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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4766

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245273**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **12/01/2014** (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 **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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	IID
	46			
(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):

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Supervisor 12/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/05/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1985
(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
11/03/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245273

December 5, 2014

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, Minnesota 55333

Dear Mr. Fischgrabe:

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 November 24, 2014 the above facility is certified for:

46 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 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 feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: December 5, 2014

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, Minnesota 55333

RE: Project Number S5273025

Dear Mr. Fischgrabe:

On October 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 15, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 15, 2014, effective November 24, 2014 and therefore remedies outlined in our letter to you dated October 22, 2014, will not be imposed.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-969

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245273	A. Building B. Wing	12/1/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**11/24/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**11/24/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GL/AK	Date: 12/05/2014	Signature of Surveyor: 15507	Date: 12/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/15/2014		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**

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(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **10/15/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :
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13.Total Certified Beds **46** (L17)

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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(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):

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 10/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/30/2014 (L20)

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

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____ 2. Facility is not Eligible
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03/01/1985
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 22, 2014

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, Minnesota 55333

RE: Project Number S5273025

Dear Mr. Fischgrabe:

On October 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Gloria Derfus, Gayle Lantto, and Sue Ruess, Unit Supervisors
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Gloria Derfus
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 November 24, 2014, 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 January 15, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 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.

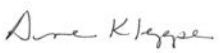
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were readily accessible for 2 of 3 residents (R5, R38) reviewed for accidents. Findings include: On 10/13/14, at 4:25 p.m. during a room observation, the resident call light was observed underneath the mattress, towards the head of	F 246	F246 Call cords have been placed within reach for residents R5 and R38. All residents needing assistance have the potential to be affected if call light placement is not within reach. Clips have beebn applied to all call cords	11/24/14

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

Electronically Signed | 10/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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 246	Continued From page 1 bed, and not visible without searching for it. R5 was lying in her bed at the time of observation. -When asked if she used the call light R5 indicated she used it. When asked to demonstrate using the call light she was hesitate but was able to do it. -At 10/13/14, at 4:19 p.m. licensed practical nurse (LPN)-A stated "sometimes she uses the call light and sometimes not." LPN-A verified the call light was not reachable for R5, as it was underneath the mattress. On 10/14/14, at 2:19 to 2:26 p.m. R5 was observed lying on top of the bed, with her eyes closed, and the television on. The call light was observed again lying on floor under bed not visible or accessible. -At 2:26 p.m. nursing assistant (NA)-A verified the call light was on the floor, out of R5's reach. NA-A verified R5 was able to and did use the call light. During the environmental tour on 10/14/14, at 2:09 p.m. the director of maintenance services stated facility policy was all call lights were supposed to be in reach at all times. On 10/14/14, at 2:40 p.m. the director of nursing (DON) stated her expectation was all residents call lights were supposed to be within reach of the resident. The fall care plan dated 12/25/13, identified R5 at risk for falls related to wandering, use of medication, pain to right knee and history of falls. The care plan directed staff to ensure Call light and personal items available and in easy reach. R5's quarterly Minimum Data Set (MDS) dated	F 246	to enable attaching them within the reach of the resident. Staff have been re-educated on the importance of residents having accesibility to call cords. The DNS/designee will audit call light placement 3 times per week for 60 days. Negative findings will be corrected immediately and reviewed at QA&A.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	10/15/2014

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F 246	Continued From page 2 9/24/14, indicated R5 had moderately impaired cognition. R5's fall Care Area Assessment dated 7/1/14, identified R5 was at risk for falls and directed staff, "call light is within reach." Call Light, Use of policy dated 2006, directed, "Be sure all call lights are placed within reach at all times, never on the floor." R38 On 10/13/14, at 3:53 p.m. during room observation, R38 was observed awake, covered in a blanket and was lying on bed. R38's call light was observed on top of bed at the foot part, and was close to the wall. The call light was not visible to R38 with the bed in a flat position, R38's head was resting on one pillow, and R38 was on a right side-lying position where R38's back was towards the wall. The call light was not within R38's reach. -At 3:55 p.m. LPN-A verified call light was not within R38's reach. LPN-A stated R38 would put call light on if she really needed to go the bathroom. LPN-A then picked the call light from foot of bed and placed it within R38's reach before leaving the room. On 10/14/14, at 2:05 p.m. R38 was observed to be seated in wheelchair facing the television, with her back towards the bed. R38's call light was observed on top of bed, behind R38 and on R38's right side. A lazy chair was on R38's right side, about a foot from wheelchair that blocked and made it impossible for R38 to maneuver wheelchair to reach for the call light. When asked, R38 did not know where the call light was located. -At 2:07 p.m. surveyor called NA-A into R38's room, where NA-A verified the call light was not within R38's reach. NA-A stated R38 could stroll around room, once in a while "would hit the	F 246		

