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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2PRF

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **704/01/2006**

6. DATE OF SURVEY 03/23/2012 (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	43	19		
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567 B. Effective March 20, 2012, the facility is certified for 43 skilled nursing facility beds and 19 Boarding Care Home Beds.

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 04/18/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 03/23/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS
Posted 05/31/2012 CO.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/13/2012 (L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5313 May 31, 2012

Mr. Shane Roche, Administrator
Golden Livingcenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

Dear Mr. Roche:

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

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

Effective March 20, 2012 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility
19 Nursing Facility II Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring, MN Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 18, 2012

Mr. Shane Roche, Administrator
Golden Livingcenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

RE: Project Number S5313022

Dear Mr. Roche:

On February 29, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2012. This survey found the most serious deficiencies to be 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 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 9, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2012, effective March 20, 2012 and therefore remedies outlined in our letter to you dated February 29, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-235

Enclosure
L&C File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245313	A. Building B. Wing	3/23/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/20/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PH/cbl	04/18/2012	12835	03/23/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/9/2012

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2PRF

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(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **02/22/2012** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
19	43			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Lisa Eischens, HFE NE II 03/22/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/13/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 04/13/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0735

February 29, 2012

Mr. Shane Roche, Administrator
Golden Livingcenter - Meadow Lane
2209 Utah Avenue
Benson, Minnesota 56215

RE: Project Number S5313022

Dear Mr. Roche:

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

This survey found the most serious deficiencies in your facility to be 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.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (218) 723-4637

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 20, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 9, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

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

Enclosure

cc: Licensing and Certification File 5313S12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/09/2012

RECEIVED
MAR 07 2012
MN Dept of Health
Duluth

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to use the least restrictive device (lap belt) for the least amount of time for 1 of 1 residents (R33) in the sample who failed to have her lap belt removed when in direct observation of staff or family. Findings include: R33 was not released from restraint at times when she was in direct observation by staff or family. During observation of resident cares on 2/6/12, at 5:30 p.m., R33 was sated in her room in her	F 221	F 221: Resident #33 has been re-evaluated for the use of her lap belt. Her care plan has been updated to reflect her current needs. All residents with restraints have been reviewed for least restrictive and least amount of time necessary for use of the device. Staff have been re-educated regarding use of restraints, including least restrictive, and least amount of time needed. DNS/designee will do audits weekly for 90 days of residents using restraints to determine least restrictive and least amount of time needed. Results of audits will be reviewed at QA&A. OK 3/22/12 PLH	

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

Executive Director 3/6/12

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

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

PRINTED: 02/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/09/2012

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to use the least restrictive device (lap belt) for the least amount of time for 1 of 1 residents (R33) in the sample who failed to have her lap belt removed when in direct observation of staff or family. Findings include: R33 was not released from restraint at times when she was in direct observation by staff or family. During observation of resident cares on 2/6/12, at 5:30 p.m., R33 was sated in her room in her	F 221	F 221: Resident #33 has been re-evaluated for the use of her lap belt. Her care plan has been updated to reflect her current needs. All residents with restraints have been reviewed for least restrictive and least amount of time necessary for use of the device. Staff have been re-educated regarding use of restraints, including least restrictive, and least amount of time needed. DNS/designee will do audits weekly for 90 days of residents using restraints to determine least restrictive and least amount of time needed. Results of audits will be reviewed at QA&A, and DNS will be responsible for ensuring compliance.	3-20-12

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

3-6-12

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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	245313	A. BUILDING _____ B. WING _____	02/09/2012

