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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6Y63

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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)

6. DATE OF SURVEY **10/29/2013** (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 **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NE II — 12/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 12/24/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/12/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5540

At the time of the standard survey completed August 23, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On October 23, 2013, the Minnesota Department of Health and, on October 29, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 23, 2013, effective September 27, 2013. Therefore, the remedies outlined in our letter dated September 4, 2013, will not be imposed.
See attached CMS-2567B forms for the results of the October 23, 2013 and October 29, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5540 December 24, 2013

Ms. Joan Gedde, Administrator
Golden Livingcenter - Henning
907 Marshall Avenue, P.O. Box 57
Henning, Minnesota 56551

Dear Ms. Gedde:

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 September 27, 2013 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 10, 2013

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue
PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540023

Dear Ms. Gedde:

On September 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 22, 2013. 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 October 23, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 29, 2013 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 August 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 22, 2013, effective September 27, 2013 and therefore remedies outlined in our letter to you dated September 4, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245540	A. Building B. Wing	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/27/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/27/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/27/2013**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/27/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/27/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/27/2013**
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** SG/AK	**Date:** 12/10/2013	**Signature of Surveyor:** 31229	**Date:** 10/23/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/22/2013

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245540	A. Building B. Wing **01 - MAIN BUILDING 01**	10/29/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**09/27/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 12/10/2013	**Signature of Surveyor:** 03006	**Date:** 10/29/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/23/2013		**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: 6Y63

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3)
(L4) **GOLDEN LIVINGCENTER - HENNING**
907 MARSHALL AVENUE, PO BOX 57
(L5) **HENNING, MN** (L6) **56551**

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 **08/22/2013** (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 **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Christine Bodick-Nord, HFE NE II — 09/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 11/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/12/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed August 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5049

September 4, 2013

Ms. Joan Gedde, Administrator
Golden Livingcenter - Henning
907 Marshall Avenue, Po Box 57
Henning, Minnesota 56551

RE: Project Number S5540023

Dear Ms. Gedde:

On August 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7365
Fax: (320)223-7348

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 October 1, 2013, 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 October 1, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 22, 2013 (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 February 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements. RECEIVED SEP 18 2013	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were provided in a dignified manner, related to rushed cares, untimely call light response and no explanation of services prior to provision of those services, for 2 of 3 residents (R32 and R34) reviewed for dignity. Findings include: R32 received cares in a rushed manner, which made him feel uncomfortable and undignified. The significant change Minimum Data Set (MDS) dated 7/23/13, revealed R32 required extensive	F 241	F241 R32 has been interviewed MN Dept of Health St.Cloud regarding preferences when cares are provided. Staff have been re-educated on resident preferences. His care sheet and care plan have been reviewed to insure preferences are documented. R34's care sheet has been updated to include his preference to attend social activities and to explain what staff are going to do prior to providing cares or repositioning. All residents needing assistance have the potential to be affected if not treated in a dignified, respectful manner. Staff have been re-educated on dignity and respectful treatment and following the care sheets for specific resident preferences.	9-27-13

OK 9/25/13

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

Joan Heddle Sr. E.D. — Sr. Executive Director — 09-18-13

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

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

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F 241	Continued From page 1 assistance for bed mobility, transfers and toilet use. The MDS identified R32 with occasional pain. During an interview on 8/22/13, at 11:00 a.m. R32 reported feeling undignified due to rushed cares provided by some of the facility nursing assistants (NAs). R32 indicated, though he believed their actions to be unintentional, some of the NAs went too fast when they assisted with turning, repositioning, changing incontinent products, dressing and daily personal hygiene tasks. R32 added that during cares, "[They] throw me around like a sack of potatoes... like a rag doll..." and they needed to slow down. R32 reported that when the NAs turned him side to side during cares, he said, "Whoa, slow down there." R32 reported that his bones were quite fragile and broke easily. He stated that he worried the NAs might break one of his bones when they turn him so fast. R32 added that he also felt the NAs went too fast during transfers using the Hoyer lift [sling lift for transfers]. R32 stated, "Your legs are dangling," and when they turn the lift, "It jerks you around." At 1:35 p.m. R32 verified his prior statements and added that some of the NAs were good with him, "But others, just throw you around." R32 was unable to identify specific NAs. During an interview on 8/22/13, at 1:33 p.m. NA-B verified R32 had informed her that some of the NAs "rush him too much," and he preferred the pace she provided during cares. R34 missed a social activity that was important to him, due to untimely response to his call light. Also, R34 had limited vision and was assisted away from the dining room table, without explanation of the NA's actions or intent.	F 241	Audits will be completed by Resident Care Coordinator or designee twice weekly x 4 weeks. Results will be brought to QAA monthly for review. addendum per email from Sr executive director on 9/25/13 audit tool consists of information staff asks residents about care they are receiving including call light response time & staff explaining cares.	

