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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1H5U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - MEADOW LANE**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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 **03/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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 **62** (L18)

13.Total Certified Beds **62** (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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	19		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 02/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/14/2014 (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
05/01/1986
(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
03/24/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5313

On March 12, 2014 A Post Certification Revisit by review of the plan of correction was completed. Based on the plan of correction, it has been determined that the facility has achieved substantial compliance pursuant to the January 10, 2014 standard survey, effective Febrauary 23, 2014. Refer to the CMS 2567b for the results of this visit.

Effective February 23, 2014, the facility is certified for 62 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5313

April 25, 2014

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, MN 56215

Dear Ms. Dillon:

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

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

Effective the above facility is certified for:

43 - Skilled Nursing Facility/Nursing Facility Beds

19 - Nursing Facility II Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

Sincerely,
Mark Meath, Enforcement Specialist
Mark Meath Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 16, 2014

Ms. Brooke Dillon, Administrator
Golden LivingCenter - Meadow Lane
2209 Utah Avenue
Benson, MN 56215

RE: Project Number S5313024

Dear Ms. Dillon:

On February 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2014, effective February 23, 2014 and therefore remedies outlined in our letter to you dated February 28, 2014, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5313r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245313	A. Building B. Wing	3/12/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **02/23/2014**	ID Prefix **F0160** Reg. # **483.10(c)(6)** LSC	Correction Completed **02/23/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **02/23/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/23/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/23/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/23/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/23/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/23/2014**	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	MM/GA	03/16/2014	28034	03/12/2014
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
1/10/2014			

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

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(L2) **306920600**

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(L3) **GOLDEN LIVINGCENTER - MEADOW LANE**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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 **01/10/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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 **62** (L18)

13.Total Certified Beds **62** (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
	43	19		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 02/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2014 (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
05/01/1986
(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
Posted 03/24/2014 CO. 1H5U

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5313

On January 10, 2013 a standardy survey was completed at this facility. Deficiencies were found with the most serioud deficiency at a scope and severity level of E. In addition at the time of the standard survey an investigation was conducted of complaint number H5313020. The complaint was unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6183

January 31, 2014

Ms. Brooke Dillon, Administrator
Golden Livingcenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

RE: Project Number S5313024 and Complaint Number H5313020

Dear Ms. Dillon:

On January 9, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 9, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5313020 that was found to be unsubstantiated.

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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Telephone: (218) 332-5140
Fax: (218) 332-5196

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 February 23, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 April 9, 2014 (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 July 9, 2014 (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
Division of Compliance Monitoring
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 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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
	245313	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 On 1/6/14 thru 1/10/14 a standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5313020 had not been substantiated during this survey. 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed at the time of the standard recertification survey. Complaint H5313020 was investigated and unsubstantiated during the survey.	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 the applicable state and federal regulatory requirements.**	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that	F 159	**F159** **-All staff have received education regarding procedures for access to personal funds after hours and on weekends.** **-Licensed staff have been educated regarding procedures for resident access to personal funds after hours and on weekends including forms and location of funds within the facility.** **- New staff will be educated regarding resident personal fund account during facility orientation.**	2-23-14

2/20/14 ok Edelgard

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

RMoore Dillon | Executive Director | 2-5-2014

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.

RECEIVED
FEB 12 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 159	Continued From page 1 account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents had access to their personal funds (resident trust account) after	F 159		

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F 159	Continued From page 2 business hours and on weekends for 1 of 2 residents (R29) identified as having a personal funds account; in addition, the facility failed to ensure residents and staff were aware of how to access resident personal funds after business office hours. This practice had the potential to affect 29 of 54 residents, who had personal funds accounts with the facility. Findings include: R29 did not have access to their personal funds account after business office hours. R29's quarterly Minimum Data Set (MDS) dated 9/20/13, indicated R29 was cognitively intact with no long or short term memory problems. On 1/6/14, at 3:56 p.m. R29 stated money from their personal funds account was not accessible on weekends. During a second interview on 1/10/14, at 8:11 a.m. R29 again confirmed being unable to receive money from their personal funds account on weekends and added being unable to access their account in the evening. R29 stated if the business coordinator (BC) "is not here, we can't get it." Staff were not aware of how to access resident personal funds accounts after business office hours. On 1/9/14, at 1:19 p.m. licensed practical nurse (LPN)-B stated she was unaware of staff access to resident trust fund money on weekends or after business hours. LPN-B stated If BC worked the weekend, residents could get money, if not, they had to "wait until Monday."	F 159		

