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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8E8N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245386**
2.STATE VENDOR OR MEDICAID NO.
(L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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 10/24/2013 (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective October 4, 2013, the facility is certified for 55 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 11/1/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (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
12/01/1986 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS
Posted 1/6/2014 ML 8E8N

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/04/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5386 December 26, 2013

Ms. Theresa Pridal, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, Minnesota 56172

Dear Ms. Pridal:

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 October 4, 2013, the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 4, 2013

Mr. Wayman Fischgrabe, Administrator
Golden LivingCenter - Slayton
2957 Redwood Avenue South
Slayton, Minnesota 56172

RE: Project Number S5386023

Dear Mr. Fischgrabe:

On September 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 5, 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 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 4, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 5, 2013, effective October 4, 2013 and therefore remedies outlined in our letter to you dated September 12, 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245386	A. Building B. Wing	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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 **F0329** Reg. # **483.25(l)** LSC	**10/04/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**10/04/2013**	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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KJ	11/01/2013	03048	11/01/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/5/2013			

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
245386	A. Building B. Wing 01 - MAIN BUILDING 01	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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 Reg. # NFPA 101 LSC K0050	Correction Completed 09/24/2013	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KQ/KJ	11/01/2013	19251	11/01/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/6/2013				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8E8N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245386**
2.STATE VENDOR OR MEDICAID NO.
(L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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 **09/05/2013** (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 **55** (L18)

13.Total Certified Beds **55** (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
	55			
(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 :
Joseph Garvey, HFE NE II — 09/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/04/2013 (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
12/01/1986
(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
12/04/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN=245386

At the time of the standard survey completed September 5,2013, 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), as evidenced by the attached CMS-2567 whereby corrections are required. 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 5148 2838

September 12, 2013

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386023

Dear Mr. Fischgrabe:

On September 5, 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:

Kathryn Serie, Unit Supervisor
Division of Compliance Monitoring
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 537-7158 Fax: (507) 537-7194
Enclosure

cc: Licensing and Certification File

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 15, 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 15, 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 December 5, 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 March 5, 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

RECEIVED
SEP 24 2013
Minnesota Department of Health
Marshall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements.	
F 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.	F 329	**F329:** Medication for resident R1 has been reviewed and parameters for use have been requested from physician. Medication for resident R59 has been reviewed and dosage reduction has been requested from physician. Residents receiving psychopharmacologic medications have the potential to be affected if clinical indicators for continued use are not identified as well as parameters being identified. Staff have been re-educated on the need to identify clinical indicators for use of medications as well as identify the targeted behaviors on the Behavior log.	

approved on 9/24/13 KMS

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 329	Continued From page 1	F 329	DRA/designee will audit 2-4 charts weekly for 60 days to ensure clinical indicators and parameters are addressed for all medications. Negative outcomes will be reviewed at QA&A.	10/4/13

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure that 2 of 5 residents (R59 and R1) reviewed for unnecessary medications, had clear indications, defined parameters, and adequate monitoring for the use of the psychoactive medications.

Findings include: R1 received the anti-anxiety medication, Lorazepam, as needed (PRN) with no clear parameters identified for the use of this medication.

R1 was admitted to the facility 4/27/10 with diagnoses that included anxiety state, bipolar disorder and schizoaffective disorder.

The current physician orders identified that the anti-anxiety medication, Lorazepam 1 mg by mouth everyday PRN had been ordered on 5/9/13. The order did not have defined parameters for when to use the medication. R1 received the medication six (6) times in June, six (6) times in July, five (5) times in August and one (1) time thus far in September 2013. Documentation was lacking in the medication administration record (MAR) to indicate the rationale for the use of the PRN medication, Lorazepam, when administered by the licensed staff.

