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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53TO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245306**

2. STATE VENDOR OR MEDICAID NO. (L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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

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

6. DATE OF SURVEY **03/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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 (PCR) of Health and Life Safety Code Surveys completed on 03/28/2016. Refer to CMS form 2567B.
Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been approved.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff Unit Supervisor 03/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/8/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245306

March 30, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

Dear Mr. Richardson:

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 22, 2016 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306026

Dear Mr. Richardson:

On February 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 14, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2016, effective March 22, 2016 and therefore remedies outlined in our letter to you dated February 29, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245306 Y1	A. Building B. Wing Y2	3/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0281	Correction	ID Prefix F0282	Correction	ID Prefix F0311	Correction
Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed
LSC	03/22/2016	LSC	03/22/2016	LSC	03/22/2016
ID Prefix F0314	Correction	ID Prefix F0425	Correction	ID Prefix F0431	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	03/22/2016	LSC	03/22/2016	LSC	03/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	03/30/2016	10160	03/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245306 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	3/14/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 02/10/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 02/10/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 02/10/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 03/30/2016	SIGNATURE OF SURVEYOR 37008	DATE 03/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53TO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245306**

2. STATE VENDOR OR MEDICAID NO. (L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **02/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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):
Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded.
Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 03/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 29, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306026

Dear Mr. Richardson:

On February 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 22, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 22, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 May 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop an initial dialysis care plan that included emergency site care and nutritional needs for 1 of 1 resident (R110) reviewed for dialysis. Findings include: R110 was observation on 2/9/16, at 2:44 p.m. when visiting with resident, also R110's dialysis access site was visualized on the upper right chest wall. Dressing was clean dry and intact. R110 indicated he received a sandwich before one of the dialysis appointments and another time didn't receive a meal until he arrived back from the dialysis appointment and the food was cold. R110's family member indicated R110 had	F 281	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	3/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	02/11/2016

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F 281	Continued From page 1 swallowing difficulties and was on a mechanical soft diet and required thickened liquids. R110 was admitted to the facility on 2/1/16 with diagnoses that included renal failure and dysphasia according to the facility's admission record. R110's hospital discharge summary dated 2/1/16 included dietary orders for a low potassium mechanical soft diet with honey- thickened liquids. Discharge summary also included need for renal dialysis three times per week. R110's initial care plan dated 2/2/16 did not identify R110's need for renal dialysis, corresponding dietary needs, or dialysis catheter care or emergency nursing interventions. During an interview on 2/10/16, at 10:02 a.m., nursing assistant (NA)-D stated did not know where R110's dialysis access site was located. During an interview on 2/10/16, at 10:07 a.m. registered nurse (RN)-C was not able to explain who was responsible for providing R110 meals on dialysis days, and stated, "I am not sure what we are doing for meals." RN-C reviewed the care plan and indicated the care plan did not address any dialysis needs. During an interview on 2/10/16, at 10:09 a.m., trained medication assistant (TMA)-A stated, "I think they [dietary staff] bring him a tray before he goes to dialysis.", in response to the question, how does meal times work for R110 on dialysis days? During an interview on 2/10/16, at 10:22 a.m. dietary aide (DA)-A stated, "We give him a cold-cut sandwich before he leaves." DA-A was not aware of who was responsible for ensuring R110 was given meals prior to leaving for dialysis. During an interview on 2/10/16, at 12:09 p.m.	F 281	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F281 -R110 no longer resides in the facility. -Residents receiving dialysis services have the potential to be affected if an initial dialysis care plan is not developed to address emergency interventions, dialysis site care, and nutritional needs. -Licensed staff has been educated on care planning requirements for residents receiving dialysis services. -Weekly audits will be completed on residents receiving dialysis services to ensure site care, emergency care, and nutritional needs are addressed in the care plan. Negative results will be immediately corrected. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	

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F 281	Continued From page 2	F 281		

registered dietician (RD) stated, she had not completed the dietary comprehensive assessment because R110 was still in the assessment period. RD stated the dietary manager visits with residents within 72 hours to determine preferences. RD explained dietary manager was new in the manager role and was still learning. RD indicated the initial care plan should be in place as soon as possible.

During an interview on 2/10/16, at 12:21 p.m. with dietary manager (DM) and RD, the DM stated she had not seen the resident yet to do the initial evaluation. DM stated usually residents were seen within 72 hours. DM explained information concerning R110's dietary needs were obtained from the hospital discharge summary. DM stated RD develops the dietary care plan. During the interview both the RD and the DM stated it was unclear who was responsible for ensuring R110 received meals on dialysis days and that it needed to be determined.

