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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2EYV

Facility ID: 00994

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **04/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Gloria Derfus, Unit Supervisor 04/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/23/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5348

On April 13, 2016 a health Post Certification Revisit (PCR) was completed to verify correction of health deficiencies re issued at the time of the February 24, 2016 survey. On March 10, 2016, the Department of Public Safety completed a PCR to determine compliance with the life safety code deficiencies pursuant to the February 24, 2016 survey. Based on the PCR, the facility was found to have corrected the remaining deficiencies for both health and life safety code, effective March 13, 2016.

As a result that the facility has achieved compliance. The Department has discontinued the Category 1 remedy of State monitoring, effective March 18, 2016.

In addition, the Department recommended the following action to the CMS Region V office:

- Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA) effective April 7, 2016, be rescinded. (42 CFR 488.417 (b))

Since, DPNA did not go into effect, the facility is not subject to a two year loss of NATCEP that was to begin, April 7, 2016.

Refer to the CMS 2567b forms for both health and life safety code.

Effective March 18, 2016, the facility is certified for 49 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245348

April 14, 2016

Ms. Kelly Nimke, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, MN 55069

Dear Ms. Nimke:

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 18, 2016 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Ms. Kelly Nimke, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348025

Dear Ms. Nimke:

On March 8, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 13, 2016. (42 CFR 488.422)

In addition, as authorized by CMS Region V Office, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 7, 2016. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 7, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on January 7, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on February 24, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 10, 2016, the Minnesota Department of Public Safety completed a PCR, and on April 13, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 24, 2016 and a standard survey completed on January 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18. 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 24, 2016 and the standard survey completed January 7, 2016, as of March 18, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 18, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 8, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 7, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 7, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 7, 2016, is to be rescinded.

In our letter of March 8, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 18, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245348		4/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 03/11/2016	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 03/18/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) GD/mm	DATE 04/14/2016	SIGNATURE OF SURVEYOR 18623	DATE 04/13/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/7/2016	[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245348 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	01/14/2016	LSC K0025	01/26/2016	LSC K0046	01/28/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0054	01/05/2016	LSC K0056	01/06/2016	LSC K0066	03/07/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	04/14/2016	27200	03/10/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/5/2016

[ ] 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: 2EYV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **02/24/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Christina Smith, HFE NEII — 03/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 04/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/23/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5348

On February 24, 2015 a Post Certification Revisit (PCR) was completed for the health deficiencies issued pursuant to the January 7, 2016 standard survey. Based on the PCR, the facility was found to not have corrected all deficiencies. The most serious deficiencies were isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections are required. Refer to the CMS 2567b for the results of this visit. PCR to follow.

As a result that the facility has not achieved substantial compliance. The Department imposed the Category 1 remedy of State monitoring, effective March 13, 2016.

In addition, Denial of Payment for new admissions must be imposed if a facility is not in substantial compliance three months after th last day of the survey identifying noncompliance. Thus, we recommended to the CMS Region V Office, who concurred with the Departments recommendation and has authorized this Department to notify you of the following imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA) effective April 7, 2016. (42 CFR 488.417 (b))

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP beginning, April 7, 2016.

Electronically delivered
March 8, 2016

Ms. Kelly Nimke, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348025

Dear Ms. Nimke:

On January 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 7, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required.

On February 24, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 16, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 7, 2016. The deficiencies not corrected are as follows:

F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 13, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 7, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 7, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Rush City is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 7, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later

than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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

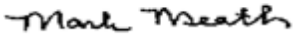
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	R 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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 An onsite post certification revisit (PCR) was completed on 02/24/16. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	{F 279}		3/11/16

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

Electronically Signed | 03/21/2016

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
	245348	A. BUILDING _____ B. WING _____	R 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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 279}	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a seizure care plan included resident specific seizure care and treatment interventions for 1 of 1 residents (R29) identified at risk for seizures. Findings Include: R29's admission record revealed multiple diagnoses including "other seizures" with an onset date of 12/18/15. Quarterly minimum data set (MDS) dated 12/28/15, indicated a diagnosis of seizure disorder. R29's plan of care dated 1/13/16, identified an impaired neurological status related to seizure disorder, history of seizure. The goals included to remain injury free. Interventions: Document length of seizure, seizure characteristics, any noted warning signs, state of postictal phase. If seizure is present, ensure safety. If seizure present, inject Diazempam (sic) per physician order for seizure lasting 60 seconds or more. The undated nursing assistant care plan, did not contain seizure care interventions for R29. R29 was included in a citation for seizure care plans during the survey exited 2/7/16. On 2/23/16, at 2:20 p.m. nursing assistant (NA)-A stated, "Seizures are a nurse thing. Her seizures just come on. I've witnessed a few. I just stay with	{F 279}	Care plan for R29 has been reviewed and updated to include individualized interventions for staff to take should a seizure occur for R29. Seizure tracking form has been implemented to document any seizure activity that occurs R29. CNA care sheets have been updated to identify residents with a history of seizures. Seizure intervention sheets have been placed in utility rooms for easy access to CNA's. Residents with seizure disorder have the potential to be affected if care plan and treatment interventions are not developed. Residents with a history of seizures have care plans developed to address individualized interventions to be taken should a seizure occur. Seizure tracking forms have been placed in resident charts for those residents with a history of seizures to document any seizure activity. IDT will review documentation, care plan, NAR sheets, tracking forms for any reported seizure activity at clinical start up. Negative findings will immediatly addressed and reproted to DNS. DNS will complete audits weekly of residents with a history of seizures to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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{F 279}	Continued From page 2 her and keep an eye on her. Usually lay her down. They last a few minutes." NA-A denied receiving any seizure training. On 2/23/16 at 4:17 p.m. NA-C was interviewed regarding the care and interventions for R29 during a seizure. NA-C stated, "I don't know anything about it. I make sure she is on her side away from everything, move her bed away from the wall and have someone get the nurse." On 2/24/16 at 10:26 a.m. the director of nursing (DON) was interviewed regarding R29's care plan, resident specific seizure protocol, and staff training provided on R29's seizures. The DON stated the nursing assistant was to stay with the resident and ensure the resident was safe. The DON indicated the care plan had been updated, but she did not update the nursing assistant care plan/group sheet. The DON verified R29's care plan was not specific to her seizures and was unable to explain R29's seizure type. The DON stated she would have to review R29's record in order to determine her seizure history and utilize the data to individualize the plan of care. The DON then added that she didn't understand why R29's seizure disorder needed to be included on the NA care plan. She further added she was unaware of a facility specific seizure tracking/assessment form for data collection. The DON also verified that R29's chart had not been audited. No other documentation or assessment regarding the care of R29's seizures was located or produced.	{F 279}	ensure the plan of care addresses individualized interventions for seizures. Audit will include a review of the seizure tracking form to ensure seizure activity is thoroughly documented. DNS will be the responsible party, negative findings will be addressed immediately and audit results will be discussed at QAPI.	
{F 281}	483.20(k)(3)(i) SERVICES PROVIDED MEET	{F 281}		3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	R 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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 281} SS=D	Continued From page 3 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Lidoderm patch prescribed for pain was administered as the physician ordered and according to standard pharmacy recommendations for 1 of 1 resident (R17) reviewed with a medication patch. Findings include: R17 had a physician's order dated, 6/26/14 and renewed on 7/19/15, for Lidoderm Patch 5% (Lidocaine), apply to mid back topically in the morning for back pain off at hour of sleep (HS) and remove per schedule. Lidocaine was used for relief of painful hypersensitivity and chronic pain in postherpetic neuralgia. R17 had a diagnosis of postherpetic neuralgia trigeminal neuralgia indicated on her medication administration record (MAR). The MAR for 2/16 indicated Lidoderm Patch 5% (Lidocaine), apply to mid back topically in the morning for back pain off at HS and remove per schedule. The MAR indicated that licensed staff and trained medical assistance (TMA)s were applying the Lidoderm patch at 5:00 a.m. and removing the patch at 8:00 p.m. The patch was on for a fifteen hours. On 2/24/16, at 9:49 a.m., licensed practical nurse (LPN)-B was asked to show this writer the	{F 281}	R17 Lidoderm Patch order was clarified by NP and corrected to reflect on 12hours off for 12 hours per manufacturer recommendations. DNS has reviewed all residents with orders for patch application to verify orders include application and removal instructions per manufacturer recommendations. Residents with Lidoderm patches may potentially be affected if manufacturer recommendations for application and removal are not followed. Nursing staff responsible for application and removal of patches have been re-educated on following the 5 rights of administration and the process to follow should discrepancies be noted. Emphasis was placed on verifying that order matches what label on the medication states. Discrepancies need to be clarified prior to administration. DNS to review new orders daily during clinical meeting to insure orders for patches include directions for application and removal. Visual check and documentation of patch application and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	R 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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 281}	Continued From page 4 Lidoderm patches. The label on the Lidoderm patches indicated the original physician order date order was on 6/24/14. The instructions on the label dispensed from pharmacy on 1/25/16 was as follows: Lidoderm Patch 5%, apply one patch daily, on 12 hours and off 12 hours. LPN-B went with this writer to observe the Lidoderm patch that was on R17 on 2/24/16 at 10:00 a.m. The Lidoderm patch was on the lower back and had been dated 2/14/16 but did not have a time when the patch had been applied. The MAR indicated that the most recent Lidoderm patch had been applied on 2/24/16 at 5:00 a.m. The audit forms were reviewed on 2/24/16 and indicated the facility was auditing the Lidoderm patch for the Lidoderm patch order if it was present and if the order had an on/off schedule in the Point Click Care (PCC) computerized chart. The audits were completed on 2/9/16, 2/15/16, and 2/22/16. Each entry indicated that the Lidoderm patch order was present and the order had an on/off schedule. The PharMerica 2012 reference guide was a specialized long-term care nursing drug book which was obtained from the director of nursing (DON). The reference indicated that the Patch (Lidoderm) was used for relief of painful hypersensitivity and chronic pain in postherpedic neuralgia. Apply patch to most painful area. Patch may remain in place up to 12 hours in any 24-hour period (page 648 and 649). The DON was interviewed on 2/24/16 at 10:30 a.m. and confirmed on the licensed staff and the TMAs had been applying the Lidoderm patch at	{F 281}	removal will be completed daily to insure patches are applied and removed per physician order. Weekly Audits continue to ensure Lidoderm Patch order accuracy. DNS will also audit weekly to ensure order matches pharmacy labels. Negative findings will be addressed immediately and reported at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	R 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 281}	Continued From page 5 5:00 a.m. and removing the patch at 8:00 p.m. The DON indicated that she had spoken to the nurse manager on the locked unit where R17 resided and that they were going to change the administration time of the patch to 8:00 a.m. when the resident would be awake. The DON confirmed that the direction on the label from pharmacy indicated the patch was to be on 12 hours and then off for 12 hours. The DON also confirmed that the facility's drug reference, PharMerica 2012, indicated that the patch was to be on for 12 hours and off for 12 hours. The DON confirmed that the facility had not been following the directions on the label from pharmacy. The DON was queried about what the expectations were of the licensed staff and the TMAs applying the patch when the MAR's directions were different from the label sent out by pharmacy. The DON's explained that her expectations of the staff applying the patch would have been for then to call the physician and pharmacy for clarification on how the Lidoderm patch was to be applied and when the patch was to be removed. The facility's pharmacy was called on 2/24/16, at 11:13 a.m. and pharmacist (PhD) was interviewed on the phone. The PhD confirmed that the pharmacy had been filling the Lidoderm prescription for the last three months with instructions for the Lidoderm Patch 5% to be on for 12 hours and off for 12 hours. The PhD further indicated that the way the facility was applying the Lidoderm patch was incorrect.	{F 281}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245348 Y1	A. Building B. Wing Y2	2/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0160	Correction	ID Prefix F0164	Correction	ID Prefix F0166	Correction
Reg. # 483.10(c)(6)	Completed	Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.10(f)(2)	Completed
LSC	02/16/2016	LSC	01/08/2016	LSC	02/16/2016
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0247	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(e)(2)	Completed
LSC	02/16/2016	LSC	02/16/2016	LSC	02/16/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed
LSC	02/16/2016	LSC	02/16/2016	LSC	02/16/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	02/16/2016	LSC	02/16/2016	LSC	02/16/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	CC/mm	03/08/2016	35567	02/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/7/2016