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F 241	Continued From page 2	F 241		

R34's quarterly MDS dated 5/30/13, revealed R34 had highly impaired vision with minimal difficulty hearing and intact cognition. The MDS indicated R34 required extensive assistance with the use of a walker for transfers, ambulation and locomotion.

On 8/21/13, R34 was constantly observed from 11:40 a.m. to 12:30 p.m. in the dining room. At 12:20 p.m. R34 was observed to sit in the dining room chair with his eyes closed. At 12:25 p.m. NA-B approached R34 and turned the chair towards NA-B without any communication to R34. NA-B placed a walker in front of R34 and then a transfer belt was applied to R34 without communication as to what NA-B was doing. NA-B then placed a hand on R34's left elbow area and stated, "we are ready to go." R34 began to walk out of the dining room with NA-B's guidance.

An interview on 8/22/13, at 10:51 a.m. with director of nursing (DON) indicated that staff should talk to the R34 and tell him what staff planned to do. The DON stated that the desirable way to approach residents and help them was to tell the resident that you're there and what you're going to do.

An interview on 8/22/13, at 1:02 p.m. with R34 indicated that it does startle him when staff, "jerk me in my chair." R34 went on to state his preference would be the staff communicate what they were going to be doing to assist R34 and when the staff were going to perform the task.

An interview on 8/22/13, at 1:33 p.m. with NA-B indicated staff should tell the residents what the staff will be doing and make their presence

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F 241	Continued From page 3	F 241		

known to the residents who cannot see or hear. NA-B stated that she should not have turned R34's chair without first communicating how she was going to assist R34.

During an interview on 8/22/13, at 1:15 p.m. R34 reported that the Sunday prior, he activated his call light to request staff to assist him to the daily coffee social at 3:00 p.m. in the facility's main dining room, but his call light was not responded to for approximately one hour and he missed the entire activity. R34 indicated it was important to him to attend the daily social as it was something he enjoyed and he did not attend many other activities outside of his room due to his limited vision. R34 stated, "Either nobody was here, or they were watching TV [television] or something... They won't tell me what really did happen." R34 added that a couple of months prior, an unnamed NA who was no longer employed at the facility, routinely brought coffee and a cookie to his room, rather than assist him to the social activity. R34 stated, "So she didn't have to bring me down there... I didn't like that at all."

During an interview on 8/22/13, at 3:04 p.m. the DON reported that NAs received training on provision of dignified care and services during their initial orientation and while on the floor, orienting to a specific resident's needs and preferences. She reported that at all times it was her expectation for NAs to provide care and services to residents in a dignified manner. The DON acknowledged that cares were to be provided at a pace that was comfortable to each individual resident and that the NAs were expected to slow their pace if a resident indicated they were uncomfortable. She also acknowledged the daily coffee social was an

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F 241	Continued From page 4 important activity to R34 and that it was not acceptable for him to have missed the activity. She was unsure of why his call light was not responded to and was unaware of these events prior to having been informed by this writer. The facility did not have a policy related to provision of dignified care and services.	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide necessary oral hygiene for 1 of 3 residents (R20) in the sample who were dependent upon staff for personal care. Findings include: R20's quarterly Minimum Data Set (MDS) dated 6/13/13, identified R20 was severely cognitively impaired and required total assistance of one staff for personal hygiene needs. During observations on 8/20/13, 8/21/13 and 8/22/13 R20's lower teeth were observed to have an excessive amount of yellow debris accompanied by an odor. The care plan, last updated on 6/13/13, identified	F 312	F312 R20 has been reassessed for oral hygiene requirements. His care plan and care sheet have been updated to include use of toothette for oral cares per resident preference and comfort. Dental services have been offered and were declined by R20 and involved family members. Residents needing assistance with oral cares have the potential to be affected if oral cares not provided according to care plan. Staff have been re-educated on provision of oral cares. Audits of oral cares will be completed twice weekly x 4 weeks by DNS or designee. Results will be brought to QAA monthly for review.	9-27-13

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F 312	Continued From page 5	F 312		

R20 required extensive assist of one staff for oral cares and was at risk for dental problems related to some natural teeth loss and dependency for oral care. The care plan did not note any difficulty or concerns specific to R20's oral cares.