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F 221	Continued From page 1 wheelchair with a tray table positioned over her lap. R33 was noted to have a Velcro lap belt across her lap during the observation. R33 was seated directly beside her sister who was visiting at the time of the observation. R33's sister remained with her until 7:00 p.m. and R33 was observed to remain in her wheelchair with a lap belt across her lap. During observation of a.m. cares at 10:00 a.m. on 2/8/12, R33 was seated in her wheel chair in her room while being assisted with eating by (NAR) -A. During the observation R33 was seated directly beside NAR-A. At 10:15 a.m. NAR-A was interviewed about the use of the lap belt and verified she had not removed it while feeding R33. NAR-A stated she did not typically feed R33 but thought her lap belt should stay on so she did not attempt to get out of her chair. During interview with Registered Nurse (RN)-A at 10:53 a.m. on 2/8/12, she stated R33 would be able to transfer out of her wheelchair independently but it would not be safe. RN-A stated R33's restraint kept her from attempting to self transfer and verified R33 was unable to remove the belt independently. The facility Care Conference Note, dated 11/29/11, identified R33 with an order in place for seat belt use in her wheelchair when not in direct supervision of staff or family. The restraint was identified as used infrequently and staff were directed to release it every 2 hours when used. The note identified the risks and benefits had been communicated to family and the family consented it's use. The note further identified R33 ambulated twice daily approximately 400 ft. with	F 221		

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F 221	Continued From page 2 assist of 1 staff and gait belt. R33 was identified as able to ambulate with the use of a 4 wheeled walker. R33's Care Plan, dated 2/23/10, identified her with a seat belt when in her wheelchair when not in direct supervision of staff and identified the belt should be removed every 2 hours while supervised and being repositioned.	F 221		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain comfortable and homelike rooms and sanitary conditions for 10 of resident's rooms (R46, R27,R41, R15, R66, R55, R45, R10, R32, R70). Findings include: During the environmental tour with the Maintenance Director (MD)-A and the administrator at 11:20 a.m. on 2/9/12, the following resident's rooms were observed to have chipped/missing paint, cracked sheet rock, screw holes in the walls, scuff marks, stained call lights cords in the bathrooms, and loose grab bars in the bathroom: R46's electric wheelchair (w/c) left arm rests had been taped with black tape which was peeling off,	F 253	F 253: Residents & rooms of R #'s 46,27,41,15,66,55,45,10,32,& 70 have been repaired to ensure a homelike and sanitary environment. A maintenance schedule has been revised to ensure all residents rooms and equipment are properly maintained to ensure a homelike, and sanitary environment. Staff have been re-educated to report maintenance concerns to the maintenance department. ED/designee will do 3 audits weekly of residents rooms to ensure compliance. Results of the audits will be brought to QA&A for review, and ED will be responsible for ensuring compliance 3-20-12	

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F 253	Continued From page 3 and a small device/guard on left side of w/c was ripped exposing the wood. R46's bedroom had scuffs on the wall by the bathroom door, the heat register was bent and scuffed, gouges noted on bathroom wall, the dresser drawers warped, and closet doors did not stay shut. R27's w/c had ragged edges on the front of the seat, rips on the right corner of the back and small tears along the back edges. R41's w/c had tears on the left arm. F41's bathroom call light was functional but lacked a pull string. R41's closet doors didn't shut or latch. R15's w/c had peeling surfaces on both arm rests. R15's bedroom had peeling surfaces on the drawer fronts along the sink countertop with exposed wood, especially on the large door under sink area. R66's bathroom call light was functional but lacked a pull string. R55's w/c had peeling surfaces on the left side arm rest. Also, the heat register behind bed was warped and black scuffs were noted on the wall by bathroom door. R45's room had a 6 inch area of molding missing from the wall next to the sink. R10's bedroom had nail/hook holes in wall in several places, heat register behind bed warped, scuffs along the wall by bathroom, and the two closet doors didn't shut or latch. R32's bedroom had peeling drawer fronts and	F 253		

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F 253	Continued From page 4 some scuffs on doors in room, and the wall by bed had white plastered areas that were in need of painting. R70's bedroom had 3 walls with nail holes and scuffs that needed repainting. MD-A verified the findings during the tour, stated the rooms were in need of maintenance work, and had been put on the list. The administrator stated they would take care of the call light systems right away. At 1:30 p.m. on 2/9/12, the director of nurses verified the the w/c's stated above were in need of repair, and the facility did have a system for reporting wheelchair problems.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	F 272: R 66 has been reassessed for the use of her bed assist bar. Her care plan has been revised to reflect her current needs. All residents with bed assist bars have been assessed to determine safe use. Licensed staff have been re-educated regarding periodic assessment of the safe use of bed assist bars. DNS/designee will do 3 audits for 90days weekly to determine compliance with safe use of bed assist rails. DNS will be responsible for ensuring compliance and Results of audits will be monitored through QA&A monthly.	3-20-12