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F 159	Continued From page 3 On 1/9/14, at 1:33 p.m. LPN-C stated there was no procedure for residents to access their funds during weekend and evening hours. LPN-C stated she directed staff to the BC, the administrator, or the director of nursing (DON) for money needs. On 1/10/14, at 9:46 a.m. DON stated she was unaware residents and staff were not utilizing a petty cash envelope, that was available after hours for resident needs. DON stated she would expect residents to have access to their trust funds as they needed, and was not aware staff had no knowledge of how to access funds for residents. On 1/10/14, at 10:00 a.m. BC stated the facility had a petty cash envelope system for staff to access residents personal funds after business office hours. BC verified the petty cash envelope had not been used for an extended period of time. BC stated she was concerned about staff not being aware of how to access funds for residents after business hours. BC also expressed concern residents did not know they could access their money any time, "It is their money, they should always have access." An undated facility policy entitled Resident Trust Fund/Valuables directed staff to reference state regulations regarding availability of funds requested after normal business hours. The policy directed how residents could start a trust account with the facility, identified the written authorizations the resident would need to open a trust account and identified the account must be interest bearing. In addition, the policy directed the use of receipts for deposits and withdrawals,	F 159		

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F 159	Continued From page 4 statements and closing the account in the event of a resident death or discharge. The policy lacked direction for accessing resident trust accounts, such as after business hours or on weekends. The policy lacked direction regarding use of a cash envelope on weekends and evenings; lacked direction on staff training and/or resident education on access of the trust accounts.	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident funds deposited into trust accounts upon death for 3 of 4 residents (R14, R24, R39) who had died. Findings include: The facility's trust fund "Trial Balance" report was printed and reviewed on 1/9/14. According to the report, the following residents (who had died greater than 30-days earlier) remained on the report with a status of "closed 1/9/14." R14 had died on 12/7/13. R14's trust account balance of $82.28 had not been conveyed to their family or R14's estate. The funds were still being	F 160	**F160** **-Refunds have been issued to all residents identified to be out of compliance in regards to reimbursement of personal funds.** **- FBOC to review personal funds by the 5th and 20th of each month to ensure funds are conveyed within the appropriate time frames.** **- ED/designee to complete an audit of personal funds by the 10th and 25th of each month for 3 months to ensure personal funds are conveyed within the appropriate time frames.** **- Results of these audits will be reviewed at QAPI**	2-28-14

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F 160	Continued From page 5 held by the facility. R24 had died on 12/6/13. R24's trust account balance of $648.46 had not been conveyed to their family or R24's estate. The funds were still being held by the facility. R39 had died on 12/1/13. R39's trust account balance of $27.59 had not been conveyed to their family or R39's estate. The funds were still being held by the facility. On 1/9/14, at 2:22 p.m. the business coordinator (BC) confirmed the above accounts to be closed and verified the trust funds had not been dispersed. BC stated she was expecting a return phone call from the county as to where the funds were to be sent. BC stated the usual process to review trust fund accounts was completed one time a month, during reconciliation of funds. BC confirmed the facility had not conveyed resident funds in the appropriate time frame for the deceased residents. BC confirmed the facility was still holding the balances of the trust funds for residents who had died more than thirty days prior. On 1/9/14, at 2:29 p.m. the director on nursing (DON) stated conveyance of trust fund monies were to be completed within 30-days of resident death. The facility's undated Resident Trust Fund/Valuables policy identified when a resident, whose funds were held and managed by the facility expired or was permanently discharged, the Business Office would ensure the balance of the account was refunded within 30-days of expiration or discharge from the facility.	F 160		