During an interview on 8/22/13, at 9:04 a.m. nursing assistant (NA)-A verified she assisted R20 that morning with activities of daily living (ADL's). NA-A stated she had not brushed R20's teeth with the toothbrush but had swabbed with a toothette (a foam swab) and water instead.
During an interview on 8/22/13, at 10:14 a.m. director of nursing (DON) indicated R20 still had some natural teeth left which did require brushing. At the surveyor's request, the DON looked at R20's teeth and commented, "They definitely could use some attention." The DON stated if the NA's had difficulty brushing resident's teeth, they should report to the nurse and the nurse would make an interdisciplinary note (IPN) and update the care plan. The DON was not aware of any recent concerns with brushing R20's teeth and stated she would talk to the NA who provided cares that morning.
The DON returned with NA-A to continue the interview. NA-A again confirmed she had not used a toothbrush and toothpaste when she provided oral cares to R20 that morning, but only a toothette and water. NA-A further stated she had been trained to use a toothette and water for R20 a few months ago and had provided oral cares that way every since. The DON stated she would expect to be informed from the NA's if they did not provide oral care according to the care plan and and had difficulty with providing oral cares.
Review of the Oral Hygiene procedure dated 2006, which was provided as the facility's policy,

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F 312	Continued From page 6 directed staff to use a toothbrush and toothpaste to provide oral hygiene. The procedure also gave direction to document any problems with providing oral hygiene and identify problems related to oral hygiene on the care plan.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to document clinical rationale	F 329	F329 R14's Pharmacist Monthly Drug Review form has been reviewed by the physician and rationale provided for declining a dosage reduction/tapering at this time. All residents on psychotropic medications have the potential to be affected if reductions/tapering are not attempted or clinical rationale for continued use is not documented. Medical Director has discussed the need for providing rationale for not attempting a dose tapering with the primary MD for R14. DNS will review all Drug Review forms for completion. Audits will be completed on all resident charts receiving psychotropic medications for complete documentation by the DNS or designee. Negative findings will be reviewed with the primary MD for completion of rationale. Results of audits will be brought to QAA monthly for review.	9-27-13

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F 329	Continued From page 7	F 329		

why a gradual dose reduction was not appropriate for 1 of 5 residents (R14) reviewed for unnecessary medications.
Findings include:
R14's diagnosis included depression. An annual Minimum Data Set (MDS) dated 8/6/13, indicated R14's cognition was moderately impaired. A care plan with a print date of 8/12/13, directed staff to encourage R14 to come out of the room for activities, provide non-pharmaceutical interventions of positive reinforcement, one to one's to decrease anxiety or depression and a medication risk/benefit and reduction plan as recommended by physician and pharmacist.
A Pharmacist's Monthly Drug Regimen Review Form dated from 6/25/12 through 7/29/13, revealed on 5/28/13, gradual dose reduction (GDR) forms were addressed by the physician. The forms (Psychopharmacological Medications Tapering Attempts) identified no decrease in R14's Prozac (anti-depressant) or PRN (as needed) Ativan (anti-anxiety) was indicated by the physician.
R14's Psychopharmacological Medications Tapering Attempts forms dated 5/29/13, indicated Prozac 40 milligrams (mg) daily, (started 7/3/12) and Ativan 0.5 mg 4 times a day PRN, (started 6/8/12) were ordered for R14. The physician checked the box to indicate no tapering attempt at this time for both Prozac and Ativan. The wording next to the no box directed that if a response was no, a clinical rational must be documented on the form or in a progress note. The physician documented in the clinical rationale area that R14 was "stable" and there was no other documentation of clinical rationale for continued use for either medication.
The physician visit notes dated 5/28/13 and 7/29/13, lacked documentation for a clinical