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F 272	Continued From page 5 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed conduct periodically a comprehensive, accurate, standardized reproducible assessment for 1 of 3 residents (R66) in the sample who utilized assist devices. Findings include: R66 was not assessed for the use of an assist device (bed assist bar) to ensure it was safe for her use. During observation at 4:40 p.m. on 2/6/12, R66 was lying in her bed in semi- prone position on her right side with her left arm sticking through the assist bar on the right upper side of her bed.	F 272		

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F 272	Continued From page 6 R66 was noted to be agitated and slapping at the floor, pulling at her mattress and shaking the assist bar vigorously. At 3:45 p.m. on 2/7/12, R66 was observed to be laying on bed and reaching over the edge of the bed. R66 had her positioning pillows, blankets, and body pillow laying on the floor beside the bed and was reaching through the assist bar. R66 demonstrated agitation by pulling up on her bed mattress and shaking the assist bar with her left hand. During review of R66's medical record it was noted she had sustained two falls out of bed in the past 30 days. On 1/16/12 a note to her physician identified R66's alarm was heard sounding and she was found lying on the floor on top of her blankets with no injury noted. On 1/14/12 R66's physician was notified she had fallen out of the bed to the floor between the wall and the bed, again with not injury noted. the facility response was to pull the bed away from the wall. The annual minimum data set (MDS) dated 1/20/12, did not address safety concerns with R66 reaching through the assist bar and falling out of bed. The MDS identified R66 with severely impaired cognition, easily distracted, non-ambulatory and unable to transfer in or out of bed without assistance. The Care Plan for Fall Risk dated 10/25/10, identified R66 at risk for falls related to medication use and assistance needed with transfers. The care plan interventions for falls included the use of a floor mat on the floor beside	F 272		

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F 272	Continued From page 7 the bed and a bed monitor in bed. The interventions also included maintaining the bed in a low position and maintain an environment free of litter and clutter. The care plan identified the 1/2 rail on outside of bed to assist with mobility. At 7:48 a.m. on 2/8/12, Registered Nurse (RN) -B was interviewed about the assist bar. RN-B went to R66's room and, during the observation, stated R66 had a bed alarm and floor mat. RN-B stated R66 did not use the rail for positioning so she could not identify any rationale for its use. RN-B verified the side rail should be reassessed for use.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280: R 55's Falls care plan has been revised to reflect current falls interventions. All residents with falls in the past 3 months have been reviewed to ensure their Falls care plans are current and reflect current interventions Licensed staff have been re-educated regarding the importance of updating care plans with current Falls interventions. DNS/designee will audit 3 residents with falls weekly for 90 days to ensure interventions are observed in place and are current in the care plan. Results of these audits will be followed through QA&A, with the DNS responsible for ensuring compliance.	3-20-12

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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan with new interventions following a fall for 1 of 3 residents (R55) in the sample reviewed for risks of falls and accidents. Findings include: R55's care plan was not revised to include safety interventions for the prevention of falls. R55 had the diagnoses that included congestive heart failure with exertional shortness of breath, coronary artery disease, and a history of falls with a previous fracture to the upper arm. The Admission Minimum Data Set (MDS) on 1/17/12 identified that R55 had impairment of memory recall and required extensive staff assistance in bed mobility, transfers, dressing, and toilet use; and was occasionally incontinent of urine. On 2/8/12, at 7:30 a.m. R55 was seated in her recliner chair in her room. Her personal fall alarm cord was still attached to the alarm box connected to the bed. At 8:23 a.m nurses aide (NA)-C answered R55's call light and assisted her to the restroom. At 11:55 a.m. NA-C was queried as to what current fall interventions were in place for R55 and remarked that to her knowledge, the fall alarms were to be used only in the bed and the recliner chair. NA-C stated she had never seen a fall mat used for R55 before. At 1:24 p.m.	F 280		