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident assessment accurately reflected the residents dental condition for 1 of 4 residents (R46) reviewed for dental status.	F 278	F278 - Resident R46 has been assessed for dental status. - Assessments for all residents have been reviewed for accuracy. - Clinical Health Status including oral assessment section has been reviewed with all staff and education given regarding completion. - Education has been provided to all staff regarding oral hygiene procedures including assessment guidelines. - DNS/designee with complete Audits of oral assessments 3x per week for 90 days to ensure assessments are complete and accurate for resident needs. - Results of these audits will be reviewed at QAPI.	2-23-14

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F 278	Continued From page 7 Findings include: R46's admission Minimum Data Set (MDS) dated 8/21/13, included severe cognitive impairment with a diagnosis of Alzheimer's disease. The MDS identified R46 had no natural teeth or tooth fragments and required extensive staff assistance with personal hygiene, including tooth brushing. The Care Area Assessment (CAA) dated 8/21/13, included R46 had no natural teeth or tooth fragments; R46 had full upper and lower dentures. R46's Dental Referral note dated 10/10/13, identified R46 had a "partial plate." R46's Quarterly Interdisciplinary Resident Review dated 11/5/13, identified R46 had a partial upper dental plate. On 1/8/14, from 7:03 a.m. until 7:20 a.m. nursing assistant (NA)-A was observed to perform R46's morning cares. NA-A stated when she provided oral hygiene assistance to R46, it included rinsing R46's oral cavity with mouth wash and applying a "partial plate." NA-A verified R46 did not have a full set of dentures as identified in the MDS and CAA; NA-A verified R46 had natural teeth. On 1/10/14, at 8:44 a.m. registered nurse (RN)-A stated R46 had a full set of dentures. RN-A was unaware R46 had any natural teeth. On 1/10/14, at 10:29 a.m. RN-A stated she had re-assessed R46, and confirmed R46 had natural upper teeth and a lower partial plate, not a full denture as identified on the 8/21/13 MDS. RN-A stated she had not performed a visual inspection of R46's oral cavity prior to coding the MDS.	F 278		

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F 278	Continued From page 8 RN-A stated she had relied on "reported" information. On 1/10/14, at 11:12 a.m., the director of nursing (DON) stated the MDS nurse should visually inspect the residents mouth to accurately assess their dental status and to accurately plan care for each resident. The CMS (Center for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) manual chapter 3 Section L: Oral/Dental Status, instructs the MDS coder to perform a visual inspection of the oral cavity with dentures or partial plates removed.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 - Resident R46 has had a care plan initiated regarding oral status including resident specific interventions. - All residents care plans have been reviewed for appropriate oral care interventions. - Education has been provided to all staff regarding oral hygiene procedures including care planning guidelines. - DNS/designee will complete audits 3 x per week for 90 days to ensure care plans are accurate for oral hygiene needs. - Results of these audits will be reviewed at QAPI	2-23-14

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F 279	Continued From page 9	F 279		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to develop an appropriate care plan regarding dental hygiene for 1 of 4 residents (R46) reviewed for dental status.

Findings include:

R46's admission Minimum Data Set dated 8/21/13, included a diagnoses of Alzheimer's disease and severe cognitive impairment; identified R46 had no natural teeth and required extensive assistance for personal hygiene, including brushing teeth. The Care Area Assessment (CAA) dated 8/21/13, identified R46 had upper and lower dentures, used psychoactive medications which could cause dry mouth and a build up of bacteria. The CAA indicated care planning would be completed to include twice a day oral cares.

R46's Quarterly Interdisciplinary Resident Review dated 11/5/13, identified R46 had a partial upper dental plate.

R46's Dental Referral Note dated 10/10/13, included she had a partial plate which was tightened. The note included, "A lot of debris in her mouth! Please brush!"

