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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 25XU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **03/23/2012** (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 IMR	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 **75** (L18)

13.Total Certified Beds **75** (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)
_X_ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A ,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	75			
(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 :
Pat Halverson, Unit Supervisor 05/08/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 05/08/2012 (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
10/01/1978
(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 5/11/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5222
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 9, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 23, 2012 the Minnesota Department of Health completed a Post Certification Revisit by review of the plan of correction. Based on the plan of correction, it has been determined that the facility had achieved substantial compliance pursuant to the standard survey completed on February 9, 2012, effective March 20, 2012. Therefore, the remedies outlined in our letter dated February 17, 2012 will not be imposed. See attached CMS-2567B for the results of the March 23, 2012 revisit.

The request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5222

May 8, 2012

Mr. Timothy Johnson, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Johnson:

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 March 20, 2012 the above facility is recommended for:

75 Skilled Nursing Facility/Nursing Facility Beds

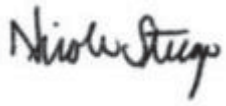
Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.
.
We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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,



Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 8, 2012

Mr. Timothy Johnson, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222021

Dear Mr. Johnson:

On February 17, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2012. 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 March 23, 2012, 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 February 9, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2012, effective March 20, 2012 and therefore remedies outlined in our letter to you dated February 17, 2012, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the February 9, 2012 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5222R12.rtf

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	(Y3) Date of Revisit
245222	A. Building B. Wing	3/23/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **03/20/2012**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/20/2012**	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** PH/NCS	**Date:** 5/8/12	**Signature of Surveyor:** 12835	**Date:** 3/23/12
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/9/2012

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: 25XU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

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2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **02/09/2012** (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 IMR	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 **75** (L18)

13.Total Certified Beds **75** (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)
X 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*,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	75			
(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 :
Katie Killoran, HFE-NEII 03/22/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/03/2012 (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
10/01/1978
(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 4/5/2012 ML
AW K67 LSC in ACO 04/05/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5222
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 9, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0374

February 17, 2012

Mr. Timothy Johnson, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222021

Dear Mr. Johnson:

On February 9, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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:

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637

Fax: (218) 723-2359

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 March 20, 2012, 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 March 20, 2012 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 May 9, 2012 (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 August 9, 2012 (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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5222S12.rtf

RECEIVED
MAR 0 5 2012
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY 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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	F156 • Education has been provided on Medicare guidelines for denial letters to RNAC and DNS. • ED/designee will audit to ensure denial letters issued timely • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS and RNAC responsible. • Completion date: March 20, 2012 OK 3/22/12 PCN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jim Johnson	Executive Director	3-1-2012

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
	245222	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control	F 156		

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure 3 of 4 residents R54, R83 R90 in the sample received the medicare	F 156		

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F 156	Continued From page 3 mandatory denial notice and expedited decision notice. Findings include: The facility did not notify R54, R83 and R90 that their Medicare covered services would terminated two days prior to the end of their services. R83 and R90's last day of Medicare Benefits was on 10/7/11. The facility did not give R83 and R90 a denial notice and/ or an expedited decision notice indicating their benefits had exhausted. R54's benefits exhausted on 11/16/11. R54's representative was notified by telephone and facsimile on 11/18/11. On 2/9/12, at 8:55 a.m. the minimum data set (MDS) registered nurse (RN)-C stated that R54 was at another facility and used Medicare days there. RN-C stated she realized the error on 11/18/11, when R54's conservator was notified by telephone and facsimile. R83 and R90 did not receive denial letters. RN-C stated that she started in the middle of May, 2011 and did not realize until January 2012, that denial letters needed to be given 2 days prior to therapy ending. On 2/8/12, at 2:00 p.m. the director of nursing (DON) stated that residents are to receive notice 48 hrs in advance that Medicare skilled services would be ending. The DON was unaware until January that denial letters needed to be given 2 days prior to therapy ending.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 4 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility did not ensure a clean odor free environment for 1 of 3 of residents R7 in the sample reviewed for incontinence. Findings include: R7's diagnoses included dementia, depression, anxiety and urinary incontinence. The annual Minimum Data Set (MDS) dated 11/30/11, indicated R7 had short and long term memory impairment and severely impaired cognitive skills for daily decision making skills. The MDS also indicated R7 was frequently incontinent of bowel and bladder and needed extensive assist of 2 staff for toileting needs. At 11:26 a.m. on 2/7/12, R7's mattress cover was observed to have large urine stains measuring 4 ft. long and 2 ft. wide and a strong urine odor was noted. At 8:30 a.m. on 2/9/12, the Director of Nursing (DON) observed the mattress along with the surveyor. The DON removed the stained mattress cover to inspect the mattress. The mattress liner was noted to be ripped in several places which allowed urine to soak through onto the mattress itself. The DON verified the mattress was soiled and stated, "the liner has failed".The	F 241	F241 • Resident #7 had mattress replaced on 2/9/12, during survey. • All mattresses in facility were audited to ensure mattress cover and mattress is in good condition and odor free. • Housekeeping and nursing staff will be educated to inform their supervisor if mattress condition requires attention/possible replacement. • Housekeeping supervisor /designee will complete random weekly audits of mattress condition. • Housekeeping supervisor/designee will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Housekeeping supervisor will be responsible. • Completion date: March 20, 2012 See addendum page 5b	

Addendum to Plan of Correction for F 241 s/s D

This addendum is created to address all potential sources of persistent odor, in addition to mattresses.