☐ 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: 2EYV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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

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

6. DATE OF SURVEY **01/07/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Kimberly Settergren, HFE NEII 02/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5348

At the time of the January 7, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections are requried. In addition, at the time of the standard survey, investigation of complaint number H5348010 was conducted and found to be unsubstantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 22, 2016

Ms. Kelly Nimke, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348025, H5348010

Dear Ms. Nimke:

On January 7, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 7, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5348010 that was found to be unsubstantiated.

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

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

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

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

Remedies - 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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 16, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 7, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date. We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000		
F 160 SS=D	An investigation of complaint H5348010 was completed and found not to be substantiated. 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident funds deposited into facility trust accounts within 30 days upon death for 3 of 4 discharged residents in the sample (R11, R38, R35) reviewed for personal	F 160	Resident funds have been conveyed to the estates of R11 and R38. Residents that have discharged and are no longer residing in the facility have the	2/16/16

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

Electronically Signed | 02/01/2016

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F 160	Continued From page 1 funds. Findings include: The facility's trust fund Trial Balance report was printed and reviewed on 1/6/16. According to the report, the following residents (who had died greater than 30-days earlier) remained on the report with a status of "closed 1/5/16." In addition a review of dispersed accounts identified a resident's account which had not been dispersed for 48 days after the resident passed. R11 had died on 11/12/15. R11's trust account balance of $2224.37 had not been conveyed to their family or R11's estate. The funds were still being held by the facility 55 days after R11 passed. R38 had died on 11/10/15. R38's trust account balance of $107.01 had not been conveyed to their family or R38's estate. The funds were still being held by the facility 57 days after R38 passed. R25 had died on 7/15/15. R25's trust account balance of $1363.75 had not been conveyed to their family or R25's estate with in 30 days. The funds were dispersed on 9/1/15, 48 days after R25 passed away. On 1/06/2016, at 1:27 p.m. the business office administrator (BOA) verified the facility protocol	F 160	potential to be affected if trust account funds are not dispersed within 30 days of discharge or expiration. FBOM has been educated on disbursement of resident trust funds to insure funds are disbursed within 30 days of discharge or expiration. Audits will be conducted within 30 days of resident discharge or expiration. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. ED will be responsible party.	

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F 160	Continued From page 2 for returning resident fund money balances had been to return monies within 30 days of the resident leaving the facility or passing. The BOA verified at this time R11 and R38's monies remained in the facility personal fund accounts. The BOA verified trust account funds for R11 and R38 had not been dispersed, greater than 30 days after death. The BOA also verified R25's personal funds had not been dispersed for 48 days after R25 passed. On 1/06/2016, at 2:33 p.m. the administrator verified resident funds were to be dispersed with in 30 days after a resident passed away. The facility policy titled Resident Trust Fund Policies dated 11/19/15, identified Closing Patient Accounts, to include "Resident trust fund expires or is permanently discharged, the business office will ensure that the balance of the account is refunded, and a full accounting provided, within 30 days of expiration or discharge..."	F 160		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		1/8/16

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F 164	Continued From page 3 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure specialized medical services remained confidential for 3 of 5 residents (R64, R14, R4) who received hospice services was visual for all to see. Findings included: On 1/6/16, at 12:21 p.m. R64, R14 and R4's personal medical charts were on a stationary shelving behind the nurses desk along with the other off white colored resident charts for the facility. The charts were in view of all who stopped at the desk. The following confidential information was visible: -A red binder which contained R64's medical	F 164	Confidential information has been removed from the chart labels for R4, R14, and R64 medical records. All residents have the potential to be affected if confidential information is readily available to the public. Medical records and hospice agencies have been educated on personal privacy/confidentiality of records. Blank spine binders with only residents name have been created to hold Hospice materials. Weekly audit will be conducted on chart labels to ensure confidential information is not visible to the public. Audit results will be reviewed at QAPI.	