An undated, untitled, nursing assistant worksheet identified R46 had a partial plate, but did not direct staff to brush teeth twice a day.

On 1/8/14, from 7:03 a.m. until 7:20 a.m. nursing

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F 279	Continued From page 10 assistant (NA)-A was observed to perform R46's morning cares. NA-A stated when she provided oral hygiene assistance to R46, it included rinsing R46's oral cavity with mouth wash and applying a "partial plate." NA-A verified R46 did not have a full set of dentures as identified in the MDS and CAA; NA-A verified R46 had natural teeth and stated she had never brushed R46's natural teeth. Although R46's care plan dated 11/10/13, directed staff to assist in personal hygiene, the care plan lacked identification of what teeth R46 had, and failed to direct staff to brush R46's teeth twice daily as indicated by the CAA on 8/21/13. On 1/10/14, at 10:29 a.m. registered nurse (RN)-A verified R46's care plan lacked direction for R46's oral hygiene. RN-A stated oral hygiene was very important to R46's well-being and should have been included on the care plan. On 1/10/14, at 11:12 a.m. the director of nursing (DON) stated oral hygiene should have been included in R46's care plan. A facility policy entitled Oral Hygiene dated 2006, directed to ensure oral hygiene with specific needs and goals, was included as part of each residents' care plan.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312 - Oral care competencies have been completed for all nursing assists and all were able to provide a return demonstration regarding proper procedure for oral care - Education has been provided to all staff regarding oral hygiene procedures. - DNS/designee will complete audits 3x per week for 90 days to ensure oral care procedures are followed per policy. - Results of these audits will be reviewed at QAPI.	2-23-14

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F 312	Continued From page 11	F 312		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide the necessary oral care to 1 of 3 residents (R46) reviewed for activities of daily living.

Findings include:

R46's admission Minimum Data Set (MDS) dated 8/21/13, included diagnoses of Alzheimer's dementia and severe cognitive impairment. The MDS identified R46 had no natural teeth and required extensive assistance with personal hygiene, including brushing teeth. The Care Area Assessment (CAA) dated 8/21/13, indicated R46 had full upper and lower dentures, used psychoactive medications which may cause a dry mouth and build up of bacteria. The CAA indicated a care plan would be developed to address these issues and to provided oral hygiene twice a day.

On 1/8/14, from 7:03 a.m. until 7:20 a.m. nursing assistant (NA)-A was observed to perform R46's morning cares. Although NA-A assisted R46 with morning cares, NA-A did not offer to perform any oral cares for R46. When interviewed at 7:20 a.m., NA-A stated all routine morning cares had been provided for R46. NA-A verified she had not assisted R46 with oral hygiene and confirmed oral hygiene should have been included with the morning cares. NA-A stated when she provided oral hygiene assistance to R46, it included rinsing R46's oral cavity with mouth wash and applying a "partial plate." NA-A verified R46 did not have a full set of dentures as identified in the MDS and

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F 312	Continued From page 12 CAA; NA-A verified R46 had natural teeth and stated she had never brushed R46's natural teeth. R46's Dental Referral Note dated 10/10/13, identified R46 had a "partial plate." The note indicated the partial was tightened to fasten to natural teeth and R46 had, "A lot of debris in her mouth! Please brush!" The note contradicted the MDS and CAA data and identified R46 had only a partial plate and natural teeth. R46's Quarterly Interdisciplinary Resident Review dated 11/5/13, identified R46 had a partial upper dental plate. The review contradicted the MDS and CAA data and identified the use of a partial. Although R46's care plan dated 11/10/13, included a personal hygiene focus, the care plan did not identify what natural teeth R46 had, did not identify R46 used a partial, and did not direct to perform oral hygiene twice a day as indicated in the CAA. In addition, the care plan did not include dental referral data such as to identify R46 had a lot of mouth debris and required more tooth brushing. On 1/10/14, at 8:44 a.m. registered nurse (RN)-A stated R46 should have had oral hygiene including brushing of the natural teeth, during morning cares. RN-A also stated oral hygiene should have been included on R46's care plan. On 1/10/14, at 10:09 a.m. the director of nursing (DON) stated she would expect oral hygiene to be performed during morning cares for R46. On 1/10/14, at 10:29 a.m. RN-A verified R46's admission MDS and CAA were inaccurate, and	F 312		

