysis and development of action plans to improve infection control throughout the facility. 2. All residents, staff and visitors have the potential to be affected. 3. Licensed nursing staff have been educated on the requirement to identify and document date of onset of S/SX of potential infections, causative agents, treatments prescribed, develop appropriate care plans and interventions to minimize risk potential for transmission to others. The facility system for tracking, trending and analysis of infections has been reviewed and revised as indicated. 4. Line listing of infections with tracking, trending and analysis will be audited weekly for 6 weeks and then randomly. Results will be presented at QAPI for review and action planning as needed. 5. Date of compliance 6/29/15	

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F 441	Continued From page 15 infection. This 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	F 441		

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F 441	Continued From page 16 type of infection identified; three of the five residents had their room number identified, and only two of the five residents had which unit of the facility they resided on identified. The sheet identified four of the five residents required antibiotic treatment for their infections. None of the five residents identified on the sheet had indication if their infection was a hospital acquired infection (HAI) or community `acquired infection (CAI). Further, their was no analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. The facility Line Listing of Resident Infections flow sheet, dated April 2015, identified five different residents in the facility had experienced possible infections. Four of the five residents had a type of infection identified, and all of the residents had their rooms, unit, symptoms, cultures, and treatment identified. Four of the five identified residents required antibiotic medication to treat their infections. Further, there was no analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. The facility Line Listing of Resident Infections flow sheet, dated May 2015, identified three residents had experienced infections so far during the month. Each resident, room and their unit were identified on the flow sheet. Resident symptoms were identified as the following: > R27 experienced, "100.5 [temperature] ... emesis X [times] 2 " and; > R50 experienced, "urgency, pain, difficulty	F 441		

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F 441	Continued From page 17 voiding" and; > R48 experienced, "lethargy, glazed look". R27 and R50 were identified to share a room, and all three of the identified residents resided on the North unit of the facility. A UA/UC (urinary analysis / urinary culture) was obtained for all of the residents, and R50 and R48 were identified as having e-coli (a bacteria) as the organism responsible for the infection. R50 and R48 required antibiotic medication to treat their symptoms. None of the residents on the form were identified has having an HAI or CAI as it was left uncompleted, and the sheet further lacked analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. When interviewed about the infection control program on 5/18/15, at 3:45 p.m., the director of nursing (DON) stated she was responsible for the facility program, and data is collected by review of nursing progress notes, physician orders, and the 24 hour report sheets. The collected infection control data is typically reviewed for trends and patterns during the facility Quality Assurance and Performance Improvement (QAPI) meetings, but it had not been completed for the past few months, "It's been a little weaker the past couple of months." Further, the DON stated no staff education was scheduled or had been completed "in the past couple of months" because of the identification and trend of e-coli urinary tract infections (UTI) on the North unit of the facility adding, "So much of what we do is informal." Although the facility had been collecting data	F 441		

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F 441	Continued From page 18 regarding their identified infections, the facility failed to consistently collected data was reviewed for trends and patterns in order to analyze where the infections were originating from, and implement actions plans to reduce the infections in the facility. R27, R50, and R48 all resided on the same unit of the facility and presented with symptoms of a UTI, two of them being diagnosed with a UTI from the same bacteria, and the facility failed to research the cause of these infections, or develop actions plans to reduce the risk of transmission to other residents in the facility. A facility Elements of an Infection Control Program policy, dated 1/9/15, identified several items an "effective infection prevention and control program incorporates", including, "Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation ..."	F 441		

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

F5336023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2015**

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GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30** **DELANO, MN 55328**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145,	K 000	POC ok w/AW for K67 FS 6-25-15 RECEIVED JUN 19 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 5-20-15 DC: 6-19-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Donahue — TITLE: Executive Director — (X6) DATE: 6-16-2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings: Golden Livingcenter Delano Main building is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (000) construction. In 1988 a single story addition was constructed to the South Wing and determined to be of Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 025	Continued From page 2	K 025		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Observations revealed that southview smoke barriers is not in accordance with NFPA 101 "The Life Safety Code" (2000 edition) section 19.3.7.3. This deficient practice could negatively affect all of the residents, staff and visitors of the wings effected in the event of a fire by allowing fire and smoke to pass from one side of the barrier to the other. Findings include: Observations during the facility tour on May 19, 2015, between 8:00 am and 11:00 am, revealed that the southview wing smoke barrier wall has various penetrations through the wall that are not sealed. The Maintenance Director (RW) verified these findings during the inspection and at the exit conference.	K 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 "K-TAG 25 plan of correction." 2. The proposed completion date will be within 30 days of approval of this plan. 3. Richard Wozniak, Maintenance Director, will be responsible for monitoring and prevention of reoccurrence of the deficiency.	7-9-15
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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K 067 SS=F	Continued From page 3 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all 38 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between the hours of 8:00AM and 11:00 AM on 05/19/2015, observations revealed that the heating, ventilation, and air conditioning systems for the building is using the corridor system as part of the air distribution system for make-up air for the bathrooms exhaust. This does not meet Exception 2 of NFPA 90A (1999 edition), Section 2-3.11.1 that allows over-pressurized corridors. This deficient practice was confirmed by the facility Maintenance Director (RW) at the time of discovery.	K 067	**K067** **See attached waiver request.**	