- Education will be provided to all staff regarding identification of potential sources of persistent odor and ideas how to resolve those odors. Staff will report all sources of persistent odor to housekeeping supervisor/ or designee.
- Those residents who are identified to contribute to persistent odors due to noncompliance issues with hygiene, incontinence or other personal care will have a care plan to address his or her noncompliance..
- ED or designee will complete weekly audit to identify any areas of persistent odors, and all odors identified during audit will be resolved.
- The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted.
- ED will be responsible
- Completion date: March 20, 2012

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F 241	Continued From page 5 DON stated the entire mattress needed to be discarded and replaced with a new one. Housekeeper (HSK)-A reentered R7's room and stated the mattresses are washed weekly with the bath schedule. HSK-A stated she thought she had reported the soiled mattress to her supervisor a couple weeks ago. The housekeeping supervisor (HS), interviewed at 11:48 a.m. on 2/9/12, stated he was not aware of the soiled mattress and the facility had extra mattresses in the basement if they need to replace any.	F 241	F247 • Facility has reviewed/revised policy for notification of new roommate • Admission coordinator and SS will be educated on policy • E.D./designee will do weekly random audits to ensure roommate notification occurs • E.D./designee will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • E.D./designee will be responsible. • Completion date: March 20, 2012	
F 247 SS=E	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 did not ensure 4 of 29 residents (R4, R50 R64, R51) in the sample were informed prior to receiving a new roommate. Findings include: On 2/06/12, at 4:54 p.m. R4 stated he was not given notice prior to a new roommate moving in. R4's minimum data set (MDS) dated 1/25/12, indicated he was cognitively intact. On 2/9/12, at 9:30 a.m. , R4 stated he was not informed verbally or with a written notice. "I was surprised, angry and disgruntled when the roommate moved	F 247		

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F 247	Continued From page 6 in but I have now adjusted to it and it is going fine." On 2/06/12, at 5:26 p.m. R50 indicated he received a new roommate without being informed by staff. "I found out when they moved in." R50's MDS dated 12/24/11, indicated he was cognitively intact. On 2/9/12, at 9:54 a.m. R50 stated he was not given a written or verbal notice of receiving a new roommate. R50 stated, "It pissed me off, it has been going okay but it would have been nice to know." On 2/07/12, 9:39 a.m., R64 indicated he was not given notice prior to a new roommate moving in. R64 stated one day he walked into his room and he had a new roommate. R64's MDS dated 1/24/12, indicated he was cognitively intact. On 2/9/12, at 1:00 p.m. R64 state he was not informed in writing or verbally when he was supposed to be getting a new roommate. R64 stated, "As I understand we are suppose to be told before we get a new roommate so I feel my rights have been somewhat violated." On 2/06/12, at 5:58 p.m. R51 stated he has had two new roommates. R51 stated, "no they did not tell me ahead of time. They just show up." R51's MDS dated 12/16/11, indicated he was cognitively intact. On 2/9/12, at 9:45 a.m., R51 stated he had never received written or verbal information that he was getting new roommates. R51 stated, "I would have liked to have known but it has worked out fine."	F 247		

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F 247	Continued From page 7 The social worker (SW), interviewed on 2/8/12, at 10:00 a.m., stated a written notification was given to the resident along with a verbal notification if the resident was available. Sometimes the resident could be out and when they return the notification and/or the new roommate is there. The SW stated the facility does not always know in advance other than a few hours if a resident will be getting a new roommate. On 2/8/12, at 3:30 p.m. the SW verified there was no documentation regarding notification of roommate change for R4, F50, R64 and R51. On 2/9/12, at 2:00 p.m. the administrator indicated it was the admission coordinators responsibility to notify a resident when they were to receive a new roommate. Many departments had a part in moving a new resident into the facility or another room. The administrator indicated he had informed staff to chart when the resident is notified they were getting a new roommate. The facility's resident room relocation policy revised 10/09, directed staff to introduce the new resident to the roommate. Inform the resident of the legal representative when he or she is receiving a new roommate.	F 247	F 253 • The 3rd fl. shower room ceiling will be repaired and painted. • The wallpaper border in the lobby on 3rd floor will be reattached/ or refinished. The brown/gold glue will be removed in the hallway at the end of 3rd floor. The wallpaper in 310 will be removed, reattached or refinished. The wall in 310 will be painted. The wallpaper in 211 will be reattached or refinished. • The sink in the utility room has been cleaned. The laminate on the vanity will be replaced. • The handrails on 3rd floor will be cleaned and/or refinished. • The elevator laminate panels will be refinished/ or replaced. • The exhaust vent in bathrooms of 302, 311, and 303 have been cleaned. • The corner of 317 by the bathroom has been cleaned. The wall in 317 will be painted. • The door of 312 and 211 will be repaired. • The dresser drawers in 310, 309, 305 and 403 will be repaired / or replaced. The laminate in 403 will be replaced. • The sticky labels on closets and/ or dressers in room 307, 205, and 215 will be removed.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		