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F 280	Continued From page 9 R55 was in her wheelchair being pushed back to her room following lunch by NA-D. Observation of her wheelchair revealed that no fall alarms were on her wheelchair at that time. NA-D was interviewed regarding when R55 should be using the fall alarms and reported that she was not the person who got R55 up in the wheelchair for lunch; but if she had been, she would have put the alarm on the wheelchair. NA-D indicated that R55's fall alarms were to be used in all chairs and her bed. Review of the Care Area Assessment (CAA) on 1/23/12, identified that R55 had balance problems moving from a seated to standing position, when walking and turning around, moving on and off toilet, and from surface to surface transfers. R55 also had difficulty maintaining a standing position. The Care Plan Considerations section of the assessment revealed R55 was at risk for falls due to weakness and forgetfulness, "She also becomes short of breath with activity. Resident did not have a fall during reference period but did fall after. Resident also has a history of falls over a year ago with an arm fracture. Resident has been confused as to where she is and what she is doing. Interventions may include cues and reminders to request assist with cares, keep call light in reach, assess any fall for time of day, medications, cause, etc." Review of the facility's Change in Condition Report-Post Fall/Trauma identified that R55 had fallen 2 times. The report on 1/19/12, at 6:50 p.m. revealed that R55 fell while transferring herself from the wheelchair to her bed. Following this fall, a bed and chair alarm where initiated and a carpet matt was to be placed at the bedside.	F 280		

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F 280	Continued From page 10 On 1/31/12, at 1:00 p.m. R55 was found on her knees calling for help after attempting to self transfer again. The report indicated that the alarm was in place. The casual/contributing factors indicated that R55 had confusion and was unable to follow safety cues. Recommendations/Interventions to Prevent Reoccurrence included encouragement of call light use and increased frequency of bed checks. The undated NA care sheet directed staff to "make sure alarms are on." Review of the care plan revealed that R55 was at risk for falls related to confusion and recent fall. The interventions included: Mat beside bed and recliner. The care plan did not indicate to use chair alarms for the bed and chair and did not include use of the alarm when also in the wheelchair. The care plan did not indicate to keep R55's bed in the low position, nor did it indicate to increase the frequency of "bed checks." Interview with NA-D on 2/8/12, at 1:25 p.m. revealed that when she works the night shift, rounds are made to check on R55 every two hours. Review of the progress notes from 1/31/12, to 2/8/12, revealed a lack of documentation to conclude that more frequent "bed checks" were made than the standard every two hours. The director of nurses (DON) was interviewed on 2/9/12, at 1:15 p.m. and verified that no immediate interventions were initiated following R55's fall on 1/31/12, and acknowledged that R55's care plan should have been revised to	F 280		

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F 280	Continued From page 11 include the use of fall alarms when in bed and in the chair, and the bed kept in the low position. The DON additionally added that R55 was supposed to have a floor matt at the bedside and by the recliner chair and these interventions should have been carried over the R55's care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care as directed by the plan of care for services for the use of a restraint (lap Belt) as directed by the active plan of care for 1 of 1 residents (R33) in the sample, reviewed for restraint use, and for 2 of 2 residents (R33, R54) reviewed for positioning in the sample. Findings include: R33's lap belt was not released as directed by the plan of care. During observation of resident cares on 2/6/12 at 5:30 p.m. R33 was seated in her room in her wheelchair with a tray table in front of her and a Velcro lap belt across her lap. R33 was seated directly beside her sister who was visiting at the time of the observation. R33's sister remained	F 282	F282: R33 has been re-assessed for the use of her lap belt and the care plan and NA assignment sheets updated to reflect her current needs. R33 and R 54 have been reassessed for their turning and repositioning needs. Their care plans and NA assignment sheets have been revised to reflect current turning and repositioning needs. Resident care plans have been reviewed to ensure care plans are current and reflect resident turning and repositioning needs. Nursing staff have been re-educated regarding the importance of following care plans when providing resident cares. DNS/designee will do 3 audits weekly for 90 days. The DNS will be responsible for compliance. Results of these audits will be followed through QA&A.	3-20-12