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F 312	Continued From page 13 R46 should have been assessed with oral cavity care, brushing her natural teeth and cleaning the partial plate. A facility Oral Hygiene policy dated 10/2006, included brushing of natural teeth as well as partial plates, and how to perform oral hygiene. The policy indicated oral hygiene would be based on the residents individual assessment of needs.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe environment for 1 of 1 resident R50 who utilized an ill fitting mattress. Findings Include: Review of admission Minimum Data Set (MDS) dated 11/14/13, identified R50 had diagnoses which included congestive heart failure, anxiety disorder and glaucoma. The MDS identified R50 was cognitively intact and required assistance with bed mobility and transfers. The Care Area Assessment (CAA) dated 11/20/2013, identified R50 had impaired cognition, physical limitations	F 323	F323 - Resident R50 has been assessed for safety risk r/t ill fitting mattress and mattress has been replaced. - All residents have been assessed for safety risk r/t mattresses and any issues identified have been resolved. - Current facility assessments have been updated to include that a visual review has been performed to assess that the mattress does not shift/slide allowing for an increased gap between the foot board, head board, and side rail. This assessment will be completed upon admission, quarterly and with sig. change. - Education has been provided to all staff regarding the new assessment, potential zones of entrapment. They have been educated that any issues identified will be reported to maintenance and the Director of Nursing/designee. - DNS/designee will complete audits 3x per week for 90 days to ensure mattresses are appropriate for bed frame and that assessments are complete and accurate. - Results of these audits will be reviewed at QAPI.	2-23-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 and required extensive assist of one with bed mobility, transfers, tolieting and was non ambulatory. Review of the care plan dated 12/4/13, identified R50 had fallen in the past, continued to be at risk for further falls and required one assist for activities of daily living including bed mobility, transferring and ambulation. In addition, the care plan identified R50 had impaired vision related to glaucoma. During observation on 1/7/14, at 3:07 p.m. the mattress was observed to be shorter then the length of the bed. There was a 7 inch gap from the foot end of the bed to the end of the mattress. There was a 1/1/2 inch gap from the head of the bed to the top of the mattress. In addition slight pushing of the mattress would cause the mattress to shift. On 1/7/14, at 3:48 p.m. nursing assistant (NA)-B stated R50 routinely required the assist of one for bed mobility and transfers. On 1/714, at 4:25 p.m. NA-C stated R50 required assist of one for transfers and bed mobility and confirmed the presence of the large gap with R50's mattress and bed frame. NA-C indicated she routinely pushed the mattress to the head of the bed when she assisted with cares. Review of Safety Risk Assessment dated 11/20/14, revealed R50 had been assessed for safe use of siderails and mattress. However, the form did not include a safety assessment of the ill fitting of mattress.	F 323		

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F 323	Continued From page 15 On 1/9/14, at 8:23 a.m. the director of nurses (DON) confirmed R50 mattress did not properly fit the bed frame. She stated she had been unaware of the ill fitting mattress and indicated the mattress would be immediately removed. The DON confirmed R50's safety risk assessment had not included assessment for the ill fitting mattress and confirmed the mattress posed a safety risk for R50. Further, the DON stated the facility utilized the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/2006 as facility policy regarding bed safety. The guidance identified the space between the inside surface of the head board or foot board and the end of the mattress may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosen head or foot boards.	F 323		
F 431 SS=E	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 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	F 431	**F431** - All medications identified with no expiration dates have been corrected. - A column has been added to the pharmacy order form Nurses to include medication expiration date on form when signing medications in from the pharmacy. Any medications identified without expiration date will be returned to pharmacy for correction. - Education has been given to all staff regarding policy regarding medication storage including expiration dates. - DNS/designee will complete audits 3x per week for 90 days to ensure expiration dates are present on all medications. These audits will include medication carts/ medication room review and audits to ensure expiration date is checked by licensed staff when meds are delivered from pharmacy. - Results of these audits will be reviewed at QAPI.	2-23-14