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F 253	Continued From page 8 by: Based on observation, interview and document review the facility failed to maintain hallways, resident rooms, resident bathrooms, shower room and resident (R7) mattress in a sanitary manner on 3 of the 3 units. This had the potential to affect 72 of 83 residents in the facility. Findings include: The environmental tour of the facility was started on 2/8/12, at 1 p.m. Staff on the environmental tour included the administrator (ADM), the person in charge of maintenance (M-A), the person in charge of housekeeping (HK-B), and a corporate service manager (CSM). Shower room 303 had cracked plaster on the ceiling approximately 4 by 4 feet area. The cracked plaster was loose and bowing down and was uncleanable. The wallpaper border in the family room at end of the 300 hall was loose and hanging down for approximately one foot. Just above the table level in this family room the wallpaper was observed to have two, 6 inch long tears several inches apart. This table was observed to be used by residents. At the end of the 300 wing hall, under an approximately 5 foot window, the wall paper was dirty and stained with a brown/gold colored substance. The substance looked like it had dripped down from under the window at one time. There were at least 6 drip areas varying from 3 to 6 inches wide and 3 inches long. The double sink in the third floor dirty utility room had a moveable cover over half of sink. The cover had debris along the edges. When the cover was lifted the sink was dirty with stains, debris and dust. The front edge of the sink vanity had an approximately 5 inch piece of laminate	F 253	F253 continued • The radiator in 310 bathroom will be sanded to remove rust and painted with a rust proof paint. The 310 bathroom floor will be cleaned along the edge. The light switch will be cleaned and the cover replaced in 310 bathroom and 410 bathroom. Room 211 bathroom grab bar will be cleaned. Room 403 bathroom wall be patched and painted. • Resident #7 had mattress replaced on 2/9/12, during survey. • All housekeeping employees will be in serviced on the deep cleaning processes in resident rooms and bathrooms to include floors, walls, mattresses, and odors. • Housekeeping supervisor /designee will complete random weekly audits of mattress condition. • ED will complete weekly environmental rounds/audit to identify needed repairs, and cleaning. • ED/designee will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring	

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F 253	Continued From page 9 that was missing. This is an uncleanable service. The hand rails on the 300 wing were visibly dirty with a black, brown sticky substance that could be scraped off using a finger nail. This substance was scattered through out the hand rails but was the thickest by room 306. The elevator sides had laminate panels with at least four large chips out of them varying from 3 to 6 inches wide and long. These chips were deep enough to see the particle board under the laminate. Room 302 bath room exhaust vent was caked with dust. Room 317 corner by the bath room door had two brown smudges each at least 3 inches long. The door knob had dented the wall which had been repaired but not painted. Room 315 built in dresser drawers top edge approximately 3 feet long was missing the laminate edge leaving the particle board exposed. The hand support bar in the bath room was dirty at the seams with built up dirt that could be scrapped off. Room 312 edge of the door was sharp. Room 311 bath room exhaust vent was dirty with thick dust. Room 310 wall paper was torn in five places. The wall next to bed by the door had gray smears a foot long and six inch wide. The CSM-A indicated that was where the paint had been rubbed off. The built in dresser drawer had a chip out of it. The bath room heater had a 3 inch scraped area with rust coming through and many other areas on this heater where the paint had been scraped off. Along the edge of the floor under the heater was debris and hair. The light colored light switch was dirty and dark gray/black around the edges and at the switch. HK-C stated that he didn't	F 253	F253 continued process based on the compliance noted. • ED is responsible. • Completion date: March 20, 2012.	

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F 253	Continued From page 10 want housekeeping staff to clean this because of the safety risk of cleaning around electricity. Room 309 built in dresser drawer edge was sharp at knee height. All four drawers had small pieces of varied sizes of white paper labels on them that had been partly removed leaving some of the paper and glue behind. Room 307 built in dresser drawers had partially removed paper labels on them. Room 305 built in dresser drawers had two drawers that had an approximately 2 inch by 5 inch gap along the right side of each of drawers. Room 303 bath room exhaust vent was dirty with thick dust. Room 211 had a hole in bath room door approximately an inch in size. The hand grasp in 211's bathroom was dirty with built up dirt in the creases. Under the wall light, there was a two by 1.5 foot area of wall paper that was shredded. Room 205 had three built in dresser drawers with partially removed paper labels with resident names still visible. The resident names did not correspond with the current inhabitants of the room. Room 215 dresser drawers had partially removed paper labels on them. CSM-A indicated that it is hard to get the paper and glue off the drawers and did not have a satisfactory way to do this. Room 410 had a cracked and dirty light switch. Room 403 bathroom had a new soap dispenser, however, the holes and glue from the old soap dispenser remained on the wall. The built in dresser had chips and a 3 by 1.5 piece of laminate was missing. At the end of the environmental tour on 2/8/12, the administrator indicated that a monthly walk through of the facility with HK-B and M-A takes place and many of the above issues have been	F 253		