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F 329	Continued From page 8 rationale to not complete a GDR for R14's Prozac and Ativan. An interview on 8/20/13, at 2:45 p.m. with registered nurse (RN)-A verified there was no clinical indication for Prozac or Ativan in the chart, on the form, or in the typed physician progress notes. An interview on 8/22/13, at 2:00 p.m. with the consultant the pharmacist revealed the physician did not document a clinical rational for the continued use of Prozac and Ativan without a GDR. The consultant pharmacist stated that the forms are used to prompt the physician to document the clinical rationale for no GDR. The consultant pharmacist stated that no GDR had been done on the Prozac or Ativan for R14 since the start of the medications.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353	F353 R32, R34, R11, R26, and R18 will have their needs met in a dignified, timely manner per their plan of care and resident preference. All residents are receiving the care and services as defined in their care plan. Appropriate staffing levels are looked at daily and adjustments made as needed. The facility continues to advertise for CNA and licensed staff. Registry staff are currently being used until positions are filled. The facility will schedule a family educational meeting and individual meetings to address family concerns..	9-27-13

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F 353	Continued From page 9 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient nursing staff to meet resident needs in a manner which enhanced each resident's quality of life, for 5 of 18 residents (R32, R34, R11 and R26) and families (R18) interviewed. Findings include: R32's family (Family-A) filed grievance reports with the facility in relation to insufficient staffing concerns. R32 also reported concerns of insufficient staffing, resulting in rushed cares and undignified care and treatment. R32's significant change Minimum Data Set (MDS) dated 7/23/13, revealed required extensive assistance for bed mobility, transfers and toilet use. The MDS identified R32 with occasional pain. Review of a Grievance Form dated 2/25/13, revealed insufficient staffing concerns within the facility. The form noted, "[Family-A] stated that she isn't sure what is going on and doesn't want to blame any workers but when she has been at the facility recently she has had to turn [R32's] call light on and they have had to wait 10 [ten] to 15 minutes. [Family-A] states that the workers are telling her they don't have enough help. [Family-A] states that concerns her."	F 353	To ensure the stated deficient practice does not recur, the facility will continue to review staffing levels daily, making adjustments as necessary to meet the resident needs. All staff will be re-educated on response to call lights. Facility will continue to advertise for additional staffing needs. The facility will continue to offer sign on bonuses for new hires, referral bonuses to current staff, and incentives to current staff to work additional shifts. Call light audits will be performed 2 times weekly x 4 weeks by DNS/designee and results communicated to the QAA committee. Audits of care provided will be conducted 2 times weekly x 4 weeks by DNS/designee. Interviews will be conducted with residents/family members at each care conference regarding any concerns by Social Services/designee. All residents and family members are encouraged to utilize the grievance process to detail concerns. All grievances will be reviewed by Social Services/designee. All findings will be brought to QAA monthly for review.	

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F 353	Continued From page 10	F 353		

Review of a Grievance Form dated 3/19/13, indicated concerns of long call light response time within the facility. The form noted, "[Complaints of] call bell on 15 min. [minutes] while resident waiting to toilet. Staff not able to assist at that time, did answer call bell x2 [times two] and let [Family-A] and resident know they'd be back in 5 [five] to 10 min. when done with other resident."

During an interview on 8/19/13, at 6:30 p.m. R32 reported that he did not feel there was enough staff available to ensure the care and assistance he needed, without having to wait a long time. R32 expressed concerns of having to wait too long for assistance to use the bathroom. During a follow-up interview on 8/22/13, at 11:00 a.m. R32 reported feeling undignified due to rushed cares provided by some of the facility nursing assistants (NAs). R32 indicated, though he believed their actions to be unintentional, some of the NAs went too fast when assisting with turning, repositioning, changing incontinent products, dressing and daily personal hygiene tasks. R32 added that during cares, "[They] throw me around like a sack of potatoes... like a rag doll..." and they needed to slow down. R32 reported that when the NAs turned him side to side during cares, he said, "Whoa, slow down there." R32 reported that his bones were quite fragile and broke easily. He stated that he worried the NAs might break one of his bones when they turn him so fast. R32 added that he also felt the NAs went too fast during transfers using the Hoyer lift [sling lift for transfers]. R32 stated, "Your legs are dangling," and when they turn the lift, "It jerks you around." R32 indicated that he believed the rushed cares were a result of insufficient staffing within the facility. At 1:35 p.m. R32 verified his prior statements and added that some of the NAs

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F 353	Continued From page 11	F 353		

were good with him, "But others, just throw you around." R32 was unable to identify specific NAs.