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	245273	A. BUILDING _____ B. WING _____	10/15/2014

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F 246	Continued From page 3 button" if R38 needed help. NA-A moved lazy chair farther from R38's wheelchair, made way to bed, took the call light from the bed and secured it in wheelchair, which was then within R38's reach. R38's Admission Record dated 12/9/13, indicated R38 had diagnoses to include: Huntington's Chorea (disease that slowly diminishes the affected individual's ability to walk, talk and reason, eventually making the affected person totally dependent upon others for his or her care), dysarthria (speech disorder), anxiety, mood disorder, and mental disorder due to medical conditions. R38's quarterly MDS dated 8/26/14, identified R38 to need extensive assist with activities of daily living (ADL). The care area assessments (CAA) dated 11/29/13, indicated R38 had ADL functional decline as evidenced by R38 requiring limited to extensive assistance with almost all of ADL. R38's care plan dated 12/3/13, indicated R38 had self-care impairment and mobility impairment. The care plan directed staff to provide R38 extensive assistance to move up in bed, from rolling side to side, get into/out of bed, sit up/lie down in bed and to put call light within R38's reach. On 10/14/14, at 2:40 p.m. the DON stated her expectation was all residents call lights were supposed to be at reach. During the environmental tour on 10/14/14, at 2:09 p.m. the director of maintenance services stated facility policy was all call lights were	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 246	Continued From page 4 supposed to be in reach at all times.	F 246		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		11/24/14

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure five residents (R54, R55, R11, R17, R3) were free of potential cross contamination when receiving blood glucose monitoring. Findings include: R54, R55, R11, R17, and R3 all had diagnoses of diabetes mellitus and required blood glucose monitoring (a test of blood sugar used for diabetic residents). On 10/13/14, at 4:48 p.m. licensed practical nurse (LPN)-A was observed to administer a blood glucose test to R11. LPN-A with lancet poked R11's finger, received a drop of R11's blood on test strip in the glucometer. After the blood glucose testing LPN-A wiped the glucometer down, on every side of it with one alcohol wipe. LPN-A set the glucometer down and stated she would let it air dry before putting the monitor back in its case. LPN-A stated this same glucometer was used for five residents on the West wing. LPN-A also stated, the facility process was to use the same monitor for residents' blood glucose testing, and to clean the monitor with an alcohol wipe in between residents. At 6:46 p.m. the director of nursing (DON) stated the glucometer was to be cleaned after each resident usage with bleach wipes and not alcohol wipes.	F 441	F441 Glucometers have all been properly cleaned according to infection control protocol. Residents requiring glucose monitoring have the potential to be affected by improper glucometer cleaning. Licensed staff have been re-educated and performed return demonstration on the proper procedure for glucometer cleaning. Staff Development Coordinator/designee will be responsible for observation of proper cleaning of glucometers by licensed staff 3 times per week for 60 days. Negative findings will be corrected immediately and reviewed at QA&A.	

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	245273	A. BUILDING _____ B. WING _____	10/15/2014

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F 441	Continued From page 6 At 6:55 p.m. DON provided a copy of the facility blood glucose monitor decontamination policy. On 10/14/14, at 1:35 p.m. LPN-A stated she had been trained at the facility to use the facility bleach wipes and not the alcohol wipes on the glucometer. LPN-A also stated she had worked at another facility where they used alcohol wipes and probably was why she used the alcohol wipe and not the bleach wipe. LPN-A further stated the DON had corrected her regarding this. On 10/15/14, at 1:26 p.m. LPN-C verified R54, R55, R11, R17, and R3's glucose monitoring was done with the same glucometer monitor observed by surveyor. Policy dated 6/12, for Blood Glucose Monitor Decontamination read: " Purpose: To implement a safe and effective process for decontaminating blood glucose monitors. A wipe that is an EPA [Environmental Protection Agency] registered as tuberculocidal; effective against HIV [human immunodeficiency virus], HBV [hepatitis B], and a broad spectrum of bacteria will be utilized to clean the monitor. It is 0.525% sodium hypochlorite which is equivalent to a 1:10 bleach dilution solution, and meets recommendation for use on equipment from Clostridium difficile rooms. If a product wipe is not available, a 1:10 bleach solution may be substituted. 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		