During interview with the director of nursing (DON) on 9/4/13 at 2:40 p.m., she verified that the order for the Lorazepam read one everyday by mouth PRN. She stated "I don't have the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 329	Continued From page 2 indications for parameters for the use of the PRN Lorazepam". Documentation was lacking in the record of R59 to indicate the rationale for the use of the antipsychotic medication, Risperdal. The rationale for not attempting a gradual dose reduction of the medication, Risperdal, was also not evident in the record of R59. Further, a system had not been developed to monitor R59's response and/or ongoing need for the use of Risperdal. R59 was admitted to the facility on 1/21/13 and had diagnoses that included: peripheral vascular disease, altered mental status, anxiety state, depression, and dementia. R59's medication regimen included the medications: Aricept 10 milligrams (mg) daily; Celexa 30 mg daily; Ativan 0.25 mg daily, and Risperdal 0.5 mg everyday. Documentation in a physician progress note on 1/28/13 listed R59 diagnoses as: dementia and depression and utilized Risperdal, Lorazepam, and Aricept. On 2/15/13 the licensed social worker (LSW) documented in the progress note that R59 score a zero (0) on her PHQ-9 assessment (depression scale) demonstrating R59 had no symptoms of depression. On 7/9/13 the consultant pharmacist made a recommendation to consider decreasing R59's Risperdal from 0.5 mg daily to 0.25 mg daily. On 7/10/13 documentation in the record indicated the family was contacted and did not want to reduce any medications at that time but would discuss it and get back with the facility. The physician returned a fax on 7/10/13 identifying if the family	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 329	Continued From page 3	F 329		

did not want the reduction of the medications he/she would order it to continue the same.

R59's mood /behavior care plan, dated 7/15/13, identified R59 with a history of wandering and looking for her family. The care plan also identified," [R59] is easily redirected. Family also reports resident with a [history] of getting fixated on something, becoming very anxious or agitated over it, with initiation of Risperdal and Lorazepam. Has diagnoses anxiety, depression, confusion,dementia; current PHQ-9[depression scale] score is zero (0)."

Staff documented on a "Daily Behavior Observation" log/sheet on each shift. The logs identified that R59 would be tracked each shift for the following: anxiety, restlessness, wandering and tearfulness. There were no indicators for psychotic episodes noted on the logs. The behavior logs identified the following notes:
In September 2013 through 9/5/13 there were no behaviors documented.
In August 2013 R59 was noted to have one (1) episode of wandering.
In July 2013 R59 had one(1) episode of anxiety.
In June 2013 R59 had six (6) episodes of anxiety and four (4) episodes of wandering.
In May 2013 R59 had three (3) episodes of anxiety and one (1) episode of wandering.
And in April 2013 R59 had three (3) episodes of wandering and (1) one episode of anxiety.
The record lacked any evidence R59 had been monitored for and/or had manifested any psychotic behaviors.

On 9/4/13 at 1:39 p.m. the director of nursing (DON) was interviewed. When asked about the use of the psychotic medications and the families

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 329	Continued From page 4 response to the reduction recommendation by the consultant pharmacist the DON verified R59's family did not want medications reduced and stated R59 had a history of behaviors. The DON verified there was lack of any evidence that education had occurred with the family concerning the use of the antipsychotic medication in absence of a psychotic diagnosis and/or manifestations. The DON was asked what diagnosis R59 had for the use of the Risperdal? The DON stated R59 had an unspecified psychosis disorder and was unsure how it was manifested. The DON further verified there were no clear indication for the use of the Risperdal and the behavior monitor logs lacked any evidence of tracking of any psychotic behaviors. R59 medical record lacked clear indication for the use of the antipsychotic medication Risperdal and the facility lacked a system to monitor any psychotic behaviors manifested by R59. Further, the medical record lacked any evidence there would be contraindications for an attempted, gradual dose reduction of the medication, Risperdal.	F 329		
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.	F 428	**F428:** Medication review has been completed and parameters for use has been addressed for resident R1. Residents receiving	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 428	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist identified clear parameters for use of a psychoactive medication for 1 of 5 residents (R1) in the sample who utilized psychoactive medications, Findings include: R1 received the anti-anxiety medication Lorazepam as needed (PRN) with no clear parameters identified for the use of the medication. R1 was admitted to the facility 4/27/10 with diagnoses that included anxiety state, bipolar disorder and schizoaffective disorder. The current physician orders identified that the anti-anxiety medication Lorazepam 1 mg by mouth everyday PRN had been ordered on 5/9/13. The physician order had not identified the parameters for when to use the medication. R1 received the medication six (6) times in June,six (6) times in July, five (5) times in August and 1 time thus far in September. Documentation was lacking in the medication administration record (MAR) to indicate the rationale for the use of the PRN medication, Lorazepam, when administered by the licensed staff. Review of the consultant pharmacist reports revealed this irregularity had not been addressed by the consultant pharmacist during the monthly reviews. During interview with the director of nursing on 9/4/13 at 2:40 p.m. she verified the consultant pharmacist had not identified, during the monthly	F 428	psychopharmacologic medications have the potential to be affected if clear parameters for use are not identified. Pharmacy staff have been re-educated on the need for parameters to be identified for use of psychopharmacologic medications. DRA/designee will audit 2-4 charts weekly for 60 days to ensure parameters for the use of psychopharmacologic medications are identified.	10/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 428	Continued From page 6 recommendations, that parameters for the use of the PRN Lorazepam had been missing in the documentation for R1.	F 428		