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	245313	A. BUILDING _____ B. WING _____	02/09/2012

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

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F 282	Continued From page 12 with her until 7:00 p.m. and R33 was observed to remain in her wheelchair with a lap belt across her lap. At 10:00 a.m. on 2/8/12, R33 was observed to be seated in her wheel chair in her room while being assisted with eating by a nursing assistant (NAR) -A. During the observation R33 was seated directly beside NAR-A. At 10:15 a.m. NAR-A was interviewed about the use of the lap belt and verified she had not removed it while feeding R33. NAR-A stated she did not typically feed R33 but thought her lap belt should stay on so she did not attempt to get out of her chair. The Care Plan, dated 2/23/10, identified R33 with a seat belt when in her wheelchair when not in direct supervision of staff and identified the belt should belt should be removed every 2 hours while supervised and being repositioned. During observation of morning cares at 8:00 a.m. on 2/8/12 nursing assistant (NAR)-A was observed to assist R33 out of her bed and transferred into her wheelchair at 8:15 a.m. R33 remained seated in her wheelchair until 11:05 a.m. at which time NAR-A transferred her to the toilet (2 hours and 50 minutes later). During interview with NAR-A at 8:10 a.m. she verified she had not performed any other cares for R33 other than assist her with eating. She verified she had not repositioned R33. During observation of a.m. cares on 2/9/12 at 7:56 a.m. R33 was observed to be assisted out of bed and placed in her wheelchair. At 11:05 a.m.(3 hours and 9 minutes later) staff returned to R33's room and assisted her to toilet. R33's family was	F 282		

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F 282	Continued From page 13 present and verified staff had not assisted her to reposition since being assisted out of bed. R33's Care Plan, dated 2/23/10, identified her at risk for pressure ulcer development related to requiring assist with bed mobility, incontinence, and resistance to cares. The plan of care identified she was to be turned and repositioned per assessment which identified she could tolerate 2 hours in wheelchair and bed. R54 was not provided with timely repositioning according to her plan of care (POC) on 2/9/12, from 7:30 a.m. until 9:55 a.m. (2 hours and 25 minutes). The current plan of care POC revised 12/16/11, identified R54 required the assistance of 1-2 staff for transfers and repositioning and directed staff to reposition R54 every 2 hours and as needed PRN).	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely	F 314	F 314: R33 and R 54 have been reassessed for their turning and repositioning needs. Their care plans and NA assignment sheets have been revised to reflect current turning and repositioning needs. Resident care plans have been reviewed to ensure care plans are current and reflect resident turning and repositioning needs. Nursing staff have been re-educated regarding the importance of turning and repositioning as directed by care plans . DNS/designee will do 3 audits weekly for 90 days, which include direct observation of turning and repositioning to ensure compliance. DNS will be responsible for ensuring compliance. Results of these audits will be followed through QA&A.	3-20-12

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F 314	Continued From page 14 repositioning for 2 of 2 residents (R33, R54) in the sample who were identified to be at risk for pressure ulcer development. Findings include: R33 was not provided assistance with repositioning as directed by the plan of care on 2/8/12 and on 2/9/12. On 2/8/12, at 8:00 a.m., nursing assistant (NAR) -A was observed to assist R33 out of her bed and transferred into her wheelchair at 8:15 a.m. R33 remained seated in her wheelchair until 11:05 a.m. at which time NAR-A transferred her to the toilet (2 hours and 50 minutes later). NAR-A, interviewed at that time, verified R33 was not repositioned since 8:10 a.m.. During observation of a.m. cares on 2/9/12 at 7:56 a.m. R33 was observed to be assisted out of bed and placed in her wheelchair. At 11:05 a.m.(3 hours and 9 minutes later) staff returned to R33's room and assisted her to toilet. R33's family was present and verified staff had not assisted her to reposition since being assisted out of bed. R33's Care Plan, dated 2/23/10, identified her at risk for pressure ulcer development related to requiring assist with bed mobility, incontinence, and resistance to cares. The plan of care identified she was to be turned and repositioned per assessment which identified she could tolerate 2 hours in wheelchair and bed. A facility Comprehensive Skin Assessment, dated 5/31/11, identified R33 could tolerate sitting and lying for 2 hours and skin perfusion remained	F 314		