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	245273	A. BUILDING _____ B. WING _____	10/15/2014

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F 441	Continued From page 7 Procedure: After performing the glucose testing, the nurse, wearing gloves will use a Clorox wipe to clean all external parts of the monitor. A second wipe will be used to disinfect the blood glucose monitor. "	F 441		

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	245273	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 15, 2014. At the time of this survey, Golden Living Center Franklin 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Golden Living Center Franklin was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The building has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 46 beds and had a census of 40 at time of the survey.	K 000		

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 22, 2014

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, Minnesota 55333

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5273025

Dear Mr. Fischgrabe:

The above facility was surveyed on October 13, 2014 through October 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	10/15/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 13, 14, and 15, 2014 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		11/24/14

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21375	Continued From page 2 Based on observation and interview the facility did not ensure five residents (R54, R55, R11, R17, R3) were free of potential cross contamination when receiving blood glucose monitoring. Findings include: R54, R55, R11, R17, and R3 all had diagnoses of diabetes mellitus and required blood glucose monitoring (a test of blood sugar used for diabetic residents). On 10/13/14, at 4:48 p.m. licensed practical nurse (LPN)-A was observed to administer a blood glucose test to R11. LPN-A with lancet poked R11's finger, received a drop of R11's blood on test strip in the glucometer. After the blood glucose testing LPN-A wiped the glucometer down, on every side of it with one alcohol wipe. LPN-A set the glucometer down and stated she would let it air dry before putting the monitor back in its case. LPN-A stated this same glucometer was used for five residents on the West wing. LPN-A also stated, the facility process was to use the same monitor for residents' blood glucose testing, and to clean the monitor with an alcohol wipe in between residents. At 6:46 p.m. the director of nursing (DON) stated the glucometer was to be cleaned after each resident usage with bleach wipes and not alcohol wipes. At 6:55 p.m. DON provided a copy of the facility blood glucose monitor decontamination policy. On 10/14/14, at 1:35 p.m. LPN-A stated she had been trained at the facility to use the facility bleach wipes and not the alcohol wipes on the	21375	Corrected	

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21375	Continued From page 3	21375		

glucometer. LPN-A also stated she had worked at another facility where they used alcohol wipes and probably was why she used the alcohol wipe and not the bleach wipe. LPN-A further stated the DON had corrected her regarding this.

On 10/15/14, at 1:26 p.m. LPN-C verified R54, R55, R11, R17, and R3's glucose monitoring was done with the same glucometer monitor observed by surveyor.

Policy dated 6/12, for Blood Glucose Monitor Decontamination read:

" Purpose: To implement a safe and effective process for decontaminating blood glucose monitors. A wipe that is an EPA [Environmental Protection Agency] registered as tuberculocidal; effective against HIV [human immunodeficiency virus], HBV [hepatitis B], and a broad spectrum of bacteria will be utilized to clean the monitor. It is 0.525% sodium hypochlorite which is equivalent to a 1:10 bleach dilution solution, and meets recommendation for use on equipment from Clostridium difficile rooms. If a product wipe is not available, a 1:10 bleach solution may be substituted.

Policy: The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents.

Procedure: After performing the glucose testing, the nurse, wearing gloves will use a Clorox wipe to clean all external parts of the monitor. A second wipe will be used to disinfect the blood glucose monitor. "

Suggested Method of Correction: The director of

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	00934	A. BUILDING: _____ B. WING _____	10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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) COMPLETE DATE
21375	Continued From page 4 nursing (DON) or her designee could review policies and procedures regarding the infection control program. The DON or her designee could ensure staff received education on the policies and procedures with a focus on proper procedures for cleaning resident equipment. Time Period for Correction: Twenty-one (21) days.	21375		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were readily accessible for 2 of 3 residents (R5, R38) reviewed for accidents. Findings include: On 10/13/14, at 4:25 p.m. during a room observation, the resident call light was observed underneath the mattress, towards the head of bed, and not visible without searching for it. R5 was lying in her bed at the time of observation. -When asked if she used the call light R5	21810	Corrected	11/24/14