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F 164	Continued From page 4 records, had a white label with red lettering which displayed R64's first name, first letter of the last name along with the words "HOSPICE" -A larger bright, white, binder contained R14's medical records. The chart was labeled with R14's first name, first letter of the last name and "hospice." -A black binder displayed R4's room number, full first and last name and "Hospice folder." On 1/06/2016, at 12:21 p.m. the (SC) staff coordinator/(LPN) licensed practical nurse verified R64, R14 and R4's charts were labeled identifying the residents received hospice services and the records were routinely stored on the stationary shelving, in view of all who stopped at the nurses desk. On 1/06/2016, at 12:26 p.m. the director of nursing (DON) confirmed hospice services was private, confidential information and stated the information "should not be for every one to see." The facility policy titled Health Information Management Manual dated November 2012, identified facility staff responsibilities to include "... will uphold the confidentiality of the medical record and protect the sensitive information contained within the medical record."	F 164	Medical records will be responsible party.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior	F 166		2/16/16

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F 166	Continued From page 5 of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unresolved grievances were acted on for 1 of 1 resident (R18) reviewed who had voiced concerns regarding the slamming of doors with the facility staff. Findings include: On 1/4/16, at 4:05 p.m. R18 was asked if she had any problems with the temperature, lighting, noise or anything else in the building that may affect her comfort. R18 stated "doors slamming." R18 stated she was bothered by the door slamming at all hours of the day and night. R18 stated she had told someone but nothing had been done about it and the door slamming was still going on. R18's quarterly Minimum Data Set (MDS) dated 9/23/15, indicated R18 had intact cognition, adequate hearing, had clear speech, was understood by others and others understood her. 1/7/16, 11:10 a.m. nursing assistant (NA)-C stated R18 and previous residents that resided in the same room had complained about the noise of the door slamming. NA-C stated the noise was from a door in the shower/hopper room. The shower/hopper room had an entry door to the shower area and then an entry door to the hopper	F 166	Noise from door closing has been resolved to satisfaction of R18. All residents have the potential to be affected if grievances are not brought forward and resolved. Education on grievance policy/procedure has been provided to all staff. Forms have been placed outside Social Service office along with the existing forms in the lobby. Random weekly interviews will be conducted to determine if grievances have been addressed and resolved. Quarterly meetings will ask as well to make sure all concerns are addressed. Audit results will be reviewed at QAPI. SSD will be responsible party.	

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F 166	Continued From page 6 (a soiled utility) room. At this time, NA-C opened and shut the hopper room door and it shut loudly. NA-C stated R18's room was on the other side of the wall of the shower/hopper room. NA-C stated she had reported the slamming door and the resident's complaints but could not remember to who. On 1/8/16, at 2:15 p.m. the maintenance director stated he was not aware of the complaint of the door slamming. On 1/8/16, at 2:17 p.m. the director of nursing stated she was not aware of the complaint of the door slamming. The facility's Grievance Guideline policy reviewed on 1/6/16, indicated all employees were responsible for ensuring customer satisfaction. If a resident or family member did not want to complete a grievance form it was the responsibility of the employee hearing the grievance to complete the form and submit the form for resolution and follow up.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		2/16/16

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F 225	Continued From page 7 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report alleged or potential mistreatment to the State agency and administrator for 1 of 5 incident reports reviewed which involved two residents (R4, R9) for abuse prohibition. In addition, the facility failed to ensure background checks were completed for 1 of 5	F 225	Reporting of alleged violation involving R4 and R9 has been completed. Background check has been completed for NA-G. All residents have the potential to be affected if alleged or potential	

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F 225	Continued From page 8 (NA-G) newly hired employees. This had the potential to affect 38 of 40 residents residing in the facility. Findings include: An incident report dated 4/6/15, indicated R4 put his hands under R29's shirt and touched her breast while in the dining room at 4:15 p.m. The report indicated the executive director (ED) and the State agency were notified of the incident on 4/7/15, at 10:00 a.m. not immediately, as required. R4's Admission Record printed 1/7/16, indicated R4 had diagnoses that included dementia, major depressive disorder, anxiety disorder and Alzheimer's Disease. R4's quarterly Minimum Data Set (MDS)dated 10/28/15, indicated R4 had a moderate impairment of cognitive skills for daily decision-making. R29's Admission Record printed 1/7/16, indicated R29 had diagnoses that included dementia with behavioral disturbance, delusional disorders, depressive disorder, borderline personality disorders and anxiety disorders. R29's comprehensive annual MDS dated 10/14/15, indicated R29 had a moderate impairment of cognitive skills for daily living. During an interview on 1/7/16, at 2:32 p.m. the director of nursing services (DNS), stated staff were directed to immediately report anything that	F 225	mistreatment is not immediately reported and thoroughly investigated. All residents have the potential to be affected if background checks on new hires are not completed prior to employment. Education has been provided to all staff on reporting requirements for alleged or potential mistreatment. BOM has been educated on requirements for required screening of new hires prior to employment. Weekly audits will be completed on all allegations of mistreatment to insure reporting is completed immediately. New hires will be audited prior to employment to insure required screening has been completed prior to hire. Audit results will be reviewed at QAPI. ED will be responsible party.	

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F 225	Continued From page 9 was a concern, even if it was questionable, to the DNS or the ED. During an interview on 1/7/16, at 4:20 p.m. the DNS verified the incident regarding R4 and R29 should have been reported right away and should not have waited until the next day. The facility was unable to provide evidence a criminal background check was obtained prior to employment for nursing assistant (NA)-G. NA-G was hired on 11/2/15, and had currently been providing care to the residents of the facility. On 1/7/16, at 5:18 p.m. the business office administrator stated the corporate human resources contact person was unable to provide the background check for NA-G. The facility's abuse policy dated 3/12, indicated all applicants for employment in the facility shall at a minimum have the following screening checks conducted: 1. Reference checks with the current and or past employer. 2. Appropriate licensing board or registry check. 3. Drug testing. 4. Fingerprinting. 5. Criminal background check.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		2/16/16

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F 226	Continued From page 10 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a policy related to the immediate reporting of alleged abuse and mistreatment to the administrator and State Agency for 1 of 5 incidents involving 2 residents (R4 and R29) reviewed for abuse prohibition. In addition, the facility failed to ensure background checks were completed as directed by facility policy for 1 of 5 newly hired employees. This had the potential to affect 38 of 40 residents residing in the facility. Findings include: An incident report dated 4/6/15, indicated R4 put his hands under R29's shirt and touched her breast while in the dining room at 4:15 p.m. The report indicated the executive director (ED) and the State agency were not notified immediately, rather were notified the next day on 4/7/15, at 10:00 a.m. The Admission Record printed 1/7/16, indicated R4 had diagnoses that included dementia, major depressive disorder, anxiety disorder and Alzheimer's Disease. R4's quarterly Minimum	F 226	Reporting of alleged violation involving R4 and R9 has been completed. Background check has been completed for NA-G. All residents have the potential to be affected if alleged or potential mistreatment is not immediately reported and thoroughly investigated. Facility policy has been amended to remove the language "immediately means as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occured was received" to "immediatlely after resident safety has been established." All residents have the potential to be affected if background checks on new hires are not completed prior to employment. Education has been provided to all staff on reporting requirements for alleged or potential mistreatment. BOM has been educated on requirements for required screening of new hires prior to employment.	

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F 226	Continued From page 11 Data Set (MDS) dated 10/28/15, indicated R4 had a moderate impairment of cognitive skills for daily decision-making. The Admission Record printed 1/7/16, indicated R29 had diagnoses that included dementia with behavioral disturbance, delusional disorders, depressive disorder, borderline personality disorders and anxiety disorders. R29's comprehensive annual MDS dated 10/14/15, indicated R29 had a moderate impairment of cognitive skills for daily living. During an interview on 1/7/16, at 2:32 p.m. the director of nursing services (DNS), stated staff were to immediately report anything that was a concern, even if it was questionable, to the DNS or the ED. The facility policy and procedure for Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements revised 3/12, directed staff to immediately report to the ED if they had reason to believe that a resident was being mistreated. The definition of immediately was defined as, "as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred was received." During an interview on 1/7/16, at 4:20 p.m. the DNS verified the incident regarding R4 and R29 should have been reported right away and should	F 226	Weekly audits will be completed on all allegations of mistreatment to insure reporting is completed immediately. New hires will be audited prior to employment to insure required screening has been completed prior to hire. Audit results will be reviewed at QAPI. ED will be responsible party.	