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F 431	Continued From page 16 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 include expiration dates on medications for 12 of 54 residents (R3, R23, R32, R35, R42, R49, R54, R55, R56, R58, R61 and R74) who received medications in the facility Findings Include: On 1/9/14, at 1:00 p.m. during observation of the Board and Care medication cart the following was observed: Two partially full cassettes of ECASA (enteric coated aspirin) and Naproxen(nonsteroidal anti-inflammatory) labeled with dose and directions for R56, lacked identification of expiration date of the medications. One partially filled cassette of	F 431		

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F 431	Continued From page 17 Atorvasastatian (used to treat high cholesterol levels) labeled with dose and directions for R35, lacked identification of an expiration date of the medication. Licensed practical nurse (LPN)-A was present during observation and verified the above findings. On 1/9/14, at 1:30 p.m. during observation of the East medication cart following was revealed: One partially filled cassette of Potassium labeled with dose and directions for R55, lacked identification of an expiration date of the medication. Two partially filled cassettes of Acidophilus and Acetaminophen with dose and directions for R3, lacked identification of an expiration date of the medication. One inhaler of Symbicort(anti-inflammatory to prevent bronchospasms) labeled with dose and direction for R23, lacked identification of an expiration date of the medication. One partially filled cassette of Tolterodine(used to treat urge incontinence) and one partially filled cassette of Metoprolol (used to treat high blood pressure) labeled with dose and direction for R42, lacked identification of an expiration date of the medication. The registered nurse (RN)-A was present during observations and verified the above findings. On 1/9/14, at t 2:00 p.m. observation of the West medication cart revealed the following: One partially filled cassette of Metropolol labeled with dose and directions for R49, lacked identification of expiration date of the medication. Four partially filled cassettes of Potassium Chloride, Triamt/HCTZ(used to treat high blood pressure), Primidone(barbituate used to treat seizures) and Citalopram(anti-depressant) labeled with dose and direction for R74, lacked direction of an expiration date of the medications. Partially filled	F 431		

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F 431	Continued From page 18 cassette of Furosemide(fluid pill) labeled with dose and direction for R32, lacked identification of an expiration date of the medication. One partially filled cassette of Trazodone(anti-depressant) labeled with dose and direction for R61, lacked identification of an expiration date of the medication. RN-A was present during the observations and verified the above findings. On 1/10/14 at 10:50 a.m., pharmacist (Pharmacist- A) stated the usual practice was to place expiration dates on all medications dispensed. Pharmacist-A confirmed the medications dispensed by this pharmacy had not included the medication expiration dates. At 11:00 a.m. pharmacist (Pharmacist- B) confirmed all medications dispensed from the pharmacy should have expiration dates identified. On 1/10/14, at 11:22 a.m. the director of nurses (DON) confirmed the medications lacked identification of the expiration dates. DON stated she would expect expiration dates to be checked prior to administering medications in the facility. Review of the facility's policy titled Medication Storage of Medications dated 12/08, revealed outdated medication would be immediately removed from stock and reordered from pharmacy.	F 431	**F441** **- Storage bags have been placed on all oxygen concentrators for storage of tubing during cares or when not in use.** **- Education has been provided to all staff regarding universal precautions and oxygen therapy policy.** **- DNS/designee will complete audits 3x per week for 90 days to ensure that tubing is placed in storage bags during cares and when not in use and to ensure that oxygen tubing does not touch the floor during cares and that infection control policies are in place.** **- Results of these audits will be reviewed at QAPI.**	2-23-14
F 441 SS=D	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	F 441		

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F 441	Continued From page 19 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen tubing and nasal cannula were stored in a manner to prevent the potential spread of respiratory	F 441		