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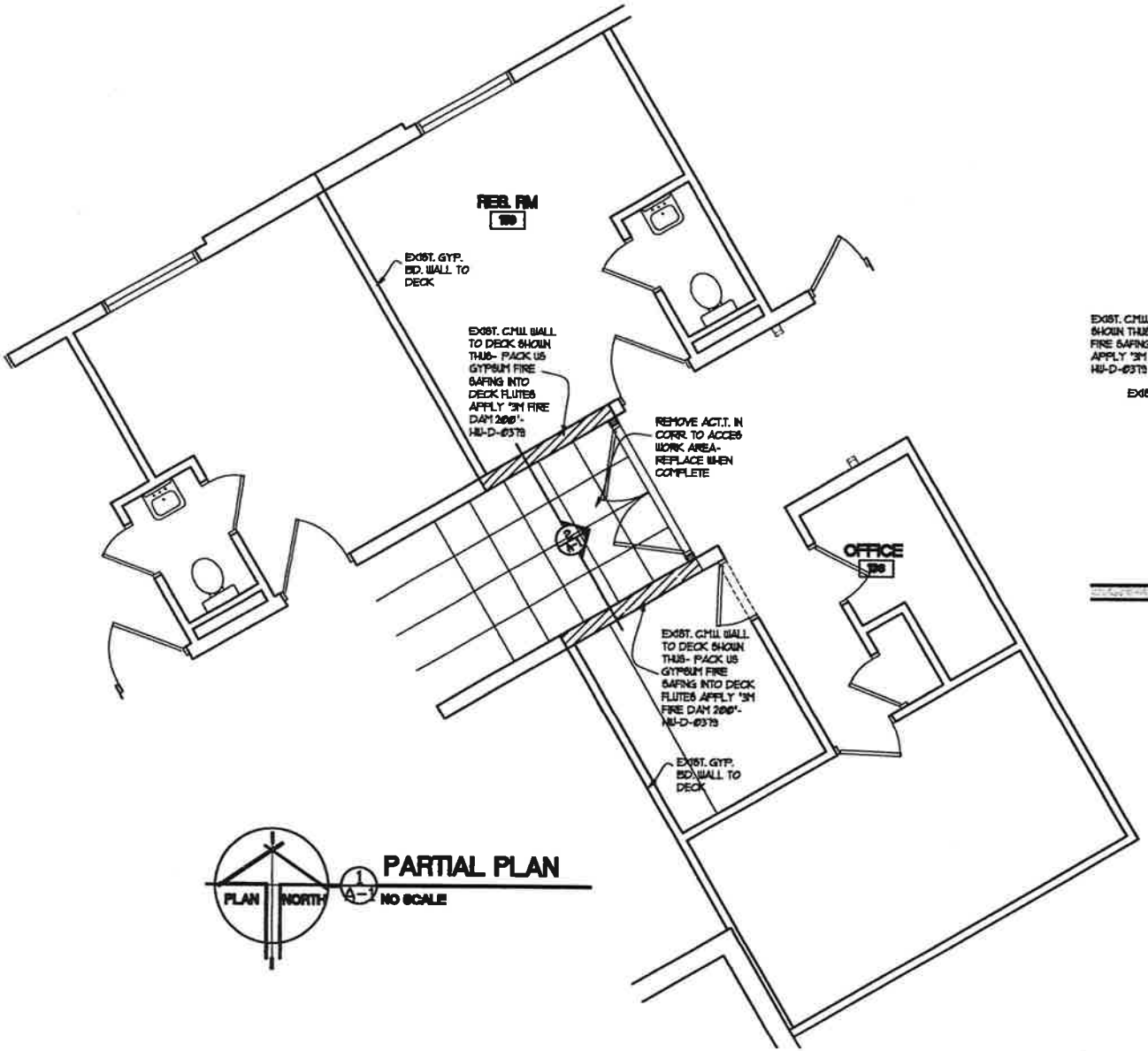
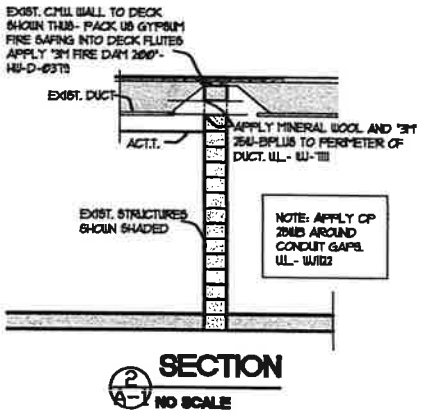
K-TAG 25
PLAN OF CORRECTION