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F 226	Continued From page 12	F 226		

not have waited until the next day. The DNS also verified the definition of immediately in the facility policy and procedure regarding vulnerable adults (VA) indicated VA reports should be as soon as possible, but no longer than 24 hours from the time of knowledge of the incident was received and not immediately, as required. The DNS stated they did not wait that long and stated the resident would be treated or safety ensured first.

Background Checks

Nursing assistant (NA)-G was employed currently providing resident care and the facility was unable to provide evidence a criminal background check was obtained prior to employment, as directed by their policy.

The facility's abuse policy dated 3/12, indicated all applicants for employment in the facility shall at a minimum have the following screening checks conducted:
1. Reference checks with the current and or past employer.
2. Appropriate licensing board or registry check.
3. Drug testing.
4. Fingerprinting.
5. Criminal background check.

NA-G was hired on 11/2/15, and was currently providing care to the residents of the facility.

On 1/7/16, at 5:18 p.m. the business office administrator stated the corporate human

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F 226	Continued From page 13 resources contact person was unable to provide the background check for NA-G.	F 226		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification was given prior to a change in roommates for 1 of 2 residents (R9) reviewed for admission, transfer and discharge. Findings include: R9's Admission Record dated 10/6/15, identified diagnoses that included pelvic fractures, diabetes and restless leg syndrome. R9's 10/13/15 quarterly Minimum Data Set (MDS) indicated R9 was cognitively intact. On 1/4/16, at 6:42 p.m., R9 stated she was not given notice before new roommates moved in to the room and she has had three roommates since admission. On 1/6/16, at 2:33 p.m. the director of social services (SS)-A stated residents were notified when they were getting a new roommate as soon	F 247	Documentation in the medical record has been completed on roommate changes for R9. Residents having changes in room or roommates have the potential to be affected if they do not receive prior notification of the change. Education has been provided to SSD on documentation of change in room/roommate. Audits to be completed on all room/roommate changes to insure proper notification and documentation have been completed. Audit results will be reviewed at QAPI. ED will be responsible party.	2/16/16

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F 247	Continued From page 14 as the facility was aware of the incoming residents. The SS-A stated this was sometimes the day of the roommates' admission. On 1/7/16, at 11:06 a.m. SS-A stated that R9 had likely had three new roommates and confirmed there was no documentation of communication with R9 regarding the new roommates. The facility policy and procedure on transfers and discharges does not address notification of roommate changes.	F 247		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		2/16/16

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F 279	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop the care plan to include a seizure disorder, treatment of seizure and related monitoring for 1 of 1 residents (R29) identified at risk for seizures. Findings include: R29's annual Minimum Data Set (MDS) dated 10/2/15, identified R29 had long and short term memory impairment, required extensive assistance for all areas of daily living and total dependence on staff for locomotion. The MDS did not identify R29's seizure disorder. R29's Physician Order Summary Report signed 1/5/16, identified R29 had diagnoses which included seizures. The Report also identified R29 was prescribed 2 mg (milligram) diazepam -Inject 2 mg intramuscularly (IM) as needed for seizure activity, Give IM for seizure lasting longer than 60 seconds. May give second dose for seizure lasting longer than 10 minutes and no relief from first dose. IM solution is 1 mg/mL(milliliter). Dose ordered is 2 mg. Review of R29's nursing progress notes dated 7/27/15, through 1/5/15, indicated R29 had a seizure on 12/7/15, and 12/16/15.	F 279	Care plan for R29 has been updated to include seizure disorder, treatment of seizure and related monitoring. All residents have the potential to be affected if a comprehensive care plan is not developed to address specific resident needs. RNAC has been provided education on development of a comprehensive care plan addressing resident needs. Audits will be completed weekly prior to scheduled care conferences to insure resident needs are addressed and include treatment and monitoring for identified areas. Audit results will be reviewed at QAPI. DNS will be responsible party.	

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F 279	Continued From page 16 The undated nursing assistant care guide did not identify R29 had seizure disorder nor did it have any related signs, symptoms or interventions for care. Review of R29's care plan, updated 7/21/15, did not identify the use of an anxiety medication for the treatment of seizures and lacked identification and monitoring of related symptoms. On 1/7/2016, at 12:07 p.m. the director of nursing (DON) verified R29 did have seizures and the care plan did not address R29's risk for seizures and the corresponding signs, symptoms and treatments. The facility policy titled The RAI and Care Planning dated October 2015, identified "As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the residents highest practicable physical , mental, and psychosocial well-being.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a	F 281	R61 no longer resides in the facility.	2/16/16

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F 281	Continued From page 17 Lidoderm patch prescribed for pain was administered as the physician ordered for 1 of 1 resident (R61) observed during the application of a patch. Findings include: R61's physician orders dated 1/1/16-1/31/16, identified diagnoses included anxiety, vascular headache, squamous cell carcinoma and sepsis infection. R61's current physician order with start date 12/16/15, indicated an order for "Lidoderm Patch 5% apply to upper arm topically in the morning related to acute pain due to trauma. Give 1 patch every am on area of R (right) arm pain confirmed with resident verbal affirmation. Ensure use for only 12 hours on and 12 hours off, during the night." On 1/06/2016, at 9:09 a.m. licensed practical nurse (LPN)-A was observed to administer R61's oral and intravenous medications. R61 removed a white medication patch from her right upper arm and handed it to LPN-A. LPN-A disposed of it and applied a new Lidoderm patch to R61's right upper arm. -At 9:18 a.m. LPN-A verified the usual practice was to remove the used Lidoderm patch and immediately apply a new one. On 1/06/2016, at 12:29 p.m. the director of nursing (DON) verified the expectation was for facility staff to follow the physician orders. The DON verified R61's physician order to apply a Lidoderm patch in the morning (a.m.) and remove	F 281	Residents with physician orders for specific application and removal of patches have the potential to be affected if orders for application and removal are not adhered to. Orders for Lidoderm patches for current residents have been reviewed to insure orders for application and removal are in place. Education has been provided to licensed nursing staff on following physician orders for patch application and removal. Medication competencies have been conducted to ensure that medications are properly administered. Weekly audits will be conducted on residents with orders for patches to insure order includes application and removal. Negative findings will be addressed immediately. Audit results will be reviewed at QAPI. DNS will be responsible party.	

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F 281	Continued From page 18 it at bed time (HS) was not followed. On 1/06/2016, at 1:06 p.m. R61 verified it was nursing staff practice to leave the Lidoderm patch on the upper right arm until a new patch was placed. The Lidoderm packaging directed the application of the patch only once for up to 12 hours in a 24-hour period (12 hours on and 12 hours off) and to remove the patch if irritation occurred. On 1/07/2016, at 3:06 p.m. via a telephone interview, the pharmacy consultant stated the Lidoderm patch removal and application should have been completed as the physician directed. The Pharmacy consultant indicated the resident electronic medication administration records (EMAR) typically had direction for removal of a patch with an area to document the removal had been completed. On 1/07/2016, at 4:02 p.m. the DON verified R61's EMAR had not directed evening staff to remove the Lidoderm patch and should have.	F 281		
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.	F 282		2/16/16

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F 282	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure fall interventions were implemented as directed by the care plan in order to minimize the risk of falls and / or injury for 1 of 1 resident (R28) reviewed for accidents. Findings include: R28's Falls care plan revised on 1/6/16, indicated R28 had the potential for falls due to a history of falls and risk factors which included impulsive behavior, mild cognitive impairment, unsteady gait and balance, supervision and assistance with transfers. The care plan indicated R28 had falls on 12/15/15, and 12/18/15. Interventions included assess for pain, have the bed in low position, have the call light or personal items available and in easy reach or provide a reacher, proper footwear to prevent slipping, keep the environment well lit and free of clutter and a mat on the floor next to the bed. Physical functioning deficit was related to Self care impairment and mobility impairment. R28 was to transfer with the stand by assistance of one staff. The nursing assistant (NA) care sheet (not dated) indicated R28 utilized nonskid footwear and the bed was to be in low position. R28 required stand by assistance of one staff with transfers.	F 282	R28 falls interventions have been reviewed and revised. Interventions are in place and implemented according to plan of care. Individualized interventions are listed on care plan and NAR care sheets. NAR have been educated to report discrepancies to DNS. Residents at risk for falls have the potential to be affected if interventions are not implemented per plan of care. Staff have been educated on following interventions for accident prevention. Random weekly rounds will be conducted to insure interventions on care plan are on NAR care sheets and in use. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. DNS will be responsible party	