On 2/10/16, at 1:34 p.m. outpatient dialysis RN-Z was interviewed pertaining to the care of the dialysis access catheter. RN-Z explained a memorandum of explicit instructions for emergency procedures and catheter care was sent to the facility with the resident. RN-Z stated facility nursing staff should do absolutely nothing with the line itself, the dressing always needs to be dry, it cannot get wet and should be covered when bathing, if the dressing would start to come off, they need to send the resident into the clinic or emergency room to have it changed. A copy of the memorandum was requested from the RN-Z to be sent to the facility by the surveyor and was received from the facility on 2/11/16.

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F 281	Continued From page 3 It was not evident R110's record contained the dialysis memorandum or the information on the memorandum that pertained to R110. During an interview on 2/11/16, at 1:34 p.m. director of nursing (DON) stated, her expectation was nursing develop an initial dialysis care plan that included communication between facility and outpatient dialysis unit, emergency plan of care for the dialysis access site, and nutritional needs of the resident. Facility policy Dialysis Guideline last reviewed 10/5/15 included: "Be aware of any meals that may be missed and arrange for routine boxed lunches to be provided by dietary if resident is transported off-site." and "care plan inclusive of safety, assessment, emergency measures in place."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care according to care plan 1 of 1 resident (R24) who had long thick fungal fingernails. Also the facility failed to utilize a walking device per the physicians order and care plan 1 of 3 residents (R26) reviewed for pressure ulcers.	F 282	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed	3/22/16

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F 282	Continued From page 4 Findings include: R24 was observed on 02/08/16, at 2:45 p.m. to have very long fingernails on his right hand. R24's fingernails were observed with register nurse (RN)-B in his room on 02/10/16 at 2:13 p.m. RN-B stated all of the fingernails on R24's right hand were think and long. At this time R24 stated he had fungus in his nails and had had this for many years. RN-B state she would talk to the nurse practitioner about getting medicine for his fingernails that had evidence of the fungus. R24's care plan instructed staff to provide nail care as needed with date initiated 09/30/2014. R24's quarterly Minimum Data Set (MDS) dated 1/16/16; revealed R168 had a brief interview for mental status score of 15 which indicated intact cognition and required extensive assist of one staff for personal hygiene. R24's nurse progress note dated 2/10/16 2:36 p.m. read, "Writer [RN-B] of note assessed residents right hand fingernails in comparison to left hand. All five nails on the right hand appear to be thicker and longer in comparison to the nails on the left hand. Writer of note spoke with CNP [certified nurse practitioner-A], she states she will assess the nails as well and make further recommendation." R24's CNP-A's visit noted dated 2/10/16 read, "...Nursing is requesting to have the fingernails on his right hand cut, as they are very thick and infected with nail fungus. Nursing has been unable to cut his fingernails on his right hand, and they are very long and thick..."	F 282	in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F282 -R24 no longer resides in the facility. R26 physicians' orders for CAM boot have been reviewed and care planned accordingly. -Residents needing assistance with nail care have the potential to be affected if routine nail care is not provided according to care plan. Additionally, residents at risk for development of pressure ulcers have the potential to be affected if devices are not utilized according to physicians order and care plan. -Licensed staff has been educated on providing services in accordance with each resident's written plan of care. CNA's have been educated on following care guides for application/removal of	

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F 282	Continued From page 5 On 2/11/16, 10:41 a.m. nursing assistant (NA)-A stated she was aware of his long thick nails on his right hand and stated people that come to do foot care take care of the nails on his right hand when he is seen. NA-A stated his nails on his right hand are too thick for her to cut. On 2/11/16, 10:58 a.m. NA-B stated the fingernails on his right hand were thicker. NA-B stated she has never trimmed R24's fingernails on the right hand and stated she thought a nurse would need to trim them. On 2/11/16, 8:53 a.m. the director of nursing (DON) stated it would not be appropriate for facility staff to clip R24's fungal nails as they were too thick. The DON stated staff monitored nails weekly for the bath and skin assessment and should be informing nursing the need for nail care. On 2/11/16, at 9:29 a.m. registered nurse (RN)-A stated she was unaware of the finger nails being think and long on R24's right hand. RN-A stated she had never looked at his finger nails before. Stated on 12/15/15 was the last skin check she has done and stated she did not notice the fungal fingernails then. RN-A stated when she completed a resident's skin assessment she looked at finger nails, toenails and pretty much everything on the resident from head to toe. RN-A stated if a concern was identified during a skin assessment with a resident's fingernails a referral would be made to either the nurse practitioner or podiatry. RN-A stated R24 had been seen by podiatry in the past and thought podiatry addressed R24's toe nails and fingernails. RN-A verified there were no podiatry notes documented	F 282	devices. -Random weekly audits will be conducted on provision of nail care. Audits will include appropriate device use/removal per physicians' orders. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	