GOLDEN LIVING DELANO
DELANO, MN.





Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, June 25, 2015 1:12 PM
To: rochi_lsc@cms.hhs.gov
Cc: 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 Sheehan, 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	GLC Delano	2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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 annual/continuing waiver is being requested for K067. A) Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: ➢ 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 the project is now bid at $274,225. ➢ There are concerns that penetration of load bearing walls on both wings would sacrifice the structural integrity of the facility. ➢ 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 until the construction is complete. The increase in noise and stimulation from the construction would also create an unreasonable hardship for those residents that suffer from dementia and related illnesses. ➢ 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 building was purchased by Beverly Healthcare in 1967. It was acquired via merger by Golden Living in 2006. Estimates of usable remaining life are 15 years after the merger, or until 2021.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date 6-25-15

Name of Facility

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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	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. ➢ The facility is protected by a supervised automatic sprinkler system.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date 6-25-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**05/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30 DELANO, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 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 18 New Health Care. This facility will be surveyed as two separate buildings: Golden Livingcenter Delano building # 2 is a 1-story addition with no basement. An addition was constructed in 2008 and was determined to be Type II (000) to the East Wing. The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000	KB 6-25-15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 17-20, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	RECEIVED JUN 17 2015 MN Dept of Health St.Cloud Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 3333 West Divison Street, Suite 212 St. Cloud, MN 56301 c/o Brenda Fischer, Unit Supervisor	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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 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 and its resolution.	2 435		

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2 435	Continued From page 2 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 4/14/15 by the social service department. There was no mention of the previous roommates that R70 had. During an interview on 05/19/2015 8:38 a.m., the	2 435		

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2 435	Continued From page 3 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.	2 435		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder	2 910		

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2 910	Continued From page 4 receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive bladder assessment was completed for 1 of 1 residents (R23) who was incontinent of urine following removal of an indwelling urinary catheter. Findings include: R23's minimum data set (MDS) dated 3/13/15 indicated R23 was continent of bladder with indwelling catheter, and required total assistance of two staff for transfers. R23's quarterly MDS dated 4/22/15 indicated R23 was frequently incontinent of bladder, had no bladder plan and required total assistance of two staff for transfers. During an observation of R23 on 5/17/15 at 4:08 p.m., resident's room had a strong urine odor and his bed sheets had been removed. An unidentified nursing assistant who was in the resident room at this time stated the sheets were wet and required changing. During an observation of R23's room on 5/18/15 at 8:30 a.m., R23's bed did not have any bed linens. Review of the facility Nursing Progress note, dated 3/18/15, indicated R23's urinary catheter was removed, a urinal was placed at his bedside and staff were also to check and changed R23 every 2 hours.	2 910		

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2 910	Continued From page 5 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."	2 910		

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2 910	Continued From page 6 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.	2 910		

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2 910	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for the comprehensive assessment for urinary incontenance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (g-tube) prior to infusing medication and formula for 1 of 1 resident (R37) observed to have a tube feeding during the survey.	2 930		

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2 930	Continued From page 8 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.	2 930		

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2 930	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for the provision of care to those residents with gastro-intestional feeding tubes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390		

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21390	Continued From page 10 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	21390		

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	00933	A. BUILDING: _____ B. WING _____	05/20/2015

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21390	Continued From page 11 residents had their room number identified, and only two of the five residents had which unit of the facility they resided on identified. The sheet identified four of the five residents required antibiotic treatment for their infections. None of the five residents identified on the sheet had indication if their infection was a hospital acquired infection (HAI) or community `acquired infection (CAI). Further, their was no analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. The facility Line Listing of Resident Infections flow sheet, dated April 2015, identified five different residents in the facility had experienced possible infections. Four of the five residents had a type of infection identified, and all of the residents had their rooms, unit, symptoms, cultures, and treatment identified. Four of the five identified residents required antibiotic medication to treat their infections. Further, there was no analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. The facility Line Listing of Resident Infections flow sheet, dated May 2015, identified three residents had experienced infections so far during the month. Each resident, room and their unit were identified on the flow sheet. Resident symptoms were identified as the following: > R27 experienced, "100.5 [temperature] ... emesis X [times] 2 " and; > R50 experienced, "urgency, pain, difficulty voiding" and; > R48 experienced, "lethargy, glazed look".	21390		