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F 441	Continued From page 20 infection during the use of oxygen for 1 of 1 resident (R26) who utilized oxygen therapy. Findings include: R26 had diagnoses to include chronic obstructive pulmonary disease (COPD) and dementia. The quarterly Minimum Data Set (MDS) dated 10/2/2013, revealed R26 had severe cognitive impairment, and required extensive assistance of one for activities of daily living (ADL's). During continual observations on 1/8/14, beginning at 8:00 a.m. and ending at 8:33 a.m., nursing assistant (NA)-E was observed to assist R26 with morning cares. Upon entering the room and during R26's cares, the oxygen concentrator (located in the corner of the room and towards the end of her bed) was observed to be running, the oxygen tubing was connected to the oxygen concentrator and the tubing and nasal cannula were observed to be curled up on the floor at the end of R26's bed. - At 8:31 the director of nursing (DON) entered the room to assist NA-E with morning cares. NA-E asked DON if she would get R26's oxygen tubing for her. DON picked up the oxygen tubing from the floor and disconnected the tubing from the oxygen concentrator. DON proceeded to connect the oxygen tubing to R26's portable oxygen tank (located on the back of R26's wheelchair), rolled the oxygen tubing up, and hung the rolled tubing around the left handle of the wheelchair. - At 8:33 a.m. NA- E proceeded to get the oxygen tubing from the left handle of R26's wheel chair and applied the nasal cannula of the oxygen tubing to R26's nose (by inserting the prongs of the soiled nasal cannula into R26's nasal	F 441		

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F 441	Continued From page 21 cavities). NA- E then turned on the flow of oxygen from the portable tank. NA-E then brought R26 out of her room into the hallway, where another staff member took R46 to the dining room for breakfast. R26 continued to have the soiled nasal cannula applied to her nose. On 1/8/14, at 12:26 p.m. NA- E verified the above findings and stated R26's oxygen tubing should have been changed after it was observed to be on the floor. On 1/8/14, at 12:26 p.m. the infection control coordinator (ICC) confirmed she would expect staff to follow the policy and to either change the oxygen tubing for a new one or clean the part that was exposed to the face. On 1/8/14, at 12:43 DON confirmed the oxygen tubing was laying on the floor in R26's room and she did not get new oxygen tubing for R26 after it had been contaminated on the floor. DON also confirmed she would expect staff to follow the policy and get new oxygen tubing for R26 after being contaminated on the floor. The facility's undated Oxygen Therapy policy identified oxygen tubing should be stored to prevent potential contamination and as an accident hazard.	F 441		

Addendum for Plan of Correction for survey ended 1-10-2014.

F 159
-ED discussed the trust fund process at resident council meeting in January.
-ED is ensuring that the Business Office is monitoring trust balances weekly.
-Business Office is updating nurses weekly/as needed on resident trust balances for after hours request.
-Resident Trust Account Policy posted by Business Office. Policy includes who to contact to obtain trust funds on weekends and after hours.
-Review results at QAPI.

F 312
-Immediately corrected the residents plan of care. Updated the CNA assignments.
-This could affect all residents; nurse managers reviewed all residents and updated CNA assignment sheets and care plan to reflect issues identified during reviews.
- DNS/Designee follow up with any issues identified during audit findings.
- Review results at QAPI.

F 441
-Resident's 02 tubing was replaced.
-Purchased cloth storage bags that were place on all concentrators in use and in storage. Bags are removable to be cleaned as necessary/appropriate.
-This could affect all residents; nurse managers reviewed all residents using oxygen and placed storage bags on all concentrators in use.
-O2 tubing replaced for all residents weekly and as necessary per Treatment Administration Record.

Received via email from Brook Dillon 5:12pm 3/27/14

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

F5313022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety. At the time of this survey, Golden Living Center - Meadow Lane 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 19 Existing Health Care. Golden Living Center - Meadow Lane is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered 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 licensed capacity of 62 and had a census of 54 at the time of the survey.	K 000		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2014**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		