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F 282	Continued From page 6	F 282		

in the records regarding services provided to R24. RN-A verified she did not see documentation of the thick, long nails in the progress notes or in the nurse practitioner visit notes she reviewed for R24.

On 2/11/16, at 11:12 a.m. R24 stated his fingernails were cut yesterday (by CNP-A) and stated he did could not recall having the fingernails on his right hand cut prior to yesterday at the facility.

LACK OF FOLLOWING CARE PLAN FOR USE OF CONTROLLED ANKLE MOVEMENT (CAM) BOOTS:

R26 was observed on 2/9/16 at 8:23 a.m., R26 was sitting in his wheelchair in the dining hall. R26 had a CAM boot on his right lower extremity.

During an observation on 2/9/16 at 3:14 p.m., R26 was observed to be sitting in his wheelchair in his room. He had a CAM boot on his right lower extremity.

During an observation on 2/9/16 at 4:01 p.m., R26 was observed to be sitting in his wheelchair in his room. His CAM boot was on his right lower extremity.

During an observation on 2/10/16 at 7:52 a.m., Nursing Assistant (NA)-C entered R26's room. R26 was observed to be fully dressed. NA-C put a shoe on R26's left foot and then proceeded to put the CAM boot on R26's right leg. NA-C then assisted R26 to a sitting position on the side of the bed. NA-C assisted the resident to his wheelchair. NA-C then finished assisting the resident with grooming cares. Once grooming was completed, NA-C attached foot pedals on

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R26's wheelchair and assisted the resident with putting his feet in them. The CAM boot had not been removed following the transfer to the wheelchair. NA-C assisted R26 down the hallway and took him to the dining room where he was placed at a table. NA-C then left the vicinity. The CAM boot was still in place on R26's right lower extremity.

During a continuous observation on 2/10/16 from 7:52 a.m. through 9:18 a.m., R26 was observed to be sitting in the dining room in his wheelchair. All the while, the CAM boot was located on his lower right extremity.

During an observation on 2/10/16 at 9:19 a.m., R26 was assisted by Nursing Assistant (NA)-B to his room. After he was given his call light NA-B left the room. R26 was observed to be sitting in his wheelchair. The CAM boot was still on his right lower extremity.

During an observation on 2/10/16 at 1:00 p.m., R26 was observed to be in the dining hall. He was sitting in his wheelchair. The CAM boot was on his right lower extremity.
R26's admission record, dated 9/22/15, included diagnoses of type 2 diabetes mellitus without complications; and non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity.

R26's care plan, dated 8/26/15, stated, "Pressure ulcer actual or at risk due to: Assistance required in bed mobility, Diabetic Ulcer, Diagnosis of diabetes, Braden Score 18 or < [less]." The goal identified that the resident's skin would remain intact. An intervention put in place to achieve this goal was to follow the treatments as ordered.

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F 282	Continued From page 8 The treatment order/start date 12/02/15 read, "Wear boot ONLY with transfers and ambulatory, otherwise remove when resting Inflate #1/#2 to patient comfort. every shift related to NON-PRESSURE CHRONIC ULCER OF UNSPECIFIED HEEL AND MIDFOOT WITH UNSPECIFIED SEVERITY (L97.409) Wear boot ONLY with transfers and ambulatory, otherwise remove when resting inflate #1/#2 to patient comfort." When interviewed on 2/10/16 at 1:29 p.m., R26 stated that he wore the boot even when he was sitting in the wheelchair. When interviewed on 2/10/16 at 1:40 p.m., Nursing Assistant (NA)-C stated that the nursing assistants were told that R26 was to wear the CAM boot all day long. When interviewed on 2/10/16 at 2:07 p.m., Nursing Assistant (NA)-B stated that R26 was to wear the CAM whenever he was up out of bed. NA-B stated that this was directed by the nursing staff as well as therapy. NA-B stated that R26 had been wearing the CAM boot for the past couple months. When interviewed on 2/10/16 at 1:56 p.m., Registered Nurse (RN)-C stated that R26 was to wear the CAM boot when he was up and out of bed. RN-C was unsure whether R26 was to wear the CAM boot when he was resting in his wheelchair. When interviewed on 2/10/16 at 2:41 p.m., the Director of Nursing (DON) stated that there was the potential for a worsening of the wound by wearing the CAM boot not as prescribed. She	F 282		