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21390	Continued From page 12 R27 and R50 were identified to share a room, and all three of the identified residents resided on the North unit of the facility. A UA/UC (urinary analysis / urinary culture) was obtained for all of the residents, and R50 and R48 were identified as having e-coli (a bacteria) as the organism responsible for the infection. R50 and R48 required antibiotic medication to treat their symptoms. None of the residents on the form were identified has having an HAI or CAI as it was left uncompleted, and the sheet further lacked analysis or trending of the data to determine possible causes of the infections, screen for possible spreading of a similar symptom, or action plans to reduce further infections of the same type in the facility. When interviewed about the infection control program on 5/18/15, at 3:45 p.m., the director of nursing (DON) stated she was responsible for the facility program, and data is collected by review of nursing progress notes, physician orders, and the 24 hour report sheets. The collected infection control data is typically reviewed for trends and patterns during the facility Quality Assurance and Performance Improvement (QAPI) meetings, but it had not been completed for the past few months, "It's been a little weaker the past couple of months." Further, the DON stated no staff education was scheduled or had been completed "in the past couple of months" because of the identification and trend of e-coli urinary tract infections (UTI) on the North unit of the facility adding, "So much of what we do is informal." Although the facility had been collecting data regarding their identified infections, the facility failed to consistently collected data was reviewed for trends and patterns in order to analyze where	21390		

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21390	Continued From page 13 the infections were originating from, and implement actions plans to reduce the infections in the facility. R27, R50, and R48 all resided on the same unit of the facility and presented with symptoms of a UTI, two of them being diagnosed with a UTI from the same bacteria, and the facility failed to research the cause of these infections, or develop actions plans to reduce the risk of transmission to other residents in the facility. A facility Elements of an Infection Control Program policy, dated 1/9/15, identified several items an "effective infection prevention and control program incorporates", including, "Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation ..." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures for monitoring, tracking, trending and analyzing infections treated within the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's	21426		

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21426	Continued From page 14 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 by: 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 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. 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	21426		

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21426	Continued From page 15 to his home in the community. Further, R37 should have had a new TB symptom screening when he admitted to the facility. A facility Tuberculosis Exposure Control Plan, dated 1/6/15, identified, "It is the policy of this facility to screen patients/residents, associates, and other persons ... for M. tuberculosis infection at intervals outlined by CDC [Centers for Disease Control], state requirements, or facility prevalence." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review the facility's policy and procedures and educate the facility staff responsible for the provision of TB skin testing and symptom screening. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehsive self administration medication assessment was completed to determine safe medication administration for 1 of 1 residents (R24) observed	21565		

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21565	Continued From page 16 to receive medication through a nebulizer (breathing treatment) during the survey. Findings include: R24's significant change Minimum Data Set (MDS), dated 2/14/15, identified R24 had severe cognitive impairment. During observation on 5/17/15, at 6:10 p.m. R24 was laying in bed with her eyes closed, and the head of the bed elevated. R24 had a nebulizer mask on, but down around her neck while it was dispensing medication into the air. Registered Nurse (RN)-A entered the room at 6:11 p.m. and 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 R24 was sleeping and it would be OK to leave her alone with the nebulizer on, "so I just stepped out for a minute." Review of R24's Doctor Order Sheet, dated 5/13/15, identified an order for "DuoNeb Solution [medication used for choric obstructive pulmonary disease (COPD)] ... 3 ml [milliliters] inhale orally every 6 hours for Respiratory congestion." R24's physician orders did not identify an order to self administer her own nebulizer medications. R24's care plan, dated 2/16/15, identified R24 had "impaired cognition", and instructed staff to, "Administer medication as ordered." R24's care plan did not identify R24 was safe to self administer her own nebulizer medication. There was no indication the facility had completed a self administration assessment, to determine if R24 was safe to be left alone when the nurses administered the nebulizer treatment. During interview on 5/17/15, at 6:20 p.m. the	21565		