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

F5386021

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

(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	K 000		

SEP 23 2013
MN DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIV

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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 06,2013. At the time of this survey, Golden LivingCenter Slayton 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to:
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St Paul, MN 55101-5145, or
By email to:
Barbara.Lundberg@state.mn.us and,
Marian.Whitney@state.mn.us

EXIT: 09.05.2013
DC: 10.15.2013

POC ok
9-24-13

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.

K 050

Golden LivingCenter - Slayton has implemented a tracking tool to ensure that fire drills are scheduled at vary times on each shift in accordance with NFPA 101 LSC (00) Section 19.7.1.2.

The Maintenance Director is responsible to monitor for compliance with K 050

9/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	9/18/13

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
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

(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 1	K 000		
	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 Slayton was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected and is Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

(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 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 52 residents, visitors and staff. Findings include: On facility tour between 8:30 AM and 11:30 AM on 9/06/2013, a review of the available fire drill reports revealed that the facility's Evening-shift fire drills in 2012 and 2013 were conducted between the hours of 9:30 PM, 3:30 PM, 3:40 PM, 4:40 PM, and the Night-shift fire drills between 11:10 PM, 11:05 PM, 11:10 PM, 5:32 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245386	GOLDEN LIVINGCENTER SLAYTON

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 22113	09-03-2013	09-05-2013	1.00	1.00	17.00	2.00	3.00	1.00
2. 28651	09-03-2013	09-05-2013	0.00	1.00	16.50	2.00	3.25	1.00
3. 30923	09-03-2013	09-05-2013	0.00	1.00	15.75	2.00	4.50	0.00
4. 31593	09-03-2013	09-05-2013	0.00	1.00	12.00	2.00	10.00	0.00
5. 32978	09-03-2013	09-05-2013	0.00	5.00	8.00	8.00	2.25	0.00
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 7.00

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245386	GOLDEN LIVINGCENTER SLAYTON

Type of Survey (select all that apply):

H	I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 19251	09-06-2013	09-06-2013	1.00	0.00	3.00	0.00	5.00	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

0.25

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245386	**GOLDEN LIVINGCENTER - SLAYTON**	*K4 **09/06/2013**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A] A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

September 26, 2013

Mr. Wayman Fischgrabe,
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

Dear Mr. Fischgrabe:

On 09/06/2013 a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Public Safety, State Fire Marshal Division staff (K tags) have been, or will be corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Unless waivers have been recommended for all deficiencies cited, we will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Patrick Sheehan, Fire Safety Supervisor
Deputy State Fire Marshal
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Pat.Sheehan@state.mn.us

cc: Licensing and Certification File
Unit Supervisor
SFM File

S5386023

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: dvo.fischgrabe@goldenliving.com
National Provider Identifier (NPI) Number: 1356392534
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: GOLDEN LIVINGCENTER SLAYTON City: SLAYTON

Name of Legal Entity Operating Provider: GGNSC SLAYTON, LLC

Name and Address of Governing Board President:

Name: SEAN FOSTER
Address: 1000 FIANNA WAY
City/State/Zip: FORT SMITH, MN 72919

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____
Address: _____
City/State/Zip: _____

SIGNATURE

Completed by: _____
Title: EXECUTIVE DIRECTOR
Date: 9/4/13

3201 MDH C&C

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Wayman Fischgrabe, Administrator
Golden Living Center-Slayton
2957 Redwood Avenue S.
Slayton, MN 56172

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Sue Streff
C. Date of Delivery 9-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

7011 2000 0002 5148 2838
(Transfer from service label)