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F 282	Continued From page 9 stated that the staff should have followed the physician's orders regarding wearing the boot only when ambulating and transferring. Review of the Skin Care Protocol (no date), it stated that a care plan was to be implemented, evaluated and revised based on the needs of the resident. For monitoring compliance, a care plan was to be in place and reflected current interventions which would include devices, support services and nutrition.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to provide nail care which at a minimum included trimming for 1 of 1 resident (R24) who had long thick fungal fingernails. Findings include: R24 was observed on 02/08/16, at 2:45 p.m. to have very long fingernails on his right hand. R24's fingernails were observed with register nurse (RN)-B in his room on 02/10/16 at 2:13 p.m. RN-B stated all of the fingernails on R24's right hand were think and long. At this time R24 stated he had fungus in his nails and had had this for many years. RN-B state she would talk to the	F 311	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	3/22/16

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F 311	Continued From page 10 nurse practitioner about getting medicine for his fingernails that had evidence of the fungus. R24's quarterly Minimum Data Set (MDS) dated 1/16/16; revealed R168 had a brief interview for mental status score of 15 which indicated intact cognition and required extensive assist of one staff for personal hygiene. R24's care plan instructed staff to provide nail care as needed with date initiated 09/30/2014. R24's nurse progress note dated 2/10/16 2:36 p.m. read, "Writer [RN-B] of note assessed residents right hand fingernails in comparison to left hand. All five nails on the right hand appear to be thicker and longer in comparison to the nails on the left hand. Writer of note spoke with CNP [certified nurse practitioner-A], she states she will assess the nails as well and make further recommendation." R24's CNP-A's visit noted dated 2/10/16 read, "...Nursing is requesting to have the fingernails on his right hand cut, as they are very thick and infected with nail fungus. Nursing has been unable to cut his fingernails on his right hand, and they are very long and thick..." On 2/11/16, 10:41 a.m. nursing assistant (NA)-A stated she was aware of his long thick nails on his right hand and stated people that come to do foot care take care of the nails on his right hand when he is seen. NA-A stated his nails on his right hand are too thick for her to cut. On 2/11/16, 10:58 a.m. NA-B stated the fingernails on his right hand were thicker. NA-B stated she has never trimmed R24's fingernails	F 311	submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F311 -R24 no longer resides in the facility. -All residents have the potential to be affected if appropriate treatment and services to maintain or improve abilities is not provided. -Nursing staff has been educated on providing appropriate treatment and services to maintain or improve resident abilities. -Weekly audits will be completed to review provision of nail care on bath days. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	

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F 311	Continued From page 11 on the right hand and stated she thought a nurse would need to trim them. On 2/11/16, 8:53 a.m. the director of nursing (DON) stated it would not be appropriate for facility staff to clip R24's fungal nails as they were too thick. The DON stated staff monitored nails weekly for the bath and skin assessment and should be informing nursing the need for nail care. On 2/11/16, at 9:29 a.m. registered nurse (RN)-A stated she was unaware of the finger nails being think and long on R24's right hand. RN-A stated she had never looked at his finger nails before. Stated on 12/15/15 was the last skin check she has done and stated she did not notice the fungal fingernails then. RN-A stated when she completed a resident's skin assessment she looked at finger nails, toenails and pretty much everything on the resident from head to toe. RN-A stated if a concern was identified during a skin assessment with a resident's fingernails a referral would be made to either the nurse practitioner or podiatry. RN-A stated R24 had been seen by podiatry in the past and thought podiatry addressed R24's toe nails and fingernails. RN-A verified there were no podiatry notes documented in the records regarding services provided to R24. RN-A verified she did not see documentation of the thick, long nails in the progress notes or in the nurse practitioner visit notes she reviewed for R24. On 2/11/16, at 11:12 a.m. R24 stated his fingernails were cut yesterday (by CNP-A) and stated he did could not recall having the fingernails on his right hand cut prior to yesterday at the facility.	F 311		

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	245306	A. BUILDING _____ B. WING _____	02/11/2016