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F 282	Continued From page 20 On 1/5/16, at 2:30 p.m. R28 was observed lying in bed. The bed height was approximately two feet from the floor. The bed was not in low the position. A fall mat was not on the floor at the bedside. No fall mat was observed in R28's room. A fall tab alarm was attached to the head of the bed with the string hanging between the bed and the mattress. The string was not attached to R28. R28 had white stockings on his feet. A pair of slippers were at the bedside. On 1/16/16, at 7:00 a.m. R28 was observed in bed. The bed was in the lowest position. A fall mat was not on the floor next to the bed. R28 had white socks on both feet. The tab alarm was on the head of the bed with the clip end under the pillow and not attached to R28. -At 7:05 a.m. NA-D entered the room and asked R28 if he would start waking up and she would be back to get him up in about 10 minutes. -At 7:20 a.m. NA-D returned to R28's room, put slippers on R28's feet. R28 sat up, complained of not feeling well and laid back down. NA-D covered R28 back up. The tab alarm clip end remained under the pillow and was observed attached to the bottom sheet. On 1/6/16, at 11:30 a.m. R28 was observed seated in the wheelchair, in the main dining room (MDR) for lunch. R28 had slippers on his feet. -At 11:49 a.m. R28 exited the MDR and returned to his room. NA-C assisted R28 to transfer from the wheelchair to the toilet. NA-C directed R28 to pull the call light when done and exited the room. -At 12:00 p.m. NA-C returned to R28's room. R28 was standing up from the toilet and attempted to transfer himself from the toilet to the wheelchair.	F 282		

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F 282	Continued From page 21 NA-C assisted R28 to turn and sit in wheelchair. NA-C stated R28 did not put the call light on to request assistance. -At 12:40 p.m. R28 was in bed. R28 had a visitor in the room. -At 1:40 p.m. the visitor exited the room. R28 remained in bed. His feet were on the arm of the wheelchair. There was no mat on the floor next to the bed. On 1/6/16, at 1:45 p.m. the NA care sheet was observed and verified with NA-D. The care sheet directed R28 was to wear nonskid footwear, have the bed in a low position, okay per therapy to walk independently and transfer with stand by assist. The NA was asked what safety devices should R28 have. The NA stated a tab alarm which R28 takes off, a mat on the floor and a low bed. The NA further stated they should be in place all the time when R28 was in bed. On 1/7/16, at 9:00 a.m. R28 was observed in bed. The bed was in the low position. The tab alarm was gone from the headboard. There was not a fall mat at the bedside. R28 had white athletic type socks on his feet and the slippers were on the seat of the wheelchair that was away from the bed and turned around. -At 10:00 a.m. this surveyor and the administrator observed R28 in bed. The administrator verified there was not a fall mat at the bedside and should have been and regular socks were on R28's feet and the wheelchair was turned away from the bed with the slippers on the seat. -At 2:23 p.m. a thick red mat was observed on the floor at R28's bedside.	F 282		

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F 282	Continued From page 22 On 1/7/16, at 9:17 a.m. the director of nursing (DON) verified R28's care plan and stated R28 should have had a fall mat in place, his bed in low position and wear nonskid footwear. The DON stated safety devices were expected to be implemented at all times as directed by the care plan. The facility's Falls Management Guideline policy dated 10/21/15, indicated the IDT would evaluate the fall prevention care plan for residents at risk for falls. Following the completion of the MDS, if a resident triggered for falls the resident would be further assessed for falls. The care plan then would be developed to further minimize the risk for falls.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate services with hospice as evidenced by two different advance directives on file for 1 of 1 resident (R64) reviewed for hospice. In addition, the facility failed to ensure nursing assistants were aware of hospice aide	F 309	R64 POLST has been reviewed and reflects current wishes. Hospice schedules and services are being coordinated with each hospice group and are implemented within the residents comprehensive plan of care. Nursing	2/16/16

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F 309	Continued From page 23 schedules and responsibilities when at the facility. Findings include: R64's Admission Record dated 12/28/15, indicated diagnoses that included pneumonitis, cerebral infarction (stroke), cognitive deficits following a stroke, diabetes, depression, anxiety, pain, insomnia and acute kidney failure. R64's care plan dated 1/6/16, indicated R64 was on hospice for end of life care. The care plan goal was for R64 to remain comfortable and have his needs met. Interventions included to coordinate care plans with hospice. R64's medical record was reviewed and the following information was revealed: -A POLST (Provider Orders for Life Sustaining Treatment) form, that indicated do not attempt resuscitation (DNR) [allow natural death]. The POLST form was signed by R64's wife and the hospice RN on 12/23/15. This POLST was in R64's hospice binder at the facility. -an immediate facility care plan dated 12/28/15, that indicated R64 was a full code (attempt CPR or cardiopulmonary resuscitation). -A POLST form signed by his wife on 12/28/15 (date of admission to facility), and signed by the facility Certified Nurse Practitioner on 1/5/16, which indicated R64 desired CPR. This POLST form was in the front of R64's facility binder (medical record). On 1/6/16, at 11:30 p.m. licensed practical nurse	F 309	staff are given schedules of visits and services to be provided. SSD has been educated in coordination of hospice services. Nursing staff has been educated on location of hospice schedules. Agencies providing Hospice services have been asked to have nurse report off to DNS after visits with the residents to ensure any changes are discussed. Weekly audits of residents receiving hospice services will be completed to insure coordination of resident wishes and schedules. Negative findings will be addressed immediately. Results will be reviewed at QAPI. SSD will be responsible party.	

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(LPN)-A stated a resident's POLST was in the front of the resident's facility hard chart. LPN-A stated the front of the facility chart was where she would look if presented with an emergency situation for a resident, even if the resident was on hospice.

On 1/6/16, at 12:03 p.m. the Social Services Director (SS)-A stated normally, nurses completed the POLST form at admission. The SS-A stated she used a checklist and if it was not done, she'd notice and do it at that time or inform the admitting nurse to complete the POLST form.

On 1/6/16, at 12:09 p.m. the hospice registered nurse (HRN)-1 stated the most current POLST or health care directive on file was the one that was effective. HRN-1 stated R64's status was DNR with their organization.

On 1/6/16, at 1:24 p.m. R64's family member (FM)-H, who had decision making authority for R64, stated she had to redo a POLST for R64 this morning and she "didn't appreciate" having to do it over when R64 was admitted and then again today. FM-H stated, and R64 nodded in agreement that R64's status was DNR. FM-H stated there was "no coordination" about R64's resuscitation status and wondered why the facility didn't just use the POLST form she signed with the hospice agency.

On 1/6/16, at 2:23 p.m. the Director of Nursing (DON) stated she was not aware hospice agencies did their own separate POLST. She also stated she was not aware R64's POLST forms didn't match. The DON stated it was the

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F 309	Continued From page 25 responsibility of the admitting RN to complete a POLST with the incoming resident and/or their family. The DON stated the process was the same regardless if the resident was on hospice or not. The DON stated they work with three separate hospice agencies consistently, but currently had a resident using yet another agency. The DON stated staff would refer to the POLST form in the front of a resident's facility hard chart. The DON also stated that having R64 listed as a full code was a miscommunication, based on looking at records from his recent hospitalization. The DON stated there was no process in place to coordinate resuscitation orders with hospice agencies. On 1/7/16, at 11:02 a.m., nursing assistant (NA)-C stated they would run into the hospice nurses when at the facility and also talk to them, but nursing assistants don't know when they were coming prior to them seeing the resident. NA-C stated sometimes there was a mix up with showers and sometimes the hospice staff would empty a catheter bag and not record the output, or know that the output was being monitored which could cause a concern when monitoring output was important.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		2/16/16

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F 323	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure fall interventions were implemented in order to minimize the risk for falls and / or injury for 1 of 1 resident R28 reviewed for accidents. Findings include: An Admission Record dated 1/7/16, indicated R28's diagnoses included chronic kidney disease, depression and anemia. R28's admission Minimum Data Set (MDS) dated 10/26/15, indicated R28 had moderately impaired cognition, required supervision of one staff with bed mobility, transfers, dressing, toilet use and required limited assistance of one staff with personal hygiene. The MDS further indicated R28 had falls prior to admission and had no falls since admission. R28's Fall Care Area Assessment (CAA) dated 10/26/15, indicated R28 had the potential for falls due to falls prior to admission and one fall since admission. Risk factors for R28 included impulsive behavior, mild cognitive impairment, unsteady gait and balance and the need for supervision and assistance with transfers. R28 was able to rebalance himself without assist.	F 323	R28 falls interventions have been reviewed and revised. Interventions are in place and implemented according to plan of care. Individualized interventions are listed on care plan and NAR care sheets. NAR have been educated to report discrepancies to DNS. Residents at risk for falls have the potential to be affected if interventions are not implemented per plan of care. Staff has been educated on following interventions for accident prevention. Random weekly rounds will be conducted to insure interventions on care plan are on NA care sheets and in use. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. DNS will be responsible party.	