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F 253	Continued From page 11 identified. Review of the current work orders and the January's deep cleaning schedule indicated that the above issues have not been noted or addressed as of 2/8/12. At 11:26 a.m. on 2/7/12, R7's mattress cover was observed to have large urine stains measuring 4 ft. long and 2 ft. wide as well as a strong urine odor. At 8:30 a.m. on 2/9/12, the Director of Nursing (DON) observed the mattress along with the surveyor. The DON removed the stained mattress cover to inspect the mattress. The mattress liner was noted to be ripped in several places which allowed urine to soak through onto the mattress itself. The DON verified the mattress was soiled and stated, "the liner has failed".The DON stated the entire mattress needed to be discarded and replaced with a new one. Housekeeper-A stated the mattresses are washed weekly with the bath schedule.	F 253	F 282 • Resident #59's fingernails were trimmed on 2/9/12, during the survey. • The care plan for Resident #59's nail care, will be reviewed and revised if indicated. • Audit of all residents' fingernails will be completed to ensure they are trimmed to appropriate length. • Audit of current residents' CPs regarding fingernail care will be reviewed and revised if indicated. • Nursing staff will be educated on providing care in accordance with the care plan. • DNS/designee to observe fingernail care provided on 2 residents per week to ensure they are completed in accordance with the plan of care. • DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: March 20, 2012	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility did not ensure the care plan was followed for 1 of 16 residents R59 who were reviewed for grooming needs. Finding include: R59 was not provided nail care according to his	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 282	Continued From page 12 plan of care. R59 had diagnoses which included quadriplegia, contracture of the left hand (significant loss of motion to a joint resulting in immobility) and anxiety. The quarterly Minimum Data Set (MDS) dated 11/2/11, indicated R59 had no cognitive impairment and required extensive assist from staff for personal hygiene. At 4:58 p.m. on 2/6/12, R59's left hand and fingers were observed to be contracted. His fingernails were noted to be approximately 1/4 inch long and were digging into his hand leaving indentations on his skin. R59 stated he would like his nails to be trimmed. R59's care plan dated 12/2/11, directed staff to provide nail care as needed (PRN). On 2/9/12, at 9:55 a.m. Registered Nurse (RN)-E verified R59's long fingernails. RN-E stated that resident finger nails are checked weekly during the skin inspection and trimmed by nursing assistants with bathing.	F 282	F 312 • Resident #59's fingernails were trimmed on 2/9/12, during the survey. • Audit of all residents' fingernails will be completed to ensure they are trimmed to appropriate length. • Nursing staff will be educated on providing care in accordance with the care plan. • DNS/designee to observe fingernail care provided on 2 residents per week to ensure they are completed in accordance with the plan of care. • DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS will be responsible. • Completion date: March 20, 2012	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 312		

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F 312	Continued From page 13 review the facility did not ensure grooming needs were provided for 1 of 3 residents R59 in the sample reviewed for ADL's. Findings Include: R59 was not provided nail care according to his plan of care R59 had diagnoses which included quadriplegia, contracture of the left hand (significant loss of motion to a joint resulting in immobility) and anxiety. The quarterly Minimum Data Set (MDS) dated 11/2/11, indicated R59 had no cognitive impairment and required extensive assist from staff for personal hygiene. At 4:58 p.m. on 2/6/12, R59's left hand and fingers were observed to be contracted. His fingernails were noted to be approximately 1/4 inch long and were digging into his hand leaving indentations on his skin. R59 stated he would like his nails to be trimmed. R59's care plan dated 12/2/11, directed staff to provide nail care as needed (PRN). On 2/9/12 at 9:55 a.m. Registered Nurse (RN)-E stated that resident fingernails are checked weekly during the skin inspection. Nursing assistants are supposed to trim fingernails with bathing weekly. RN-E verified R59's fingernails had not been trimmed.	F 312	F329 • Resident #51's labs have been completed as ordered • All current residents' charts will be audited to ensure all lab orders in past 90 days have been completed as ordered. • Nursing will be educated on lab processing guidelines. • DNS/designee will complete random audit of lab orders to ensure completed as ordered. • DNS/designee will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on compliance noted • DNS/designee will be responsible • Completion date: March 20, 2012	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 14 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for use of medications for 1 of 10 resident (R51) in the sample reviewed for unnecessary medications. Findings include: Physician ordered lab test results were not found in the medical record. R51's physician orders included Glipizide (antidiabetic agent) 15 mg before meals, Lasix 20	F 329		

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F 329	Continued From page 15 mg every day for edema and Crestor (medication to reduce the total cholesterol). The physician's orders include lab tests to monitor the effect and potential side effect of the medications. R51 had diagnoses that included diabetes mellitus, hypertension, hyperlipidemia, seizure disorder and depression. Physician's orders dated 1/5/12, included the following lab tests: CBC a (complete blood count), A1C1 (measures average blood sugars levels) and fasting lipids (measures total cholesterol). Record review on 2/8/12 indicated the lab test results were not in the medical record. The registered nurse (RN)-C, interviewed on 2/8/12, at approximately 2 p.m., stated the lab test results could not be located and there was no evidence to indicate that R51 refused the blood draw. RN-C verified the lab tests were not completed.	F 329	F356 • Hours posting sheet has been updated to include, facility name, resident census, total # of RNs, LPNs and NAs and total hours on each shift. • Staffing Coordinator / Nursing charge educated on expectation that posting sheet must be posted by beginning of shift • E.D./designee will complete random audits to ensure compliance • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Administrator will be responsible. • Completion date: March 20, 2012	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		

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F 356	Continued From page 16 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility did not ensure the total number of nursing staff hours was posted fore each shift. The facility did not include the name of their facility or the resident census on the posting. This had the potential to affect all 41 residents residing in the facility. Findings include: On entrance to the facility on 2/6/12, at 2:00 p.m., the number of nursing staff working each shift was posted for the week of 1/30/12 through 2/5/12. The posting did not include how many staff and how many total hours on each shift. The facility nursing staff postings dated 1/23/12 through 2/9/12, lacked the facility name, the resident census and the total hours for each category of nursing staff for each shift. On 2/9/12, at 11:35 a.m., the staffing coordinator verified the nurse staff posting did not include the	F 356		

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F 356	Continued From page 17 number of hours per shift.	F 356		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, March 15, 2012 2:47 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'Johnson, Timothy 20 [LC00871]'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Golden Living Center Chateau (245222) K67 Annual Waiver Request

This is to inform you that GLC Chateau is requesting an annual waiver for K67, corridors as a plenum. The exit date was 2-9-12.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division, Est. 1905
Office: 651-201-7205, Cell: 651-470-4416
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility

GGNSC Minneapolis Chateau dba Golden Living Center - Chateau

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
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum	A. An annual/ continuing waiver is being requested for K-067 Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: 1. The most recent cost estimate for a complying HVAC dated March 14, 12 ^ $432,250.00 to upgrade the facility's HVAC system to comply with NFPA 90 2. A complying HVAC system will force the following disruptions to the facility residents: relocation of residents from 4 rooms at a time. The installation of required ductwork would reduce the headroom in the corridor (and/or sleeping rooms) below the minimums specified in LSC 3. Under the current CMS reimbursement rates, it is estimated to take approximately a minimum of 2-5 years to recoup the costs during with the following upgrades will be delayed or cancelled: equipment and furniture replacement, new nurse call system, tub, windows, and other upgrades. 4. Financing will add approximately $87,500 to $175,000 to the overall costs. 5. The building is 49 years old and is slated for replacement in a unknown amount of years. There are concerns about whether the building electrical system is adequate to handle the additional HVAC equipment required. There are concerns about whether the penetration of load bearing walls to install required ductwork would adversely affect the structural integrity of the building. B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because: 1. The facility type is II(222) construction and interior finishes of Class A or Class B. 2. The walls, floors, ceiling and vertical opening resist the passage of smoke. 3. The following life safety features are installed: EST and Notifier fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification; complete supervised automatic wet standpipe sprinkler system throughout; portable fire extinguishers on all units; pyrochem kitchen hood wet chemical system. Annual service and maintenance contracts exist. 4. In accordance with LSC 18.7.2.2/19.7.2.2, the facility has a compliant fire safety plan. 5. The facility addresses the following operation plans: Safe Smoking; Fire Watch; Fire Policy; Dryer safety. 6. The facility sets a staff to resident ratio at 4.68 hours per patient per day. 7. There are 2 smoke compartments per floor of the facility. 8. There is no TCU, and no memory care unit. Residents are located on the 2nd, 3rd, and 4th floor. 9 The closest fire department is .93 miles away and has an average response time of 2-4 minutes.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	Fire Safety Supervisor	State Fire Marshal	3-15-12

master

ENGINEERING ■ DEVELOPMENT ■ CONSTRUCTION

March 14, 2012

Mr. Timothy Johnson
Golden Living Center – Chateau
2106 Second Ave South
Minneapolis, MN 55404

RE: HVAC Request for Proposal – Air Distribution to Resident Rooms

Dear Mr. Johnson:

Master Properties Minnesota, LLC: Engineering, Real Estate, and Construction (Master) is pleased to provide you with the proposal to perform construction management services at the above note facility.

OVERVIEW OF PROJECT

As requested and proposed, our scope of work is to provide ventilation air to each resident room

Master proposes to Subcontract and manage the required Contractors to perform the work outlined below.

SCOPE

This project scope requires the installation of a new HVAC ductwork system that will provide distribution to the resident rooms. Our proposal is based on our site walk-thru and not engineered plans and specifications. We would utilize Design Build Contractors qualified to provide the required design/engineering for this project.

To meet the required air distribution, major structural and building alterations will be needed. The below noted proposal cost does NOT include costs related to structural engineer or costs associated with major structural work or major building alterations.

General Conditions: Master includes full time onsite supervision, project management, overhead, cleaning of our work, permits, fees and insurance. We anticipate that use of existing bathrooms, water usage, and electrical usage. We also anticipate that a dumpster for our debris can be place close to the building. Our proposal requires the ability to work in 4 resident rooms at the same time. Golden Living staff will coordinate safety or management of occupants around our work area. We have included an allowance of $ 10,000 for clean up in recognition that this healthcare facility and will remain in operation during the course of construction.

Mechanical HVAC: In order to provide 60-cfm's of ventilation air to each resident room, we propose the following; Extend existing ductwork that currently supplies the hallway of each floor. This ductwork will 10" x 25" and will extend down the entire hallway. At each resident room a 6" round supply duct will come off the large duct and enter the room. The ductwork will be exposed and un-insulated. Ductwork will be installed tight to the ceiling. In order for the existing air handling unit to accommodate the added static pressure from the new ductwork, we have included to increase the size of the blower motor. This scope will provide Design Build engineered plans, specifications, obtain permits and coordinate inspections.

Patching and Painting: Patching and painting of disturbed areas by the new HVAC installation and the new ductwork is included.

Page 2 - Golden Living Center – Chateau - HVAC Request for Proposal – Air Distribution to Resident Rooms

Exclusions:

- Governmental charges other than indicated herein
- Structural support and/or Structural verification
- Electrical work related to ductwork installation
- Low voltage work related to ductwork installation
- Costs associated with resident relocation
- Handling of residential personal property or FF & E
- Cost to produce 3rd party engineered plans & specifications
- Signage other then required by code
- Fire Extinguishers
- Work associated with hazardous materials, other then noted above
- Modifications to scope due to unforeseen conditions behind the existing construction

Proposed total for above scope of work: Four Hundred and Thirty Two Thousand and Two Hundred and Fifty Dollars.$ 432,250.00

Due to the current volatility of the market, this proposal is valid for thirty (30) days. Upon return receipt of the acceptance below and Notice to Proceed, Master will forward its standard contract for review and final authorization.

Please call or email should you have any questions and again Master thanks you for the opportunity to assist the Golden Living Center – Chateau with this work.

Sincerely,

Master Properties Minnesota, LLC
Greg Ottum
President
Direct: 612.236.1610
Cell: 612.396.5977
Email: grego@masterpropertiesmn.com

Signature Date

Printed Name Title

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2012

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

DC 03.21.12

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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Chateau 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.