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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 services and treatments to promote healing and prevent new pressure ulcers from developing for 1 of 3 residents (R26) reviewed for pressure ulcers. Findings include: R26 was observed during the following dates and time to be wearing a controlled ankle movement (CAM) boot which was ordered by the physician to be worn only when transferring or ambulating as R26 had an open pressure ulcer located on the right heel: On 2/9/16 at 8:23 a.m., R26 was observed to be sitting in his wheelchair in the dining hall. He had a CAM boot on his right lower extremity. On 2/9/16 at 3:14 p.m., R26 was observed to be sitting in his wheelchair in his room. He had a CAM boot on his right lower extremity. On 2/9/16 at 4:01 p.m., R26 was observed to be	F 314	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19	3/22/16

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F 314	Continued From page 13 sitting in his wheelchair in his room. His CAM boot was on his right lower extremity. On 2/10/16 at 7:52 a.m., Nursing Assistant (NA)-C entered R26's room. R26 already had clothes on. NA-C then put a shoe on R26's left foot and then proceeded to put the CAM boot on R26's right leg. He then assisted R26 to a sitting position on the side of the bed. NA-C assisted the resident to his wheelchair. NA-C then finished assisting the resident with grooming cares. Once completed, NA-C attached foot pedals on R26's wheelchair and assisted the resident with putting his feet in them. The CAM boot is still on R26's right lower extremity. NA-C assisted R26 down the hallway and took him to the dining room where he was placed at a table. NA-C then left the vicinity. The CAM boot was still in place on R26's right lower extremity. On 2/10/16 from 7:52 a.m. through (continuous observation) 9:18 a.m., R26 was observed to be sitting in the dining room in his wheelchair. All the while, the CAM boot was located on his lower right extremity. On 2/10/16 at 9:19 a.m., R26 was assisted by Nursing Assistant (NA)-B to his room. After he was given his call light NA-B left the room. R26 was observed to be sitting in his wheelchair. The CAM boot was still on his right lower extremity. On 2/10/16 at 1:00 p.m., R26 was observed to be in the dining hall. He was sitting in his wheelchair. The CAM boot was on his right lower extremity. R 26' s' admission record, dated 9/22/15, included diagnoses of type 2 diabetes mellitus without complications; and non-pressure chronic ulcer of unspecified heel and midfoot with unspecified	F 314	programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F314 -R26 physicians' orders for CAM boot have been reviewed and care planned accordingly. -Residents at risk for development of pressure ulcers have the potential to be affected if devices are not utilized according to physicians order and care plan. -Licensed staff has been educated on providing services in accordance with each resident's written plan of care. CNA's have been educated on following care guides for application/removal of devices. -Random weekly audits will be conducted on appropriate device use/removal per physicians' orders. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	

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F 314	Continued From page 14 severity. The treatment order/start date 12/02/15 read, "Wear boot ONLY with transfers and ambulatory, otherwise remove when resting Inflate #1/#2 to patient comfort. every shift related to NON-PRESSURE CHRONIC ULCER OF UNSPECIFIED HEEL AND MIDFOOT WITH UNSPECIFIED SEVERITY (L97.409) Wear boot ONLY with transfers and ambulatory, otherwise remove when resting inflate #1/#2 to patient comfort." R26's care plan, dated 8/26/15, stated, "Pressure ulcer actual or at risk due to: Assistance required in bed mobility, Diabetic Ulcer, Diagnosis of diabetes, Braden Score 18 or < [less]." The goal identified that the resident's skin would remain intact. An intervention put in place to achieve this goal was to follow the treatments as ordered. R26's wound evaluation flow sheet multiple weeks, initiated on 8/11/15, indicated that the resident had a wound first identified on 8/11/15; it was located on his right heel. At 8/11/15, it measured 3 cm (length) x 3.5 cm (width) x 1 cm (depth). It was categorized as unstageable (described as tissue loss in which the base of the ulcer is obscured). Pain management was in place. The wound did have drainage which was categorized as sanguineous (blood colored), thin, minimal with a strong odor. At wound evaluation week 12, dated 11/10/15, the wound measured 3 cm (length) x 6.5 cm (width) x 0.5 cm (depth). It stated that the wound had not healed. R26's wound evaluation flow sheet multiple weeks, initiated on 12/3/15, indicated that the resident had a wound first identified on 7/11/15; it	F 314		

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F 314	Continued From page 15	F 314		

was located on his right heel. On 12/3/15, it measured 4.7 cm (length) x 2.5 cm (width) x 0.5 cm (depth). It was categorized as a pressure ulcer (an injury to skin and underlying tissue resulting from prolonged pressure on the skin) and it was at stage 4 (tissue low with exposed bone, tendon or muscle). The wound bed was described as 100% slough (dead) tissue. The wound was white in color. At wound evaluation week 9, signed on 2/8/16, the wound measured 1 cm (length) x 0.5 cm (width) x 0.3 cm (depth). The wound bed was warm to the touch. There was 95% granulation (new tissue on a healing surface of an ulcer) tissue and 5% slough tissue.