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F 314	Continued From page 15 within normal limits. The facility did not assess tissue perfusion beyond two hours. The assessment identified R33 at medium risk for pressure ulcers development related to poor food/fluid intake, resistance to cares, cognitive impairment, and incontinence. Interventions developed based on the assessment included: weekly skin checks and a 2 hour repositioning schedule. The facility conducted a Braden Scale assessment that identified R33 with a medium risk score (16) for the development of pressure ulcers. R54 was not provided with timely repositioning according to her plan of care(POC)on 2/9/12, from 7:30 a.m. until 9:55 a.m. 2 hours and 25 minutes). R54 had diagnoses including Alzheimer's disease and functional debility. The annual Minimum Data Set (MDS) dated 11/14/11, indicated R54 had severely impaired cognition and memory. The MDS identified R54 required extensive assistance with bed mobility, transferring, locomotion, and toileting. The Pressure Ulcer Care Area Assessment (CAA) dated 6/9/11, indicated R54 was at risk for pressure ulcers due to extensive assist needed with bed mobility, dementia and forgets to reposition self. The CAA indicated she did make slight changes but was dependent on staff for major changes and was incontinent of bowel and bladder which also puts her at risk. The current Braden Scale (a tool used for predicting pressure ulcer risk) dated 11/14/11, identified R54's score of 16 which indicated the resident was at risk for developing pressure	F 314		

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F 314	Continued From page 16 ulcers. The facility's Positioning Data Collection Tool (a tool used to determine the skin's ability to withstand pressure in sitting and lying positions and which can be used to determine an appropriate repositioning schedule) dated 6/8/11, indicated R54 tolerated 2 hours when sitting. The current plan of care (POC) revised 12/16/11, identified R54 required the assistance of 1-2 staff for transfers and repositioning and directed staff to reposition R54 every 2 hours and as needed (PRN). On 2/9/12, at 7:45 a.m. R54 was seated in a wheelchair (w/c) in her room. During random observations at 8:00 a.m., 8:15 a.m., and 8:30 a.m. R54 remained seated in the w/c in her room. At 8:35 a.m. R54 was wheeled to the dining room. At 9:35 a.m. R54 was wheeled into the resident's room by nursing assistant (NA)-A and remained in the w/c. At 9:55 a.m. NA-A assisted R54 on to the toilet, R54 ' s bottom was red. At that time, NA-A verified R54 had last been repositioned at 7:30 a.m. and stated R54's care plan directed staff to reposition the resident every 2 hours. On 2/9/12, at 10:00 a.m. NA-A stated R54 had not been repositioned since 7:30 a.m. NA-A verified R54 should be repositioned every 2 hours which would have been due at 9:30 a.m., but verified R54 was not repositioned until 9:55 a.m., which was 25 minutes late.	F 314		

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F 314	Continued From page 17 On 2/9/12, at 1:20 p.m. the DON verified R54 should be repositioned every 2 hours as the care plan directed	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the resident environment remains as free of accident hazards for 1 of 3 (R66) in the sample who used assit bars. Findings include: R66 failed to have the use of an assist device (bed assist bar) assessed to identify if it was safe for her use. During observation of R66 at 4:40 p.m. on 2/6/12 she was noted to be lying in her bed in semi-prone position on her right side with her left arm sticking through the assist bar on the right upper side of her bed. The resident was noted to be agitated and slapping at the floor, pulling at her mattress and shaking the assist bar vigorously.	F 323	F 323: R 66 has been reassessed for the use of her bed assist bar. Her care plan has been revised to reflect her current needs. All residents with bed assist bars have been assessed to determine safe use. Licensed staff have been re-educated regarding periodic assessment of the safe use of bed assist bars. DNS/designee will do 3 audits for 90days weekly, which include direct observation of bed assist rail use. DNS will be responsible for ensuring compliance with safe use of bed assist rails. Results will be monitored through QA&A monthly.	3-20-12