Please return within 5 days

PS Form 3811, February 2004 24536 Domestic Return Receipt SP 102595-02-M-1

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MDH

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monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **09/03/13** To F2: **09/05/13**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **GOLDEN LIVINGCENTER - SLAYTON**	Provider Number: **245386**	Fiscal Year ending:
Address: **2957 REDWOOD AVENUE SOUTH, SLAYTON, MURRAY, MN 56172**		
Telephone Number: F6 **507-836-6135**	State/County Code: **MN / MURRAY**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11 **n/a**		
Ownership: F12 **03 - For Profit - Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **Golden Living**		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0** Huntington's Disease F21 **0** Other Spec Rehab. F23 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0** Ventilator/Respiratory Care F22 **0**	
Does the facility currently have an organized resident group? F24		**Yes**
Does the facility currently have an organized group of family members of residents? F25		**Yes**
Does the facility conduct experimental research? F26		**No**

Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **n/a**	Hours waived per week: F29 **n/a**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **n/a**	Hours waived per week: F31 **n/a**

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**84**	**71**	**0**
Physician Services	F34	**Yes No No**			
Medical Director	F35		**0**	**0**	**6**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**Yes No No**	**0**	**0**	**0**
Nursing Services	F38	**Yes No No**			
RN Director of Nursing	F39		**0**	**64**	**0**
Nurses with Admin Duties	F40		**80**	**62**	**0**
Registered Nurses	F41		**313**	**68**	**0**
Licensed Practical/ Vocational Nurses	F42		**143**	**155**	**0**
Certified Nurse Aides	F43		**766**	**473**	**0**
Nurse Aides in Training	F44		**0**	**0**	**0**

Medication	F45		0	0	0
Pharmacists	F46	Yes No No	0	0	0
Dietary Services	F47	Yes No No			
Dietitian	F48		0	7	0
Food Service Workers	F49		174	204	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes Yes No	0	0	12
Occupational Therapy Assistant	F52		0	0	43
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes Yes No	0	0	17
Physical Therapy Assist	F55		0	0	32
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes Yes No	0	0	36
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	Yes No No	0	0	0
Other Activities Staff	F60	Yes No No	0	88	0
Qualified Social Workers	F61	Yes No No	86	0	0
Other Social Services Staff	F62	No No No	0	0	0
Dentists	F63	No No Yes	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	No No Yes	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No Yes			
Diagnostic X-ray Services	F68	No No Yes			
Administration Storage of Blood	F69	No No Yes			

Housekeeping Services	F70	Yes No No	223	159	0
Other	F71		0	0	0
Name of Person Completing Form: **Dru Fischgrabe**					Date: **09/05/13**

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Information on this website is available in alternative formats upon request.

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Protecting, maintaining and improving the health of all Minnesotans

MDH

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

GOLDEN LIVINGCENTER - SLAYTON				
Provider No. **245386**	Medicare F75 **7**	Medicaid F76 **28**	Other F77 **17**	Total Residents F78 **52**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **0**	F80 **45**	F81 **7**
Dressing	F82 **1**	F83 **47**	F84 **4**
Transferring	F85 **2**	F86 **45**	F87 **5**
Toilet Use	F88 **3**	F89 **41**	F90 **8**
Eating	F91 **20**	F92 **27**	F93 **5**

A. Bowel/Bladder Status	**B. Mobility**
F94 **6** With indwelling or external catheter.	F100 **4** Bedfast all or most of time..
F95 Of total number of residents with catheters, **4** were present on admission.	F101 **42** In chair all or most of time.
F96 **35** Occasionally or frequently incontinent of bladder.	F102 **5** Independently ambulatory.
F97 **17** Occasionally or frequently incontinent of bowel.	F103 **27** Ambulation with assistance or assistive device.
F98 **41** On individually written bladder training program.	F104 **1** Physically restrained.

F99 **19** On individually written bowel training program.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **27** With contractures.

F107 Of total number of residents with contractures, **24** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **19** With documentation signs and symptoms of depression.

F110 **16** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **25** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **22** With behavioral symptoms.

F113 **22** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **4** With pressure sores (exclude stage I).

F116 **4** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **46** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **6** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **1** Receiving chemotherapy.

F122 **0** Receiving dialysis.

F123 **2** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.

F124 **9** Receiving respiratory treatment.

F125 **0** Receiving tracheostomy care.

F127 **0** Receiving suction.

F128 **8** Receiving injections (exclude vitamin B12 injections)

F129 **0** Receiving tube feedings.

F130 **12** Receiving mechanically altered diets including pureed and all chopped food (not only meat).

F131 **10** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).

F132 **5** Assistive devices while eating.