R34 reported insufficient staffing concerns which resulted missed opportunities to participate in group activities.

The quarterly MDS dated 5/30/13, revealed R34 had highly impaired vision with minimal difficulty hearing and intact cognition. The MDS indicated R34 required extensive assistance with the use of a walker for transfers, ambulation and locomotion.

During an interview on 8/19/13, at 6:59 p.m. R34 indicated long call light response times. R34 specified that Sundays were short on staff coverage. He indicated a wait of up to one hour on the Sunday prior to this interview. During a follow-up interview on 8/22/13, at 1:15 p.m. R34 reported that the Sunday prior, he activated his call light to request staff assist him to the daily coffee social at 3:00 p.m. in the facility's main dining room, but his call light was not responded to for approximately one hour and he missed the entire activity. R34 indicated it was important to him to attend the daily social as it was something he enjoyed and he did not attend many other activities outside of his room due to his limited vision. R34 stated, "Either nobody was here, or they were watching TV [television] or something... They won't tell me what really did happen." R34 added that a couple of months prior, an unnamed NA who was no longer employed at the facility, routinely brought coffee and a cookie to his room, rather than assisting him to the social activity. R34 stated, "So she didn't have to bring me down there... I didn't like that at all."

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 353	Continued From page 12	F 353		

R11 and R26 reported concerns of long call light response times within the facility.

R11's quarterly MDS dated 8/1/13 revealed R11's cognition was intact and he required extensive assistance for most activities of daily living.

During an interview on 8/19/13, at 6:48 p.m. R11 reported he did not feel there was sufficient staffing within the facility to ensure appropriate care. He identified the night shift as needing more staff coverage. R11 indicated call light response times of approximately one hour. During follow-up interview on 8/22/13 at 1:25 p.m. R11 reported that he had to wait a half hour for assistance to get into and out of his chair. He stated the long response time was frustrating to him.

R26's quarterly MDS dated 5/29/13, revealed R26's cognition was intact and she required extensive assistance for most activities of daily living.

During an interview on 8/20/13, at 8:46 a.m. R26 reported she had to wait 15 to 20 minutes for a response to her call light. She specified the night shift was most concerning for staffing coverage. During a follow-up interview on 8/21/13 at 9:20 a.m. R26 verified these statements. She added, "They try to get by with less staff than needed on the night shift."

R18's family (Family-B) reported concerns of insufficient staffing within the facility.

During telephone interview on 8/19/13, at 7:38 p.m. Family-B stated that the staff were rushed and were not able to complete all of the needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 13	F 353		

cares. She added that she had "never seen staff running around so much as they have lately." Family-B reported she was at the facility earlier that evening for the dinner meal. Family-B expressed concern the surveyors would not get an accurate picture of the facility's staffing coverage because the amount of employees present and assisting residents was atypical, "since you guys came." Family-B reported that there had been significant turnover in facility staffing in the past six months.

Employee interviews verified concerns of insufficient staffing.

During an interview on 8/21/13, at 7:20 a.m. licensed practical nurse (LPN)-B indicated there were concerns of insufficient staffing within the facility. She reported she felt she was "short changing" the residents by not having time to listen to their stories or give them an extra back rub. She stated feeling she always had to rush to the next task.

During an interview on 8/21/13, at 8:33 a.m. NA-C reported there was "not always" enough staffing coverage within the facility. She added that she was able to get all assigned tasks done, but had to rush to get through them within her shift time.

During an interview on 8/21/13, at 8:40 a.m. LPN-A indicated she had insufficient staffing concerns within the facility. She denied knowledge of resident complaints on the matter, but reported that residents had pointed out that staff "look so tired" and "worn out." LPN-A indicated the facility had experienced a significant amount of NA turnover and this made it more

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 14	F 353		

difficult, due to having to always teach and train new people.

During an interview on 8/21/13, at 9:00 a.m. NA-B reported concerns of insufficient staffing within the facility. She indicated the facility was experiencing a high turnover rate and verified she had heard residents complain that there was not enough staff. She also confirmed that there had been occasions when a resident had become incontinent as a result of her not being able to answer their call light in a timely manner. NA-B reported she felt overworked and worn out. NA-B expressed concern over the facility's plans to discontinue the restorative nursing program in order to have more NAs available to work on the floor.