R26's Operative Report-Orthopedic Surgery, dated 12/2/15, stated that the resident was evaluated for a routine follow up of right foot wound. Upon examination, it was identified that there was a reddened area on the plantar surface over the head of the first metatarsal which appeared to be pressure related. "[R26] was instructed to only use his boot for ambulation and transfers and to remove it when resting."

R26's Progress Notes, dated 1/29/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 1/30/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 1/31/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 2/1/16, stated that the resident wore a protective boot to his right

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F 314	Continued From page 16	F 314		

lower extremity when out of bed.

R26's Progress Notes, dated 2/4/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 2/7/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 2/8/16, stated that the resident wore a protective boot to his right lower extremity when out of bed.

R26's Progress Notes, dated 2/9/16, stated that the resident wore a protective boot to his right lower extremity when he was out of bed.

A document provided that was used by all nursing assistants in the facility (no date) that instructed on how to care for each resident gave the following instructions for R26: "CAM (a brace that allows one to walk even with the most intensive injuries) boot during transfers ...ask therapy if unsure."

When interviewed on 2/10/16 at 1:29 p.m., R26 stated that he wore the boot even when he was sitting in the wheelchair.

When interviewed on 2/10/16 at 1:40 p.m., Nursing Assistant (NA)-C stated that the nursing assistants were told that R26 was to wear the CAM boot all day long.

When interviewed on 2/10/16 at 2:07 p.m., Nursing Assistant (NA)-B stated that R26 was to wear the CAM whenever he was up out of bed. NA-B stated that this was directed by the nursing

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F 314	Continued From page 17 staff as well as therapy. NA-B stated that R26 had been wearing the CAM boot for the past couple months. When interviewed on 2/10/16 at 1:56 p.m., Registered Nurse (RN)-C stated that R26 was to wear the CAM boot when he was up and out of bed. RN-C was unsure whether R26 was to wear the CAM boot when he was resting in his wheelchair. When interviewed on 2/10/16 at 2:41 p.m., the Director of Nursing (DON) stated that there was the potential for a worsening of the wound by wearing the CAM boot not as prescribed. She stated that the staff should have followed the physician's orders regarding wearing the boot only for transfers and ambulation. Review of the Skin Care Protocol (no date), it stated that a care plan was to be implemented, evaluated and revised based on the needs of the resident. For monitoring compliance, a care plan was to be in place and reflected current interventions which would include devices, support services and nutrition. A policy for pressure ulcers was requested and none received.	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		3/22/16

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F 425	Continued From page 18 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) was checked for placement prior to medication administration for 1 of 1 resident (R114) who had a PICC line. Findings include: R114 was observed during a medication administration on 2/10/16, at 1:30 p.m. when registered nurse (RN)-C disinfected the injection cap of the PICC, correctly flushed the line with 10 milliliters (ml) normal saline, then connected the antibiotic ball (type uses positive pressure to infuse medication without a pump). However, RN-C did not check for blood return that would verify the catheter line end was placed in the blood vessel prior to the infusion of the antibiotic medication. On asking about checking for placement by checking for blood return RN-C said that the placement was checked by verifying how much catheter tubing was showing from the insertion site and would not aspirate for blood	F 425	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate	