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21810	Continued From page 5 indicated she used it. When asked to demonstrate using the call light she was hesitate but was able to do it. -At 10/13/14, at 4:19 p.m. licensed practical nurse (LPN)-A stated "sometimes she uses the call light and sometimes not." LPN-A verified the call light was not reachable for R5, as it was underneath the mattress. On 10/14/14, at 2:19 to 2:26 p.m. R5 was observed lying on top of the bed, with her eyes closed, and the television on. The call light was observed again lying on floor under bed not visible or accessible. -At 2:26 p.m. nursing assistant (NA)-A verified the call light was on the floor, out of R5's reach. NA-A verified R5 was able to and did use the call light. During the environmental tour on 10/14/14, at 2:09 p.m. the director of maintenance services stated facility policy was all call lights were supposed to be in reach at all times. On 10/14/14, at 2:40 p.m. the director of nursing (DON) stated her expectation was all residents call lights were supposed to be within reach of the resident. The fall care plan dated 12/25/13, identified R5 at risk for falls related to wandering, use of medication, pain to right knee and history of falls. The care plan directed staff to ensure Call light and personal items available and in easy reach. R5's quarterly Minimum Data Set (MDS) dated 9/24/14, indicated R5 had moderately impaired cognition. R5's fall Care Area Assessment dated 7/1/14, identified R5 was at risk for falls and directed staff, "call light is within reach."	21810		

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21810	Continued From page 6 Call Light, Use of policy dated 2006, directed, "Be sure all call lights are placed within reach at all times, never on the floor." R38 On 10/13/14, at 3:53 p.m. during room observation, R38 was observed awake, covered in a blanket and was lying on bed. R38's call light was observed on top of bed at the foot part, and was close to the wall. The call light was not visible to R38 with the bed in a flat position, R38's head was resting on one pillow, and R38 was on a right side-lying position where R38's back was towards the wall. The call light was not within R38's reach. -At 3:55 p.m. LPN-A verified call light was not within R38's reach. LPN-A stated R38 would put call light on if she really needed to go the bathroom. LPN-A then picked the call light from foot of bed and placed it within R38's reach before leaving the room. On 10/14/14, at 2:05 p.m. R38 was observed to be seated in wheelchair facing the television, with her back towards the bed. R38's call light was observed on top of bed, behind R38 and on R38's right side. A lazy chair was on R38's right side, about a foot from wheelchair that blocked and made it impossible for R38 to maneuver wheelchair to reach for the call light. When asked, R38 did not know where the call light was located. -At 2:07 p.m. surveyor called NA-A into R38's room, where NA-A verified the call light was not within R38's reach. NA-A stated R38 could stroll around room, once in a while "would hit the button" if R38 needed help. NA-A moved lazy chair farther from R38's wheelchair, made way to bed, took the call light from the bed and secured	21810		

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21810	Continued From page 7 it in wheelchair, which was then within R38's reach. R38's Admission Record dated 12/9/13, indicated R38 had diagnoses to include: Huntington's Chorea (disease that slowly diminishes the affected individual's ability to walk, talk and reason, eventually making the affected person totally dependent upon others for his or her care), dysarthria (speech disorder), anxiety, mood disorder, and mental disorder due to medical conditions. R38's quarterly MDS dated 8/26/14, identified R38 to need extensive assist with activities of daily living (ADL). The care area assessments (CAA) dated 11/29/13, indicated R38 had ADL functional decline as evidenced by R38 requiring limited to extensive assistance with almost all of ADL. R38's care plan dated 12/3/13, indicated R38 had self-care impairment and mobility impairment. The care plan directed staff to provide R38 extensive assistance to move up in bed, from rolling side to side, get into/out of bed, sit up/lie down in bed and to put call light within R38's reach. On 10/14/14, at 2:40 p.m. the DON stated her expectation was all residents call lights were supposed to be at reach. During the environmental tour on 10/14/14, at 2:09 p.m. the director of maintenance services stated facility policy was all call lights were supposed to be in reach at all times. A SUGGESTED METHOD FOR CORRECTION: An interdisciplinary team [IDT] could review,	21810		

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21810	Continued From page 8 revise and implement policies and procedures to ensure that residents receive care appropriate to their individualized needs and preferences. The IDT or designee could educate all staff. The facility could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21810		