During an interview on 8/21/13, at 9:10 a.m. NA-D reported there had been a large amount of turnover during the past year and full-time employees had to work a lot of overtime. She stated she felt the staff were overworked. She reported NAs expressed frustration over the facility's acceptance of new admissions because they did not feel the facility had enough staff for the residents they already had.

During an interview on 8/21/13, at 11:25 a.m. NA-E verified concerns of insufficient staffing within the facility. She reported feeling rushed and overworked. She stated that she had to work "too long of shifts" and never knew how long she was going to have to stay at work when she arrived for her shift each day. She reported the NAs were often expected to work 12 hour shifts. NA-E reported she was concerned when the facility took on new admissions recently. She added, "We complained to them about that too."

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 67 HENNING, MN 56551

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F 353	Continued From page 15	F 353		

During an interview on 8/21/13, at 1:15 p.m. LPN-C reported that she did not feel the facility had sufficient staffing levels for timely care and services. She indicated that she noticed more frustration in the tone of employees when she called to ask them to fill shifts. She stated, "Everyone has been working long shifts, 12 hour shifts, and it's starting to ware on people." LPN-C reported that she had noticed a decline in job satisfaction and less willingness to do anything extra among the facility employees.

During an interview on 8/22/13, at 7:25 a.m. NA-F reported she felt the facility was short on staff. She also expressed dissatisfaction over the facility's plans to discontinue the restorative nursing program to have more NAs working on the floor.

During an interview on 8/22/13, at 9:04 a.m. NA-A reported that she was feeling worn out due to having to work long shifts and was concerned with being scheduled to work 12 hour shifts, when the shifts tended to run over the scheduled times as it was.

During an interview on 8/22/13, at 9:35 a.m. the administrator denied any specific concerns of sufficient staffing having been expressed to the facility by family or residents. However, the administrator did confirm knowledge of some employees having expressed concerns in this area. The administrator explained the facility had a budgeted staffing ratio for all departments, but did consider acuity and when some of the residents needed more support, adjustments were made. The administrator indicated the facility was at their usual or higher staffing ratio.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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F 353	Continued From page 16 She verified the facility currently had one full-time and three part-time NA positions, one full-time MDS nurse position and one full-time registered nurse (RN) position that had been unfilled, along with several part-time weekend rotation RN positions. She indicated some of the positions had job offers pending at the time of interview. The administrator stated that all of the employees had pulled together to cover the shifts needed and she had not yet required the use of pool staff to fill open shifts. The administrator denied employees having expressed concerns of feeling burnt out or over worked. She verified that employees who wished to remain full time were likely to be required to do 12 hour shifts and that all staff were expected to work beyond their scheduled hours if there were assigned tasks left to be done, such as charting. The administrator denied knowledge of any negative resident outcomes that had occurred in relation to the facility's staffing coverage. She reported that concerns of residents feeling rushed during cares were addressed individually with the specific employee(s). The administrator confirmed the facility had accepted two new admissions recently. However, she added the admissions were only accepted due to intentions for short term stays, without a high level of care being required. She verified other admission inquiries had been declined due to the staffing coverage available. The facility did not have a policy related to sufficient staffing coverage to meet resident needs.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 17 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served under sanitary conditions. This had the potential to affect 11 of 11 residents who received meal trays in their rooms. Findings include: During an observation of the noon meal service on 8/21/13, from 10:45 a.m. to 11:40 a.m., cook-A touched her face with her shirt collar, touched a plate and plate cover, washed her hands, wiped her nose with a towel and then with her shirt, and then touched a plate. During this observation, cook-A was noted to sweat and a bead of sweat dropped from her face to the counter portion of the steam table. Dietary manager (DM) cleaned the area with a towel from the sanitizer bucket. Both DM and dietician were present at the time of the observation. Cook-A continued to set up the room trays and room trays were then delivered to residents. DM served the remainder of the food for the residents who ate in the dining room. When interviewed on 8/21/13, at 11:20 a.m.,	F 371	F371 Dining services staff have been re-educated on appropriate hand washing protocol and control of excessive sweating. Audits will be completed weekly by DSM/designee for appropriate hand washing and control of excessive sweating. Results of audits will be brought to QAA monthly for review.	9-27-13