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R28's Falls care plan revised on 1/6/16, indicated R28 had the potential for falls related to falls prior to admission and one fall since admission. Risk factors included impulsive behavior, mild cognitive impairment, unsteady gait and balance, supervision and assistance needed with transfers. The care plan indicated R28 had falls on 12/15/15, and 12/18/15. Interventions included assess for pain, have the bed in low position, have the call light or personal items available and in easy reach or provide a reacher, proper footwear to prevent slipping, keep the environment well lit and free of clutter and a mat on the floor next to the bed. Physical functioning deficit was related to Self care impairment and mobility impairment. R28 was to transfer with the stand by assistance of one staff.

The nursing assistant (NA) care sheet (not dated) directed R28 to utilize nonskid footwear, the bed to be in low position and R28 required stand by assistance of one staff with transfers.

An incident report dated 12/15/15, at 9:40 a.m. indicated R28 was found on floor in his room. The investigative findings included R28 was wearing slippery socks which caused R28 to slip. The Post fall Analysis/Plan indicated R28 slipped and prior to the fall R28 was ambulating and doing usual activities. R28 had a history of falls and was wearing socks. Possible causal/contributing factors and observations included R28 was wearing socks and had weakness. Recommendations/interventions taken to prevent reoccurrence included gripper socks to be worn. The care plan was not revised. The interdisciplinary team (IDT) reviewed the fall on

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F 323	Continued From page 28 1/6/16. An incident report dated 12/18/15, at 7:20 p.m. indicated R28 was found on the floor on his left side next to his bed. R28 was on his way to the bathroom and fell. R28 had gripper socks on. Contributing factors were unknown. R28 had possibly slipped on the urinary drainage leg bag as it was laying by him. R28 needed the assistance of one staff to ambulate and used a walker. R28 was sent to the emergency room (ER) to be evaluated. The Post Fall Analysis/Plan indicated R28 slipped and R28 stated he was on his way to the bathroom. R28 had a history of falls. A Physical Assessment after the fall indicated R28 had a change in activities of daily living (ADL), an old bruise on the right buttock and pain with movement of the lower extremities with a change in range of motion (ROM). Recommendations included have the assistive device within reach, keep the bed in low position and have the call light within reach. The care plan was reviewed and updated to include staff would supervise or assist with ambulation. R28's progress notes revealed the following: On 12/19/15, R28's son was called and R28's weakness was discussed. The staff also told the son about the plan to keep R28 safe. The plan included staff would give R28 a bed pan for bowel movements, have the call light within reach, a fall matt on floor next to the bed and a bed alarm. R28 had been instructed to use the call light for assistance and not to get out of bed on his own. R28 verbalized understanding.	F 323		

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On 12/27/15, R28 had a huge purple/ yellow bruise on the right hip that went partially down his posterior right leg. The bruise also was on the right buttock. The bruise measured 20.0 centimeters (cm) by 25.0 cm. R28 denied pain and denied falling or injuring the area. R28 did have two falls last week and was sent into the hospital for an evaluation.

On 1/4/2016, R28 needed the assistance of one for cares. R28 used the walker and wheelchair for mobility. R28 has had two falls in the past month. R28 had bruising on his right hip and was seen in the ER. The bed was to be kept in the low position.

On 1/5/16, at 2:30 p.m. R28 was observed lying on top of the bed covered with two blankets. The bed height was approximately two feet from the floor. The bed was not in low the position. There was not a fall mat on the floor at the bedside. No fall mat was observed in R28's room. A tab alarm was attached to the head of the bed with the string hanging between the bed and the mattress. The string was not attached to R28. R28 had white athletic type stocking on his feet. A pair of slippers were at the bedside.

During constant observation from 7:00 a.m. to 7:20 a.m. on 1/6/16, the following was observed:

-At 7:00 a.m. R28 was laying on the bed, a fall mat was not on the floor next to the bed, the bed was in the low position and R28 had white socks

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on both feet. The tab alarm remained on the head of the bed with the string across bed with the clip end under the pillow and not attached to R28.
-At 7:05 a.m. NA-D entered the room and asked R28 if he would start waking up and she would be back to get him up in about 10 minutes.
-At 7:20 a.m. NA-D returned to R28's room and put the slippers on R28's feet. R28 sat up, complained of not feeling well and laid back down. The NA covered R28 back up and exited the room. The tab alarm string was under the pillow and attached to the bottom sheet.

On 1/16/16, at 11:30 a.m. R28 was observed seated in the wheelchair in the main dining room (MDR) for lunch. R28 had slippers on his feet.
-At 11:49 a.m. R28 exited the MDR and returned to his room. NA-C assisted R28 to transfer from the wheelchair to the toilet. The NA directed R28 to pull call light when done and exited the room.
-At 12:00 p.m. NA-C returned to R28's room. R28 was standing up from the toilet and attempted to transfer himself from the toilet to the wheelchair. R28 had his pants and brief up but not fastened. The NA assisted R28 to turn and sit in wheelchair. The NA stated R28 did not put the call light on. R28 returned to the MDR.
-At 12:40 p.m. R28 exited the MDR and stated he had to go to the bathroom. R28 transferred onto the toilet with NA-D. When finished R28 transferred himself off of the toilet, into the wheelchair and then put himself onto the bed. NA-D entered the room and acknowledged R28 had done this then exited the room. R28 had visitors in the room. The bed was raised approximately two feet off the floor, the tab alarm string was laying on the bed not attached and

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F 323	Continued From page 31 R28 had white socks on with the slippers on the floor at the bedside. There was not a fall mat on the floor next to the bed. -At 1:40 p.m. the visitors exited the room. R28 was sideways on the bed with his feet on the arm of the wheelchair. The was no change in the safety devices. On 1/6/16, at 12:35 p.m. family member (FM)-E was interviewed. FM-E stated after the second fall he/she was told the facility would keep R28 in bed and when he/she would visit R28 was found to be up in the wheelchair. The FM stated he/she was told R28's slippers were too hard soled and slippery. The FM was planning on getting new slippers. The FM stated R28 originally had a bed alarm but had never seen R28 with the bed alarm on. The FM had observed the bed alarm on the bed but not attached. The FM further stated R28 previously had a fall mat and the last time he/she visited the mat was tipped up in front of the television. On 1/6/16, at 1:45 p.m. the NA care sheet was observed and verified with NA-D. The care sheet directed R28 was to wear nonskid footwear, have the bed in a low position, okay per therapy to walk independently and transfer with stand by assist. The NA was asked what safety devices should R28 have and NA stated a tab alarm which R28 took off, a mat on the floor and a low bed. The NA further stated they should be in place all the time when R28 was in bed. On 1/7/16, at 9:00 a.m. R28 was observed in bed. The bed was in the low position. The tab alarm	F 323		