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F 425	Continued From page 19 return because risk of blood clotting in the line. During an interview on 2/11/16, at 1:38 p.m. director of nursing (DON) stated she expected nurses to follow the facility protocol. DON stated she verified the standard of practice of checking for blood return prior to medication administration with Mayo clinic educators and infusion therapy registered nurse specialist and learned that the PICC line should be checked for placement each time a medication is to be given by the line access. Facility procedure Flushing Midline and Central Line IV Catheters included the flushing technique that directed staff to "use a push-pause or pulsing motion for flushing technique. Aspirate the CVAD [central venous access devices] catheter for blood return to confirm patency prior to administration of medications and solutions." The complications listed in the policy included the warning in all capitol letters "IF RESISTANCE OR LACK OF BLOOD RETURN ARISE AT ANY TIME DURING FLUSHING STOP THE FLUSH AND CONSULT IV NURSE SPECIALIST OR OR PHYSICIAN."	F 425	submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F425 -R114 PICC line has been removed. -Residents receiving IV medication have the potential to be affected if proper placement is not assured prior to medication administration. -Licensed staff has been educated and completed competency testing on proper medication administration via PICC lines. -Observation audits will be completed 3 times weekly on residents receiving IV medication administration. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		3/22/16

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F 431	Continued From page 20 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure tuberculosis testing solution included an open date to determine expiration date which affected 9 of 9 residents (R109, R110, R111, R112, R113, R114, R115, R116 & R117) who received an outdated dose of Tubersol. Findings include: During medication storage review with the director of nursing, (DON) on 2/9/16, at 10:21 a.m. three partially used vials of Tubersol solution (medication used to perform tuberculosis skin test (TST) were stored with no open date of these	F 431	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged	

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F 431	Continued From page 21 three vials in the medication refrigerator. The label indicated the pharmacy dispensed the medication to the facility on 12/19/15. All three vials had the same lot number and expiration date. DON indicated she had reviewed the resident admissions following the date of Tubersol dispense date and reported the first date they would have been used was on 12/21/15. Thirty days after 12/21/15 to determine out date would be 1/20/16 and R109, R110, R111, R112, R113, R114, R115, R116 & R 117 had a high potential to have received an outdated dose of Tubersol as follows: · R109 was admitted to the facility on 2/3/16 and administered the TST on 2/3/16 · R110 was admitted to the facility on 2/1/16 and administered the TST on 2/2/16 · R111 was admitted to the facility on 2/5/16 and administered the TST on 2/5/16 · R112 was admitted to the facility on 1/22/16 and administered the TST on 1/22/16 · R113 was admitted to the facility on 1/26/16 and administered the TST on 1/26/16 · R114 was admitted to the facility on 2/2/16 and administered the TST on 2/2/16 · R115 was admitted to the facility on 1/27/16 and administered the TST on 1/27/16 · R116 was admitted to the facility on 1/25/16 and administered the TST on 1/25/16 · R117 was admitted to the facility on 1/21/16 and administered the TST on 1/22/16 During an interview on 2/9/16, DON indicated the facility's physician and consulting pharmacist indicated the TST would need to be repeated for residents who receive Tubersol after 1/20/16 due to possibly getting an outdated dose of Tubersol. Tubersol package insert included the direction, "A vial of Tubersol® [Tuberculin Purified Protein Derivative (Mantoux)] which has been entered	F 431	or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F431 -R109, R110, R111, R115, and R116 no longer reside in the facility. R112, R113, R114, and R117 had their TST repeated. -All residents have the potential to be affected if expired or outdated medications are administered. -Staff responsible for medication administration have been educated on proper labeling of medication and disposition of unlabeled and expired medication. -Weekly audits will be completed to insure open dates and/or expiration dates are in place. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible. -Corrective action will be completed by 3/22/16.	

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F 431	Continued From page 22 and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Failure to store and handle Tubersol® as recommended will result in a loss of potency and inaccurate test results." Facility policy Storage of Medications with a revision date of 11/11 included, "Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, blood sugar solutions and strips, once opened, require an expiration date shorter than the manufacture's expiration date to insure mediation purity and potency."	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on February 09, 2016 At the time of this survey, Golden Livingcenter - Rochester West was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester West is a 1-story building, with a partial basement. The facility was built in 1963 and was determined to be of Type II(111) construction The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 38 beds at the time of the survey.	K 000		
K 067 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901**

(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
K 067	Continued From page 2 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed and tested in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 38 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 02/09/2016, observation revealed, that the ventilation system utilizes the egress corridor as the supply air for the resident rooms. Date of building construction is 1963. There was no balance report available. HVAC system shut down upon activation of the fire alarm system. This deficient practice was confirmed by the Maintenance Supervisor at the time of discovery.	K 067	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. K067 Waiver requested March 4, 2016.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from,	K 072		2/10/16

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K 072	Continued From page 3 or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal of residents in an emergency situation, Findings include: On facility tour between 10:00 AM and 1:00 PM on 2/09/2016, it was observed that the facility's south wing exit door exceeded the allowed 15lbs of pressure to open the door. This deficient practice was verified by the Maintenance Supervisor.	K 072	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. K072 1. The weather stripping on exit door on south wing, causing more than 15 lbs of pressure to used to open door, has been removed and new weather stripping was added in a manner that does not interfere with the function of the door.	