EXIT: 02.09.12

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St. Paul, MN 55101-5145
Pat.Sheehan@state.mn.us

RECEIVED
MAR - 5 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
w/ AW for K67
3-15-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	3-2-2012

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 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. Golden Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 68 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 interviews, it could	K 067	K 067 Waiver requested. Refer to justification on form Part IV Recommendation for waiver of specific Life Safety Code provisions. ~~Completion date: March 20, 2012~~	

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K 067	Continued From page 2 not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/07/2012, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0374

February 17, 2012

Mr. Timothy Johnson, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5222021

Dear Mr. Johnson:

The above facility was surveyed on February 6, 2012 through February 9, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rule. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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 this office at Minnesota Department of Health, 320 West Second St, Room 703, Duluth, Minnesota 55802-1402. 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,

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00937	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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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 2/6/12 through 2/9/12, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

Minnesota Department of Health

Li Johnson Executive Director TITLE 3-1-12 (X6) DATE

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

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2 000	Continued From page 1 Certification Program; 320 West 2nd Street, Duluth, MN 55802	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 435	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	2 435		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility did not ensure 4 of 29 residents (R4, R50 R64, R51) in the sample were informed prior to receiving a new roommate.

Findings include:

On 2/06/12, at 4:54 p.m. R4 stated he was not given notice prior to a new roommate moving in.

R4's minimum data set (MDS) dated 1/25/12, indicated he was cognitively intact. On 2/9/12, at 9:30 a.m. , R4 stated he was not informed verbally or with a written notice. "I was surprised, angry and disgruntled when the roommate moved in but I have now adjusted to it and it is going fine."

On 2/06/12, at 5:26 p.m. R50 indicated he received a new roommate without being informed by staff. "I found out when they moved in."

R50's MDS dated 12/24/11, indicated he was cognitively intact. On 2/9/12, at 9:54 a.m. R50 stated he was not given a written or verbal notice of receiving a new roommate. R50 stated, "It pissed me off, it has been going okay but it would have been nice to know."

On 2/07/12, 9:39 a.m., R64 indicated he was not given notice prior to a new roommate moving in. R64 stated one day he walked into his room and he had a new roommate.

R64's MDS dated 1/24/12, indicated he was

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2 435	Continued From page 3 cognitively intact. On 2/9/12, at 1:00 p.m. R64 state he was not informed in writing or verbally when he was supposed to be getting a new roommate. R64 stated, "As I understand we are suppose to be told before we get a new roommate so I feel my rights have been somewhat violated." On 2/06/12, at 5:58 p.m. R51 stated he has had two new roommates. R51 stated, "no they did not tell me ahead of time. They just show up." R51's MDS dated 12/16/11, indicated he was cognitively intact. On 2/9/12, at 9:45 a.m., R51 stated he had never received written or verbal information that he was getting new roommates. R51 stated, "I would have liked to have known but it has worked out fine." The social worker (SW), interviewed on 2/8/12, at 10:00 a.m., stated a written notification was given to the resident along with a verbal notification if the resident was available. Sometimes the resident could be out and when they return the notification and/or the new roommate is there. The SW stated the facility does not always know in advance other than a few hours if a resident will be getting a new roommate. On 2/8/12, at 3:30 p.m. the SW verified there was no documentation regarding notification of roommate change for R4, F50, R64 and R51. On 2/9/12, at 2:00 p.m. the administrator indicated it was the admission coordinators responsibility to notify a resident when they were to receive a new roommate. Many departments had a part in moving a new resident into the facility or another room. The administrator indicated he had informed staff to chart when the resident is notified they were getting a new	2 435		

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2 435	Continued From page 4 roommate. The facility's resident room relocation policy revised 10/09, directed staff to introduce the new resident to the roommate. Inform the resident of the legal representative when he or she is receiving a new roommate. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of roomate/room change. All staff involved with notifying the resident of the changes could be educated regarding the procedure. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one(21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation interview and document review the facility did not ensure the care plan was followed for 1 of 16 residents R59 who were reviewed for grooming needs. Finding include: R59 was not provided nail care according to his plan of care.	2 565		

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2 565	Continued From page 5 R59 had diagnoses which included quadriplegia, contracture of the left hand (significant loss of motion to a joint resulting in immobility) and anxiety. The quarterly Minimum Data Set (MDS) dated 11/2/11, indicated R59 had no cognitive impairment and required extensive assist from staff for personal hygiene. At 4:58 p.m. on 2/6/12, R59's left hand and fingers were observed to be contracted. His fingernails were noted to be approximately 1/4 inch long and were digging into his hand leaving indentations on his skin. R59 stated he would like his nails to be trimmed. R59's care plan dated 12/2/11, directed staff to provide nail care as needed (PRN). On 2/9/12, at 9:55 a.m. Registered Nurse (RN)-E verified R59's long fingernails. RN-E stated that resident finger nails are checked weekly during the skin inspection and trimmed by nursing assistants with bathing. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop systems to ensure the comprehensive plan of care is readily available to all appropriate staff members. The Director of Nursing or her designee could educate all appropriate staff members on the need to use the comprehensive plan of care. The Director of Nursing or her designee could develop a monitoring system to ensure the plan of care is being used. TIME FOR CORRECTION: Twenty one (21) days.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet	2 860		

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2 860	Continued From page 6 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility did not ensure grooming needs were provided for 1 of 3 residents R59 in the sample reviewed for ADL's. Findings Include: R59 was not provided nail care according to his plan of care R59 had diagnoses which included quadriplegia, contracture of the left hand (significant loss of motion to a joint resulting in immobility) and anxiety. The quarterly Minimum Data Set (MDS) dated 11/2/11, indicated R59 had no cognitive impairment and required extensive assist from staff for personal hygiene. At 4:58 p.m. on 2/6/12, R59's left hand and fingers were observed to be contracted. His fingernails were noted to be approximately 1/4 inch long and were digging into his hand leaving indentations on his skin. R59 stated he would like his nails to be trimmed. R59's care plan dated 12/2/11, directed staff to provide nail care as needed (PRN). On 2/9/12 at 9:55 a.m. Registered Nurse (RN)-E stated that resident fingernails are checked	2 860		