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F 323	Continued From page 18 During observation of resident at 3:45 p.m. on 2/7/12 resident was observed to be laying on bed reaching over the edge of the bed. The resident had her positioning pillows, blankets, and body pillow laying on the floor beside the bed and was noted to be reaching through the assist bar. The resident demonstrated agitation and was pulling up on her bed mattress and shaking the assist bar with her left hand. During review of R66's medical record it was noted she had sustained two falls out of bed in the past 30 days. On 1/16/12 a note to her physician identified R66's alarm was heard sounding and she was found lying on the floor on top of her blankets with no injury noted. On 1/14/12 R66's physician was notified she had falling out of the bed to the floor between the wall and the bed. She was identified to not sustain injury with either fall. The facility response was to pull the bed away from the wall. The facility reassessed the assist bar on 1/30/12 and the assessment identified R66 with memory problems, severely impaired cognition, easily distracted, non-ambulatory and unable to transfer in or out of bed without assistance. The facility failed to assess the residents safety with the use of the device even when she had fallen out of bed and demonstrated agitation in the bed. R66's Care Plan for Fall Risk dated 10/25/10 identified her at risk for falls related to medication use, and assistance needed with transfers. The care plan interventions for falls included the use of a floor mat on the floor beside the bed and a bed monitor in bed. The interventions also included maintaining the bed in a low position and	F 323		

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F 323	Continued From page 19 maintain an environment free of litter and clutter, She was identified to have a 1/2 rail on outside of bed to assist with mobility. At 7:48 a.m. on 2/8/12 Registered Nurse (RN) -B was interviewed about the assist bar. The RN went to R66's room and during the observation RN-B stated the R66 had an alarm in her bed and had a mat on the floor beside the bed and did not use the rail for positioning so she could not identify any rationale for its use. She verified if the resident was not using the assist bar and was agitated the rail needed to be reassessed for use. At 12:10 p.m. on 2/8/12 RN-B was interviewed again and she stated she had the assist bar removed this a.m. after our discussion about the necessity and safety. RN-B verified the resident was not using the rail and in light of her falls from bed there should be a reassessment and stated after reassessing it today she deemed it not indicated and had it removed. RN-B conducted a new Side Rail Assessment on 2/8/12 that identified R66 with memory problems, periods of restlessness, and requiring assistance with transfers and bed mobility, R66 was further identified to be able to turn self in bed and transfer in/out of bed with assistance. The assessment also identified R66 did not use rail to turn and indicated R66 had no medical diagnosis that warranted side rail use. At 8:02 a.m. on 2/9/12 nursing assistant (NAR)-A was interviewed about the use of the side rail. NAR-A stated,"It is good the side rail was removed because [R66] did not use them to turn but was very resistive to cares and would grab	F 323		

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F 323	Continued From page 20 the bars tightly and shake the rail and it was difficult to transfer her out of bed." NAR-A stated R66 had been unable to us the bar to assist with transfers for several months R66's last assessment dated 1/20/12 was an Annual Minimum Data Set (MDS) assessment. Even though the facility reassessed the use of R66's side rail on 1/30.12 the assessment failed to be comprehensive and assess the potential safety concerns with it's use and failed to accurately reflect her ability to utilize the device. Based on observation, interview and document review, the facility failed to follow care plan interventions for falls; and failed to revise the care plan with new interventions following a fall for 1 of 3 residents (R55) in the sample reviewed for risks of falls and accidents. Findings include: R55's care plan was not revised with new fall interventions following a fall on 1/31/12, and staff were not following R55's care plan with the appropriate fall prevention precautions. R55 had the diagnoses that included congestive heart failure with exertional shortness of breath, coronary artery disease, and a history of falls with a previous fracture to the upper arm. The Admission Minimum Data Set (MDS) on 1/17/12 identified that R55 had impairment of memory recall and required extensive staff assistance in bed mobility, transfers, dressing, and toilet use; and was occasionally incontinent	F 323		