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21565	Continued From page 17 director of nursing (DON) reviewed R24's medical record and stated R24 was recently started on nebulizers. The DON was unable to identify any assessment of R24 regarding her ability to self administer her own nebulizer medications, or a physician order allowing her to do so. Further, the DON stated R24 should have been assessed for safety to self administer her own medications before being left alone with the nebulizer, "We need to do an assessment." A facility Self-Administration of Medications policy, dated 2/2007, identified, "If a resident desires to self-administer medications, an assessment by the IDT [inter-disciplinary team] will be completed and must show that the resident's cognitive, physical, and visual abilities are conducive to safe self administration of meds." Further, the policy directed, "A physician's order is required for a resident to self-administer medications." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for the provision of self admininstration of medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance	21630		

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21630	Continued From page 18 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 patches in the facility. Furthermore, the facility failed to ensure only licensed staff had access to resident medication. Findings include: 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."	21630		

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21630	Continued From page 19 The facility's single medication room was observed with licensed practical nurse (LPN)-C on 5/17/15, at 1:32 p.m.. The room was opened with a key, and a covered plastic container labeled "Hazardous Waste" was sitting on the counter with a yellow post-it note taped to the lid reading, "Coumadin [an anti-coagulant medication], Warfarin [Coumadin], Nicotine ONLY ... No Fentanyl Patches." The lid was removed from the container, and inside the following used Fentanyl duragesic patches were found: Four - 50 mcg [micrograms]/hr [hour] and; Three - 25 mcg/hr patches. LPN-C stated all of the nurses, and the staffing person have keys to the medication room door. Further, the used Fentanyl duragesic patches should not have been placed in the container, but rather flushed down the hopper [wash basin] in the Utility Room as used patches still contained some Fentanyl medication, and were at risk for theft or diversion, "The potential is always there." When interviewed on 5/17/15, at 3:08 p.m. the facility staffing coordinator (SC) verified she had a key that allowed access to the medication room. Further, she had the key for "maybe a year." During interview on 5/17/15, at 4:05 p.m. the assistant director of nursing (ADON) stated staff should be removing the patch from the resident, sticking it to a tissue, and flushing it down the drain. The ADON stated the SC was not a licensed nurse, and added staff should not have 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	21630		

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21630	Continued From page 20 dispensing pharmacy] is to flush them [used Fentanyl duragesic patches]." When interviewed on 5/18/15, at 10:50 a.m. the dispensing pharmacist (DP) stated the Food and Drug Administration (FDA) recommends to fold used patches in half and flush them down to drain to avoid theft and diversion of the narcotic. A facility Medication Destruction policy, dated 05/12, identified, "Destruction methods comply with federal and state laws and regulations", and listed a procedure which included, "Medications should not be flushed down the toilet or drain unless the package insert specifically instructs you to do so (i.e. Fentanyl patches) [refer to state laws and regulations]." An undated Duragesic (Fentanyl Transdermal System) package insert identified, "The high content of Fentanyl in the patches ... may be a particular target for abuse and diversion." Further, the insert identified a process for disposal of the patches which included bolded print of, "Flush the used Duragesic down the toilet right away. A used Duragesic patch may be dangerous for or even lead to death in babies, children, pets, and adults who have not been prescribed ..." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for the disposal of medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		

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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. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the	21880		

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21880	Continued From page 22 requirement for a written internal grievance procedure. This MN 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 which have a "dead horse smell" to them. R59 stated she voiced her concerns several times to the facility staff, but nothing had changed and staff still were still bringing the trash bins out in the hallway and leaving them set there for extended periods of time. Further, R59 stated she was bothered by having smelly trash cans in the hallway outside her room, "This is my home, and you don't have a trash can outside your room that smells like a dead horse." When interviewed on 5/18/15, at 1:36 p.m. 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	21880		

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21880	Continued From page 23 [about the trash bins] in the past though." During interview on 5/19/15, at 8:36 a.m., NA-B stated staff typically have the trash bins out in the hallway until 10:00 a.m., however they were told not to have equipment (including the trash bins) in the hallway during the State survey. Further, NA-B stated R59 had complained about the trash bins being in the hallway before, and added the bins should be kept in the closet "year round, not just when you guys [state surveyors] come." When interviewed on 5/19/15, at 8:45 a.m. the licensed social worker (LSW)-A stated she was not aware of any concern for R59 pertaining to the trash bins being kept in the hallway. Further, if staff were getting complaints about them, they should have reported this to management so a grievance resolution process could be started. A facility Grievance Process policy, dated 10/2009, identified, "All employees are responsible for ensuring customer satisfaction within the LivingCenter." Further, the policy directed staff to complete a grievance policy and turn it in "for processing." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for the following up on grievances. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		