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2 860	Continued From page 7 weekly during the skin inspection. Nursing assistants are supposed to trim fingernails with bathing weekly. RN-E verified R59's fingernails had not been trimmed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The Director of Nursing could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1)	21415		

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21415	Continued From page 8 low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on interview, policy review and personnel file review, the facility failed to complete a timely 2-step tuberculin skin testing (TST) for 2 of 2 employees (CNA-B and CNA-C) and did not have verification that they had a two step TST. Findings include: Review of employee files indicated that CNA-B	21415		

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21415	Continued From page 9 received two TST, but the tests were more than a year apart. Review of employee files revealed CNA-B was hired on 10/17/11. CNA-B had the first TST on 2/26/10, prior to being hired. The second TST was administered on 10/5/11, a year and 8 months after the first step TST. Review of employee files revealed CNA-C was hired on 1/12/12. CNA-C had the first step TST on 8/11/10, prior to being hired. The second step TST was on on 12/30/11. This was a year and 4 months apart. The facility's policy on employee tuberculin skin testing was requested and two different policies were received. The facility's policy clarification dated 4/17/09 indicated that they would give the second step TST with in 1 to 3 weeks after the first test and would accept up to 3 months between the TST. The second revised policy dated October 2011 indicated that the initial TB testing will be the two step TST. The second TST is to be administered 1 to 2 weeks after the first test. Review of the Annual Tuberculosis Risk Assessment indicated the facility was at medium risk for TB and would do annual TST of employees On 2/8/11, at 3:15 p.m. the director of nurses (DON) and infection control consultant verified that CNA-B and CNA-C had not received the two step TST in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could	21415		

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21415	Continued From page 10 monitor to assure TB screening procedures were developed and implemented to ensure staff receive the two-step TST. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21415		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not ensure residents had a chair or place other than the bed to sit on for 9 of 20 resident	21670		

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21670	Continued From page 11 rooms (rooms 201-B, 203-B, 207-A, 209-A, 209-B, 211-A, 211-B, 301-A, 301-B). Beginning on 2/6/12 at approximately 4:40 p.m., and continuing throughout the survey ending on 2/9/12 at 4:00 p.m., the above noted rooms were not furnished with chairs for residents or visitors to sit on. On 2/9/12 at 9:04 a.m. the director of nursing (DON-A) was interviewed and verified not all of the rooms were furnished with chairs. On 2/9/12 at 9:15 a.m., the administrator was interviewed and stated he aware there were resident rooms without chairs. The facility was unable to provide a policy and procedure on room furnishings. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing, Housekeeping and/or designee could monitor to assure that each resident room has a chair for resident's or visitors to sit on. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21670		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		

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21695	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain hallways, resident rooms, resident bathrooms, shower room and resident (R7) mattress in a sanitary manner on 3 of the 3 units. This had the potential to affect 72 of 83 residents in the facility. Findings include: The environmental tour of the facility was started on 2/8/12, at 1 p.m. Staff on the environmental tour included the administrator (ADM), the person in charge of maintenance (M-A), the person in charge of housekeeping (HK-B), and a corporate service manager (CSM). Shower room 303 had cracked plaster on the ceiling approximately 4 by 4 feet area. The cracked plaster was loose and bowing down and was uncleanable. The wallpaper border in the family room at end of the 300 hall was loose and hanging down for approximately one foot. Just above the table level in this family room the wallpaper was observed to have two, 6 inch long tears several inches apart. This table was observed to be used by residents. At the end of the 300 wing hall, under an approximately 5 foot window, the wall paper was dirty and stained with a brown/gold colored substance. The substance looked like it had dripped down from under the window at one time. There were at least 6 drip areas varying from 3 to 6 inches wide and 3 inches long. The double sink in the third floor dirty utility room had a moveable cover over half of sink. The cover had debris along the edges. When the cover was lifted the sink was dirty with stains, debris and dust. The front edge of the sink vanity had an approximately 5 inch piece of laminate that was missing. This is an uncleanable service.	21695		

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	00937	A. BUILDING _____ B. WING _____	02/09/2012

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21695	Continued From page 13 The hand rails on the 300 wing were visibly dirty with a black, brown sticky substance that could be scraped off using a finger nail. This substance was scattered through out the hand rails but was the thickest by room 306. The elevator sides had laminate panels with at least four large chips out of them varying from 3 to 6 inches wide and long. These chips were deep enough to see the particle board under the laminate. Room 302 bath room exhaust vent was caked with dust. Room 317 corner by the bath room door had two brown smudges each at least 3 inches long. The door knob had dented the wall which had been repaired but not painted. Room 315 built in dresser drawers top edge approximately 3 feet long was missing the laminate edge leaving the particle board exposed. The hand support bar in the bath room was dirty at the seams with built up dirt that could be scrapped off. Room 312 edge of the door was sharp. Room 311 bath room exhaust vent was dirty with thick dust. Room 310 wall paper was torn in five places. The wall next to bed by the door had gray smears a foot long and six inch wide. The CSM-A indicated that was where the paint had been rubbed off. The built in dresser drawer had a chip out of it. The bath room heater had a 3 inch scraped area with rust coming through and many other areas on this heater where the paint had been scraped off. Along the edge of the floor under the heater was debris and hair. The light colored light switch was dirty and dark gray/black around the edges and at the switch. HK-C stated that he didn't want housekeeping staff to clean this because of the safety risk of cleaning around electricity. Room 309 built in dresser drawer edge was sharp	21695		