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F 323	Continued From page 32 was gone from the headboard. There was not a fall mat at the bedside. R28 had white athletic type socks on his feet and the slippers were on the seat of the wheelchair that was away from the the bed and turned around. -At 10:00 a.m. this surveyor and the administrator observed R28 in bed. The administrator verified there was not a fall mat at the bedside and should have been and regular socks were on R28's feet and the wheelchair was turned away from the bed with the slippers on the seat. -At 2:23 p.m. a thick red mat was observed on the floor at the bedside. On 1/7/16, at 9:17 a.m. the director of nursing (DON) verified R28's care plan directed staff to have the bed in the low position, have the call light in reach, wear nonskid footwear and have a fall mat on the floor at the bed side. The DON stated it was expected the safety devices would be in place at all times when R28 was in bed. The DON also verified the NA care sheet directed R28 to utilize nonskid footwear, bed to be in low position and R28 required stand by assistance of one staff with transfers. The DON stated the NAs would know what devices were needed by what was on the care sheet. The DON verified the incident report from the fall on 12/18/15, indicated R28 was to be assisted with transfers and ambulation and the NA sheet directed independent ambulation. The DON further stated the facility process after a resident fell was the nurse assessment before moving to determine injury, fill out an incident report, update the family, the doctor, the DON and the administrator followed by the completion of a post fall analysis and recreate the fall in IDT. The IDT met every morning then went to a stand up meeting on the	F 323		

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F 323	Continued From page 33 floor and the care plan was updated and staff received a print out of the clinical stand up meeting information. The facility's Falls Management Guideline policy dated 10/21/15, indicated the IDT would evaluate the fall prevention care plan for residents at risk for falls. Following the completion of the MDS, if a resident triggered for falls the resident would be further assessed for falls. The care plan then would be developed to further minimize the risk for falls.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		2/16/16

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F 431	Continued From page 34 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were properly secured for 1 of 1 resident (R 61) whose medications were left unattended in a public area. Findings include: On 1/06/2016, at 8:39 a.m. licensed practical nurse (LPN)-A was observed to lock the medication cart, leave the area and enter a residents room. The medication cart was against the wall to the left of the juncture of a residents living hall and a hall that lead to the dining room. The med cart had an interventions solution of Vancomycin (antibiotic), and a Lidoderm patch 5% (for Pain) on top of the cart. -At 8:49 a.m. ten minutes later, LPN-A returned to the cart and immediately left the area again. The antibiotic and pain patch remained on top of the medication cart with out staff supervision. -At 8:58 a.m. nine minutes later LPN-A returned to the cart.	F 431	R61 no longer resides in the facility. All residents have the potential to be affected if medications are left unsecured or unattended. Staff responsible for administration of medications have been educated on responsibilities for securing medications and medication carts when unattended. Medication competencies have also been conducted on staff administering medications. Daily audits will be completed to insure medication carts are locked when unattended and no medications are left unsecured. Negative findings will be addressed immediately. Results will be reviewed at QAPI. DNS will be responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 35 On 1/6/15, at 9:00 a.m. LPN-A verified the medications were left unattended on the top of the medication cart. On 1/7/16, at 4:04 p.m. the director of nursing (DON) verified medications were not to be left on top of the medication cart while unsupervised for ten minutes. The DON stated "it's a huge safety issue, anyone could walk by and take those." The facility policy titled Storage of Medications, dated 6/3/14, identified Procedures "B. Only licensed nurses, pharmacy personal, and those lawfully authorized to administer medications(such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		2/16/16

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F 441	Continued From page 36 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control practices were implemented for proper disinfection of a multi-use INR (checks blood coagulation time) monitor for 1 of 1 resident (R61) observed during an INR check. Findings include: On 1/6/16, at 9:09 a.m. licensed practical nurse (LPN)-A with gloved hands, was observed to use a lancet to draw blood from R61's finger. LPN-A	F 441	R61 no longer resides in the facility. INR machine has been properly disinfected according to manufacturer recommendations to prevent spread of infection. Residents needing INR checks have the potential to be affected if proper disinfection of INR machine is not completed between resident use. Licensed staff have been educated on	

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F 441	Continued From page 37 touched the test strip of the INR machine to the drop of blood on R61's finger. LPN-A read the INR machine reading out loud, removed the test strip from the machine and placed the INR machine back into its case with out any disinfection or cleaning of the machine. On 1/6/16, at 11:26 a.m. LPN-A verified the INR machine was not disinfected after use with R61. LPN-A stated "I forgot." LPN-A verified the usual procedure was to disinfect the INR machine with the same Micro-kill wipe used for the glucometer (checks blood sugar levels). On 1/6/16, at 12:29 p.m. the director of nursing (DON) verified the INR machine was used for multiple residents and the facility currently had three residents who utilized the machine. The DON stated the usual facility protocol for cleaning the INR machine and the glucometer was to disinfect it with a bleach type wipe for one minute between each resident use. The provided facility policy titled Blood Glucose Monitoring Decontamination dated 6/12, identified the following - Purpose: To implement a safe and effective process for decontaminating blood glucose monitors. -Policy: The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents.	F 441	proper disinfection of INR machine. Competencies have been conducted to ensure everyone is using the machine correctly. Random audits will be conducted when INR testing is ordered to insure proper disinfection occurs. Negative findings will be corrected immediately. Results will be reviewed at QAPI. DNS will be responsible party.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		2/16/16

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	245348	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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F 465	Continued From page 38 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, homelike and sanitary environment for 18 or 40 residents' rooms (Rooms: 104-A, 106-A, 107-B, 109-B, 111-B, 114, 115-B, 117-A, 119-A, 120-A, 120-B, 121-B, 122-A, 122-B, 123-A, 125-B, 127-A, 127-B) and the west hall carpet observed in soiled and / or in disrepair. In addition, the facility failed to ensure residents' personal wheelchairs were maintained in a clean manner for 4 of 4 residents (R2, R23, R29, R12) observed to have soiled wheelchairs and wheelchair seat cushions. Findings Include: On 1/7/16, at 3:00 p.m. an environmental tour was conducted with the maintenance director (MD) and the following was observed: -Room 104-A the edges of the fall mat were cracked with areas of the covering missing. -Room 106-A the edges of the fall mat were cracked with areas of the covering missing. -Room 107-B the edges of the fall mat were	F 465	Fall mats in rooms 104-A, 106A, 107-B, and 111-B have been replaced. 107-B window curtain hooks have been replaced and curtain is connected to the curtain rod. Marks on front of heat register in room 109-B have been removed. 111-B heat register has been repainted and seam has been repaired. Hole in wall behind room door room 114 has been patched and painted. Gaps in seams of heat register room 115-B have been repaired. Bathroom floor tiles in room 117-A have been replaced. Floor stain in bathroom 119-A has been cleaned. Floor tiles between toilet and wall that were cracked or had gaps have been replaced in bathroom 119-A. Walls in shared bathrooms 120-A, 120-B, 122-A, and 122-B have been repaired and painted. Holes in walls have been repaired and painted in shared bathrooms	

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	245348	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 465	Continued From page 39 cracked with areas of the covering missing. The window curtain on the right side had approximately six to seven hooks that were not connected to the curtain rod and the curtain was hanging outward. -Room 109-B the heat register had several black marks along the front. -Room 111-B the heat register's paint was scrapped off and at the seam along the edge was apart and raised. The edges of the fall mat were cracked with areas of the covering missing. -Room 114 there was a hole in the wall behind the door to the room. -Room 115-B the heat register seams had gaps and was pulled out. -Room 117-A the floor tiles in the bathroom, by the toilet were cracked. -Room 119-A the bathroom floor had a brown stain near the front of the toilet. The floor tiles between the toilet and the wall were cracked with gaps that were filled with dark dirt. -In a shared bathroom for rooms 120-A, 120-B, 122-A and 122-B the painted wallpaper was cracked from the sink to the mirror approximately 18 inches long. In addition there are six small holes with plastic screw anchors in the wall between the sink and the mirror. -Room 121-B the bathroom wall between the door and the sink near the floor the paint was scraped. In the resident's room, the wall behind the door at the top of the baseboard had several	F 465	120 and 122. Bathroom wall 121-B has been repaired and painted. Wall behind door at top of baseboard room 121-B has been repaired and painted. Ceiling vent and wall room 121-B has been cleaned. Peeling wallpaper room 121-B has been repaired. Ceiling below vent room 121-B has been cleaned. Bathroom wall room 123-A has been repainted. Stains on floor around toilets in shared bathrooms 125-B, 127-A, and 127-B have been removed. Carpet seams of west hall entrance have been temporarly glued down. Carpet stains outside room 121 and between rooms 115 and 119 have been attempted to be removed. Facility has taken steps and started working with contractors to remove carpeting. Carpeting will be replaced with wood laminate throughout the facility. Target date for completion will be April 1, 2016. Wheelchairs and cushions for R2, R12, R23, and R29 have been cleaned. A cleaning schedule has been reported to housekeeping to ensure they are cleaned on bath days. Random checks will be conduced weekly by department managers. All residents have the potential to be affected if a safe, functional, sanitary, and comfortable environment is not maintained. Maintenance has been educated on	