F126 **1** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **27** Receiving any psychoactive medication.	F140 **6** With unplanned significant weight loss/gain.
F134 **10** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **4** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **25** Receiving antidepressant medications.	F143 **44** With advance directives.
F137 **2** Receiving hypnotic medication.	F144 **24** Received influenza immunization.
F138 **12** Receiving antibiotics.	F145 **42** Received pneumococcal vaccine.
F139 **32** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Dru Fischgrabe	**Executive Director**	**09/05/2013**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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Larson, Monica (MDH)

From: oracle@health.state.mn.us
Sent: Wednesday, December 04, 2013 9:05 PM
To: Olson, Cynthia (MDH); Sherry, Lisa (MDH); Larson, Monica (MDH)
Subject: GOLDEN LIVINGCENTER - SLAYTON - Move LNC Survey to Web

The Facility GOLDEN LIVINGCENTER - SLAYTON (HFID - 00915) Survey Project 'S5386023' and Aspen Event ID '8E8N11' is successfully moved to Web.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

(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		
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.	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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F 329	Continued From page 1	F 329		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure that 2 of 5 residents (R59 and R1) reviewed for unnecessary medications, had clear indications, defined parameters, and adequate monitoring for the use of the psychoactive medications.

Findings include: R1 received the anti-anxiety medication, Lorazepam, as needed (PRN) with no clear parameters identified for the use of this medication.

R1 was admitted to the facility 4/27/10 with diagnoses that included anxiety state, bipolar disorder and schizoaffective disorder.

The current physician orders identified that the anti-anxiety medication, Lorazepam 1 mg by mouth everyday PRN had been ordered on 5/9/13. The order did not have defined parameters for when to use the medication. R1 received the medication six (6) times in June, six (6) times in July, five (5) times in August and one (1) time thus far in September 2013. Documentation was lacking in the medication administration record (MAR) to indicate the rationale for the use of the PRN medication, Lorazepam, when administered by the licensed staff.

During interview with the director of nursing (DON) on 9/4/13 at 2:40 p.m., she verified that the order for the Lorazepam read one everyday by mouth PRN. She stated "I don't have the

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F 329	Continued From page 2	F 329		

indications for parameters for the use of the PRN Lorazepam".
Documentation was lacking in the record of R59 to indicate the rationale for the use of the antipsychotic medication, Risperdal. The rationale for not attempting a gradual dose reduction of the medication, Risperdal, was also not evident in the record of R59. Further, a system had not been developed to monitor R59's response and/or ongoing need for the use of Risperdal.

R59 was admitted to the facility on 1/21/13 and had diagnoses that included: peripheral vascular disease, altered mental status, anxiety state, depression, and dementia. R59's medication regimen included the medications: Aricept 10 milligrams (mg) daily; Celexa 30 mg daily; Ativan 0.25 mg daily, and Risperdal 0.5 mg everyday.

Documentation in a physician progress note on 1/28/13 listed R59 diagnoses as: dementia and depression and utilized Risperdal, Lorazepam, and Aricept.

On 2/15/13 the licensed social worker (LSW) documented in the progress note that R59 score a zero (0) on her PHQ-9 assessment (depression scale) demonstrating R59 had no symptoms of depression.

On 7/9/13 the consultant pharmacist made a recommendation to consider decreasing R59's Risperdal from 0.5 mg daily to 0.25 mg daily. On 7/10/13 documentation in the record indicated the family was contacted and did not want to reduce any medications at that time but would discuss it and get back with the facility. The physician returned a fax on 7/10/13 identifying if the family

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F 329	Continued From page 3 did not want the reduction of the medications he/she would order it to continue the same. R59's mood /behavior care plan, dated 7/15/13, identified R59 with a history of wandering and looking for her family. The care plan also identified," [R59] is easily redirected. Family also reports resident with a [history] of getting fixated on something, becoming very anxious or agitated over it, with initiation of Risperdal and Lorazepam. Has diagnoses anxiety, depression, confusion,dementia; current PHQ-9[depression scale] score is zero (0)." Staff documented on a "Daily Behavior Observation" log/sheet on each shift. The logs identified that R59 would be tracked each shift for the following: anxiety, restlessness, wandering and tearfulness. There were no indicators for psychotic episodes noted on the logs. The behavior logs identified the following notes: In September 2013 through 9/5/13 there were no behaviors documented. In August 2013 R59 was noted to have one (1) episode of wandering. In July 2013 R59 had one(1) episode of anxiety. In June 2013 R59 had six (6) episodes of anxiety and four (4) episodes of wandering. In May 2013 R59 had three (3) episodes of anxiety and one (1) episode of wandering. And in April 2013 R59 had three (3) episodes of wandering and (1) one episode of anxiety. The record lacked any evidence R59 had been monitored for and/or had manifested any psychotic behaviors. On 9/4/13 at 1:39 p.m. the director of nursing (DON) was interviewed. When asked about the use of the psychotic medications and the families	F 329		