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21695	Continued From page 14 at knee height. All four drawers had small pieces of varied sizes of white paper labels on them that had been partly removed leaving some of the paper and glue behind. Room 307 built in dresser drawers had partially removed paper labels on them. Room 305 built in dresser drawers had two drawers that had an approximately 2 inch by 5 inch gap along the right side of each of drawers. Room 303 bath room exhaust vent was dirty with thick dust. Room 211 had a hole in bath room door approximately an inch in size. The hand grasp in 211's bathroom was dirty with built up dirt in the creases. Under the wall light, there was a two by 1.5 foot area of wall paper that was shredded. Room 205 had three built in dresser drawers with partially removed paper labels with resident names still visible. The resident names did not correspond with the current inhabitants of the room. Room 215 dresser drawers had partially removed paper labels on them. CSM-A indicated that it is hard to get the paper and glue off the drawers and did not have a satisfactory way to do this. Room 410 had a cracked and dirty light switch. Room 403 bathroom had a new soap dispenser, however, the holes and glue from the old soap dispenser remained on the wall. The built in dresser had chips and a 3 by 1.5 piece of laminate was missing. At the end of the environmental tour on 2/8/12, the administrator indicated that a monthly walk through of the facility with HK-B and M-A takes place and many of the above issues have been identified. Review of the current work orders and the January's deep cleaning schedule indicated that the above issues have not been noted or addressed as of 2/8/12.	21695		

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21695	Continued From page 15 At 11:26 a.m. on 2/7/12, R7's mattress cover was observed to have large urine stains measuring 4 ft. long and 2 ft. wide as well as a strong urine odor. At 8:30 a.m. on 2/9/12, the Director of Nursing (DON) observed the mattress along with the surveyor. The DON removed the stained mattress cover to inspect the mattress. The mattress liner was noted to be ripped in several places which allowed urine to soak through onto the mattress itself. The DON verified the mattress was soiled and stated, "the liner has failed".The DON stated the entire mattress needed to be discarded and replaced with a new one. Housekeeper-A stated the mattresses are washed weekly with the bath schedule. SUGGESTED METHOD OF CORRECTION: The Director of Environmental Services or his designee could develop a system to ensure the handrails; floors and other needed equipment are checked on a routine basis. The Director of Environmental Services or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The Director of Environmental Services or his designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there	21800		

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21800	Continued From page 16 are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not ensure 3 of 4 residents R54, R83 R90 in the sample received the medicare mandatory denial notice and expedited decision notice. Findings include:	21800		

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21800	Continued From page 17 The facility did not notify R54, R83 and R90 that their Medicare covered services would terminated two days prior to the end of their services. R83 and R90's last day of Medicare Benefits was on 10/7/11. The facility did not give R83 and R90 a denial notice and/ or an expedited decision notice indicating their benefits had exhausted. R54's benefits exhausted on 11/16/11. R54's representative was notified by telephone and facsimile on 11/18/11. On 2/9/12, at 8:55 a.m. the minimum data set (MDS) registered nurse (RN)-C stated that R54 was at another facility and used Medicare days there. RN-C stated she realized the error on 11/18/11, when R54's conservator was notified by telephone and facsimile. R83 and R90 did not receive denial letters. RN-C stated that she started in the middle of May, 2011 and did not realize until January 2012, that denial letters needed to be given 2 days prior to therapy ending. On 2/8/12, at 2:00 p.m. the director of nursing (DON) stated that residents are to receive notice 48 hrs in advance that Medicare skilled services would be ending. The DON was unaware until January that denial letters needed to be given 2 days prior to therapy ending. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents received a mandatory denial notice for Medicare and the expedited decision notice to traditional medicare beneficiaries who are receiving Medicare. The director of nursing or her designee could develop monitoring systems to ensure	21800		

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21800	Continued From page 18 ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation interview and document review the facility did not ensure a clean odor free environment for 1 of 3 of residents R7 in the sample reviewed for incontinence. Findings include: R7's diagnoses included dementia, depression, anxiety and urinary incontinence. The annual Minimum Data Set (MDS) dated 11/30/11, indicated R7 had short and long term memory impairment and severely impaired cognitive skills for daily decision making skills. The MDS also indicated R7 was frequently incontinent of bowel and bladder and needed extensive assist of 2 staff for toileting needs. At 11:26 a.m. on 2/7/12, R7's mattress cover was observed to have large urine stains measuring 4 ft. long and 2 ft. wide and a strong urine odor was noted. At 8:30 a.m. on 2/9/12, the Director of Nursing (DON) observed the mattress along with the	21805		

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21805	Continued From page 19 surveyor. The DON removed the stained mattress cover to inspect the mattress. The mattress liner was noted to be ripped in several places which allowed urine to soak through onto the mattress itself. The DON verified the mattress was soiled and stated, "the liner has failed".The DON stated the entire mattress needed to be discarded and replaced with a new one. Housekeeper (HSK)-A reentered R7's room and stated the mattresses are washed weekly with the bath schedule. HSK-A stated she thought she had reported the soiled mattress to her supervisor a couple weeks ago. The housekeeping supervisor (HS), interviewed at 11:48 a.m. on 2/9/12, stated he was not aware of the soiled mattress and the facility had extra mattresses in the basement if they need to replace any. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are treated with dignity. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		