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F 465	Continued From page 40 areas where the paint was chipped off. The ceiling vent had a black dust like substance on the grates and on the wall on each side. Below the vent, the wall paper was peeling at the bottom right corner. The ceiling below the vent was chipped and broken at the corner. -Room 123-A the bathroom wall between the door and the sink near the floor the paint was scraped. -A shared bathroom for rooms 125-B and 127-A and 127-B had a brown stain on the floor around the toilet. -The carpet on the floor of the west hall entrance area was frayed at the seam with three to four open areas where the seam was apart. A large, round, dark stain outside room 121 was noted and several white stains were also noted on the carpet between rooms 115 and 119. During the environmental tour, the MD verified the above findings. The MD stated he had a corporate computer program that directed preventative maintenance but did not have a system where he routinely checked areas in need of repair including resident rooms. The MD stated the nursing and housekeeping staff were expected to alert him of the areas in need of repair. The MD stated there was a three ringed binder at the nursing station and in each hopper room where staff could write down areas needing repairs. The MD stated the majority of the areas were housekeeping issues. 1/7/16, 4:30 p.m. a policy was requested and the administrator stated there was not one.	F 465	completing and documenting routine maintenance rounds and making needed repairs when identified. Nursing staff have been educated on notifying maintenance of needed repairs and housekeeping of cleaning needs when identified. IDT has been educated on completing non-clinical rounds to identify areas needing attention. Daily non-clinical rounds will be completed 5 times weekly to identify areas needing repair and/or cleaning. Negative findings will be addressed immediately. Results of audits will be reviewed at QAPI. ED will be responsible party.	

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F 465	Continued From page 41 Wheelchairs: Throughout the survey in the secured unit, on 1/4/16, 1/5/16, 1/6/16, and 1/7/16, the following was observed: -R2's wheelchair seat cushion was heavily soiled with what appeared to be dried food particles on the front, sides and top of the cushion. -R12's wheelchair arm rests were soiled with dried food debris and the metal hardware of the wheelchair from the arm rests to base of the wheel chair was heavily soiled with red and white colored dried debris. -R23's black wheelchair seat cushion was soiled and spotted with white debris. -R29's black concave wheelchair seat cushion had numerous white spots on the right and left sides of the cushion and on the framework of the wheelchair surrounding the cushion. The curved back support cushion of the wheelchair also had a heavy buildup of white flaky debris in a depression on each side near R29's shoulders. On 1/7/16, at 9:14 a.m. Nursing assistant (NA)-B stated a log was kept for housekeeping staff for residents identified in need of wheelchair cleaning because the NAs did not have time. NA-B stated "they should be washed on nights but they don't get done." NA-B indicated wheel chairs were more likely to become soiled due to the number of residents currently eating independently. On 1/7/16, at 9:36 a.m. NA-H verified R2 and R12 had soiled wheelchairs and both needed to be cleaned. NA-H stated the usual practice was for staff to fill out forms to alert housekeeping of	F 465		

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F 465	Continued From page 42 any soiled wheelchairs. NA-H stated once a form was completed, it remained in the log book until housekeeping had completed the request. On 1/7/2016, at 10:09 a.m. NA-E verified R23 and R29's wheelchair cushions were soiled. NA-E stated a cleaning form would be written to inform housekeeping the wheelchairs needed to be cleaned. On 1/07/2016, at 12:14 p.m. the administrator stated wheelchairs were usually cleaned on bath days. The administrator also verified the process of the completion of request from for housekeeping to clean the wheelchairs, when needing an extra cleaning. The administration was unaware of the residents soiled wheel chairs. Review of the housekeeping logs in the three ring binder identified each resident had a section with papers to be completed for cleaning requests. At this time no wheelchair cleaning request forms had been completed and placed in the book for R2, R23, R29 or R12 for wheelchair cleaning.	F 465		

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Golden Living Center-Rush City was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

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

Electronically Signed | 01/28/2016

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Golden Living Center-Rush City is a 1-story building with a partial basement. The building was constructed in 1967. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET.	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the residents, visitors, and staff members of the facility. Findings include:	K 017	On 1/14/16 new ceiling tiles were purchased to replace existing tiles. Facility also purchased extras due to breakage every time they are removed for inspection underneath. Broken tiles are able to be immediately replaced. Maintenance Director will follow up on these monthly with preventative maintenance program.	1/14/16

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K 017	Continued From page 3 On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, observations revealed, that there are numerous penetrations in the ceiling tiles that are located throughout the corridors. This deficient condition was verified by a Maintenance Supervisor.	K 017		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include:	K 025	On 1/26/2015 the facility replaced drywall above smoke compartments. Fire repellent caulk was also placed around the pipes and wires going through the wall. Maintenance director will monitor with contractors coming into the building.	1/26/16

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2016**

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GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 025	Continued From page 4 On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, observation revealed that there were sections of drywall missing in the smoke barrier walls in the spaces above the ceiling tile over the corridor smoke barrier doors at both of the facility's smoke barrier walls. This deficient condition was verified by a Maintenance Supervisor.	K 025		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could affect residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility could not provide documentation for 1 of 12 monthly tests of the battery backup emergency lights had been completed.	K 046	The monthly emergency light tests have historically printed on the 8th of every month. That date has been changed to the 1st of every month to allow more days to insure that the tests are completed within the same month. The maintenance director will perform and complete this task within the month it is assigned. Every month, he will print out the completed task and deliver it to the Administrator to insure the test has been performed monthly as required.	1/28/16

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K 046	Continued From page 5 This deficient practices was confirmed by the Maintenance Supervisor.	K 046		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient practices was confirmed by the Maintenance Supervisor.	K 054	On 1/5/16 forms were printed from CMS website and they will be used for sensitivity testing. This allows for an actual count of smoke detectors as well as a P/F report. Sensitivity testing is scheduled for March 2016. Facility has been placed on an auto renewal for the contractor to automatically come out when sensitivity is to be done. Maintenance director will follow up for compliance and make sure CMS form is used. Test results will be reported at QAPI.	1/5/16
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		1/6/16

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K 056	Continued From page 6 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, observations revealed that the facility did not have at least 2 spare sprinkler heads for every style and type of fire sprinkler heads that are being used throughout the facility. This deficient practices was confirmed by the	K 056	Sentry was called on 1/6/16 and spare sprinklers were brought out to the building on 1/6/16. An FYI note has been placed in the storage box notifying individuals taking a sprinkler head out to have it replaced with a phone number to call. Facility also put system into place when sprinklers are tested in the building that the storage box will also be verified for compliance. Maintenance Director will sign off that 2 replacements for every type of head are in the storage box.	

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K 056	Continued From page 7 Maintenance Supervisor.	K 056		
K 066 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to meet requirements for the inside designated smoking area in accordance with NFPA LSC (00) Edition Section 19.7.4. This deficient practice could affect all residents, staff and visitors if an fire incident were to occur in the smoking area.	K 066	As of January 1, 2016 facility is working towards becoming a smoke free environment. Current residents will be grandfathered in until their discharge or a failure of smoking assessment. New residents admitted will not be allowed to smoke on the facility property and	3/7/16

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K 066	Continued From page 8 Findings include: On facility tour between 12:30 PM to 5:30 PM on 1/05/2016, it was observed that staff were smoking and disposing of smoking materials outside of the exit located by the facility's kitchen on the ground, on a metal food cart, and in a combustible trash can. This area was not designated as a smoking area as per the facility's smoking policy and was not equipped with a noncombustible self-closing metal container. This deficient practices was confirmed by the Maintenance Supervisor.	K 066	cigarettes will not be allowed to be kept in rooms. Resident Ashtray is made of non combustible material is in compliance with NFPA. Facility is also rolling out new smoking policy to incorporate smoking aprons and direct supervision by staff for the safety of the residents. As of March 7, 2016 staff, new admits, and families will not be permitted to smoke on the facility property. Administrator will monitor for compliance and report findings to QAPI.	