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F 323	Continued From page 21 of urine. On 2/8/12, at 7:30 a.m. R55 was seated in her recliner chair in her room. Her personal fall alarm cord was still attached to the alarm box connected to the bed. At 8:23 a.m nurses aide (NA)-C answered R55's call light and assisted her to the restroom. At 11:55 a.m. NA-C was queried as to what current fall interventions were in place for R55 and remarked that to her knowledge, the fall alarms were to be used only in the bed and the recliner chair. NA-C stated she had never seen a fall mat used for R55 before. At 1:24 p.m. R55 was in her wheelchair being pushed back to her room following lunch by NA-D. Observation of her wheelchair revealed that no fall alarms were on her wheelchair at that time NA-D was interviewed regarding when R55 should be using the fall alarms and reported that she was not the person who got R55 up in the wheelchair for lunch; but if she had been, she would have put the alarm on the wheelchair. NA-D indicated that R55's fall alarms were to be used in all chairs and her bed. Review of the Care Area Assessment (CAA) on 1/23/12, identified that R55 had balance problems moving from a seated to standing position, when walking and turning around, moving on and off toilet, and from surface to surface transfers. R55 also had difficulty maintaining a standing position. The Care Plan Considerations section of the assessment revealed R55 was at risk for falls due to weakness and forgetfulness, "She also becomes short of breath with activity. Resident did not have a fall during reference period but did fall after. Resident also has a history of falls over	F 323		

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F 323	Continued From page 22 a year ago with an arm fracture. Resident has been confused as to where she is and what she is doing. Interventions may include cues and reminders to request assist with cares, keep call light in reach, assess any fall for time of day, medications, cause, etc." Review of the facility's Change in Condition Report-Post Fall/Trauma identified that R55 had fallen 2 times. The report on 1/19/12, at 6:50 p.m. revealed that R55 fell while transferring herself from the wheelchair to her bed. Following this fall, a bed and chair alarm where initiated and a carpet matt was to be placed at the bedside. On 1/31/12, at 1:00 p.m. R55 was found on her knees calling for help after attempting to self transfer again. The report indicated that the alarm was in place. The casual/contributing factors indicated that R55 had confusion and was unable to follow safety cues. Recommendations/Interventions to Prevent Reoccurrence included encouragement of call light use and increased frequency of bed checks. The undated NA care sheet directed staff to "make sure alarms are on." Review of the care plan revealed that R55 was at risk for falls related to confusion and recent fall. The interventions included: Mat beside bed and recliner. The care plan did not indicate to use chair alarms for the bed and chair and did not include use of the alarm when also in the wheelchair. The care plan did not indicate to keep R55's bed in the low position, nor did it indicate to increase the frequency of "bed checks."	F 323		

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

PRINTED: 02/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	02/09/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 Interview with NA-D on 2/8/12, at 1:25 p.m. revealed that when she works the night shift, rounds are made to check on R55 every two hours. Review of the progress notes from 1/31/12, to 2/8/12, revealed a lack of documentation to conclude that more frequent "bed checks" were made than the standard every two hours. The director of nurses (DON) was interviewed on 2/9/12, at 1:15 p.m. and verified that no immediate interventions were initiated following R55's fall on 1/31/12, and acknowledged that R55's care plan should have been revised to include the use of fall alarms when in bed and in the chair, and the bed kept in the low position. The DON additionally added that R55 was supposed to have a floor matt at the bedside and by the recliner chair.	F 323		

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	245313	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2012

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

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K 000	INITIAL COMMENTS Surveyor: 27200 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety. At the time of this survey, Golden Living Center - Meadow Lane was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Living Center - Meadow Lane is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a licensed capacity of 62 and had a census of 52 at the time of the survey.	K 000		

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

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