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

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F 371	Continued From page 18 about the above concerns, the dietician stated cook-A only touched the plate on the rim, and if she was observed to touch the food area, the plate was exchanged. DM stated they would ask cook-A to stop every couple minutes to wash her hands. When interviewed on 8/22/14, at 8:44 a.m., the dietician verified cook-A should have been pulled from serving line sooner. She stated they do provide headbands in the kitchen. Dietician also verified cook-A should have washed her hands after each time she touched her shirt to wipe her face. Facility Hand Washing Policy dated 2011 indicated hands should be washed after touching bare human body parts such as face, mouth, ears or eyes.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure the physician and	F 428	F428 R14's Pharmacist Monthly Drug Review form has been reviewed by the physician and rationale provided for declining a dosage reduction/tapering at this time. All residents on psychotropic medications have the potential to be affected if reductions/tapering are not attempted or clinical rationale for continued use is not documented. Medical Director has discussed the need for providing rationale for not attempting a dose tapering with the primary MD for R14. DNS will review all Drug Review forms for completion. Audits will be completed on all resident charts receiving psychotropic medications for complete documentation by the DNS or designee. Negative findings will be reviewed with the primary MD for completion of rationale. Results of audits will be brought to QAA monthly for review.	9-27-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	08/22/2013

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F 428	Continued From page 19	F 428		

director of nursing acted on the pharmacists recommendations for 1 of 5 residents (R14) reviewed for unnecessary medications.
Findings include:
R14's diagnosis included depression.

A Pharmacist's Monthly Drug Regimen Review Form dated from 6/25/12 through 7/29/13, revealed on 5/28/13, gradual dose reduction (GDR) forms were addressed by the physician. The forms (Psychopharmacological Medications Tapering Attempts) identified no decrease in R14's Prozac (anti-depressant) or PRN (as needed) Ativan (anti-anxiety) was indicated by the physician.
R14's Psychopharmacological Medications Tapering Attempts forms dated 5/29/13, indicated Prozac 40 milligrams (mg) daily, (started 7/3/12) and Ativan 0.5 mg 4 times a day PRN, (started 6/8/12) were ordered for R14. The physician checked the box to indicate no tapering attempt at this time for both Prozac and Ativan. The wording next to the no box directed that if a response was no, a clinical rational must be documented on the form or in a progress note. The physician documented in the clinical rationale area that R14 was "stable" and there was no other documentation of clinical rationale for continued use for either medication.
The physician visit notes dated 5/28/13 and 7/29/13, lacked documentation for a clinical rationale to not complete a gradual dose reduction (GDR) for R14's Prozac and Ativan.
An interview on 8/20/13 at 2:45 p.m. with registered nurse (RN)-A indicated that there was no clinical indication for Prozac or Ativan in the chart on the form or in the typed physician progress note.
An interview on 8/22/13 at 2:00 p.m. with the

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	245540	A. BUILDING _____ B. WING _____	08/22/2013

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F 428	Continued From page 20 consultant the pharmacist revealed that the physician did not document a clinical rational for the continued use of Prozac and Ativan without a GDR. The consultant pharmacist stated that the forms are used to prompt the physician to document the clinical rationale for no GDR. The consultant pharmacist stated that no GDR had been done on the Prozac or Ativan for R14.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

DC: 10.01.2013

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

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

EXIT: 08.22.2013

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Golden Livingcenter - Henning 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by e-mail to:

RECEIVED
SEP 18 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
FS 9-20-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joan Medele S.E.D.	Sr. Executive Director	09-18-13

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
	245540	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Golden Livingcenter - Henning is a 1-story building with out a basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire	K 000		

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	245540	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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	Continued From page 2 Alarm Code" 1999 edition. The facility has a capacity of 50 beds and had a census of 38 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that one of ten hazardous area corridor doors tested is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which could negatively impact all 50 of the	K 029	K029 Items stored in Rm. 42 will be removed and use of this room for storage will be discontinued. Maint. Dir. will be responsible for removing stored items. ED will be responsible for monitoring that room is not utilized for storage.	09-27-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 3 residents, the staff and any visitors of the facility. Findings include: Observations during the facility tour on August 23, 2013, between 8:45 am and 10:00 am, by surveyor 03006, revealed that room 42 is now being used for storage and the corridor door is not 3/4 hour fire rated nor self-closing as required. The Director of Maintenance verified this finding during the facility tour and with the Administrator at the exit conference.	K 029		