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K 072	Continued From page 4	K 072	2. Above correction was made on February 10, 2016 3. Maintenance Director, Eric Schaefer, made above correction and egress doors are checked daily (week days) and a log is kept to ensure regular completion.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM and 1:00 PM on 2/09/2016, during record review, the facility failed to provide a separate policy on the automatic sprinkler system out of service policy. This deficient practice was verified by the Maintenance Supervisor.	K 154	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition	2/10/16

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K 154	Continued From page 5	K 154	to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. K154 1. Facility policy relating to Fire Sprinkler System Impairments has been updated. Updated policy is now included in Facility Emergency Action Plan. 2. Corrective action above was completed on February 10, 2016. 3. Maintenance Director, Eric Schaefer, made above correction. Facility Safety Committee will be responsible to ensure Emergency Action Plans are complete, updated and dispersed as needed.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 155	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	2/10/16

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K 155	Continued From page 6 Findings include: On facility tour between 10:00 AM and 1:00 PM on 2/09/2016, during record review, the facility failed to provide a separate policy on the fire alarm system out of service policy. This deficient practice was verified by the Maintenance Supervisor.	K 155	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. K155 1. Facility policy relating to Fire Alarm System Impairments has been updated. Updated policy is now included in Facility Emergency Action Plan. 2. Corrective action above was completed on February 10, 2016. 3. Maintenance Director, Eric Schaefer, made above correction. Facility Safety Committee will be responsible to ensure Emergency Action Plans are complete, updated and dispersed as needed.	

Name of Facility

Golden Living Rochester West - 2215 Hwy 52 North, Rochester, MN 55901 - (507) 288-1818

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K067 HVAC system shall comply with section 9.2 and NFPA 90A	A waiver is requested for the following reasons: 1. There are no adverse effects on the health or safety of residents or staff a. The building is equipped with an approved full-corridor smoke detection system b. The facility is fully protected by an automatic sprinkler system c. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building's fire alarm and/or sprinkler systems d. Annual service and maintenance contracts are in place to ensure proper service of all the facility's fire protection systems (fire alarm, sprinkler system, portable extinguishers) e. The building's fire alarm system is monitored to provide automatic notification to the fire department f. Fire safety training is provided for all new hires during orientation and for all employees annually g. Fire drills are conducted at least quarterly on each shift 2. Compliance with this provision would impose an unreasonable hardship on the facility: a. Compliance would cost an estimated $126,200 to upgrade the facility's HVAC system to comply with NFPA 90a b. The required work would be a hardship as residents would need to be relocated and the associated dust from this work could lead to infection control issues.

Surveyor *(Signature)*	Title	Office	Date
Thomas R Lee	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	3-29-16
Fire Authority Official *(Signature)*	Title	Office	Date

HIMEC
MECHANICAL

1400 7th Street NW
Rochester, MN 55901
Phone: (507) 288-7713
Fax: (507) 281-5206
www.himec.com

April 15, 2014

Golden Living Center
West 2215 HWY 52 N
Rochester, MN 55901

RE: Ducting Both Wings

- Fabricate all Return air ducting for both north and south wing
- Take down ceiling after hours and reinstall after work has been completed
- Provide and install all return air duct in hallway
- Provide and install return air for each room
- Provide and install supply air registers to the middle of each room
- Test and balance both rooftops/duct work and provide a copy to the owner and city as required
- Provide and Install fire smoke dampers in each wall for supply and return
- Install balancing dampers in each run
- Provide moving of all pipes and electrical in the way above the ceiling
- Provide and install a fire rated wall in each corridor above the ceiling and all the way up to the deck with 5/8 gyp board and all fire caulking. This needs to be done through both wings above the ceiling
- Provide coned off work areas everyday with plastic enclosures
- Labor/Materials
- Start-up
- Permit
- Test and balance
- Engineered cost for plans are included in this price

Total.....$126,200.00

Please let me know if I can be of further assistance to you, or should you have any questions regarding this, please feel free to contact me at (507) 288-7713.

Sincerely,

Bryce Beckel
Project Manager Service Division

Acceptance_____ Date:_____

Proposal Guaranteed For 30 Days