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 329	Continued From page 4 response to the reduction recommendation by the consultant pharmacist the DON verified R59's family did not want medications reduced and stated R59 had a history of behaviors. The DON verified there was lack of any evidence that education had occurred with the family concerning the use of the antipsychotic medication in absence of a psychotic diagnosis and/or manifestations. The DON was asked what diagnosis R59 had for the use of the Risperdal? The DON stated R59 had an unspecified psychosis disorder and was unsure how it was manifested. The DON further verified there were no clear indication for the use of the Risperdal and the behavior monitor logs lacked any evidence of tracking of any psychotic behaviors. R59 medical record lacked clear indication for the use of the antipsychotic medication Risperdal and the facility lacked a system to monitor any psychotic behaviors manifested by R59. Further, the medical record lacked any evidence there would be contraindications for an attempted, gradual dose reduction of the medication, Risperdal.	F 329		
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.	F 428		

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 428	Continued From page 5	F 428		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure the consultant pharmacist identified clear parameters for use of a psychoactive medication for 1 of 5 residents (R1) in the sample who utilized psychoactive medications,

Findings include: R1 received the anti-anxiety medication Lorazepam as needed (PRN) with no clear parameters identified for the use of the medication.

R1 was admitted to the facility 4/27/10 with diagnoses that included anxiety state, bipolar disorder and schizoaffective disorder.

The current physician orders identified that the anti-anxiety medication Lorazepam 1 mg by mouth everyday PRN had been ordered on 5/9/13. The physician order had not identified the parameters for when to use the medication. R1 received the medication six (6) times in June,six (6) times in July, five (5) times in August and 1 time thus far in September. Documentation was lacking in the medication administration record (MAR) to indicate the rationale for the use of the PRN medication, Lorazepam, when administered by the licensed staff. Review of the consultant pharmacist reports revealed this irregularity had not been addressed by the consultant pharmacist during the monthly reviews.

During interview with the director of nursing on 9/4/13 at 2:40 p.m. she verified the consultant pharmacist had not identified, during the monthly

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(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 428	Continued From page 6 recommendations, that parameters for the use of the PRN Lorazepam had been missing in the documentation for R1.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH** **SLAYTON, MN 56172**

(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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 06,2013. At the time of this survey, Golden LivingCenter Slayton 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and, Marian.Whitney@state.mn.us	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH** **SLAYTON, MN 56172**

(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 1 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 Slayton was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected and is Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	**2957 REDWOOD AVENUE SOUTH** **SLAYTON, MN 56172**

(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 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 52 residents, visitors and staff. Findings include: On facility tour between 8:30 AM and 11:30 AM on 9/06/2013, a review of the available fire drill reports revealed that the facility's Evening-shift fire drills in 2012 and 2013 were conducted between the hours of 9:30 PM, 3:30 PM, 3:40 PM, 4:40 PM, and the Night-shift fire drills between 11:10 PM, 11:05 PM, 11:10 PM, 5:32 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2838

September 12, 2013

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386023

Dear Mr. Fischgrabe:

On September 5, 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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Division of Compliance Monitoring
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 537-7158 Fax: (507) 537-7194
Enclosure

cc: Licensing and Certification File

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 15, 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 15, 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 December 5, 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 March 5, 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

MINNESOTA
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 12, 2013

Mr. Wayman Fischgrabe, Administrator
Golden LivingCenter - Slayton
2957 Redwood Avenue South
Slayton, Minnesota 56172

Re: Project Number S5386023

Dear Mr. Fischgrabe:

The above facility survey was completed on September 5, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 24, 2013

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386023

Dear Mr. Fischgrabe:

On September 5, 2013, a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Sincerely,

Kathryn Serie

Kathryn Serie, RN, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 507-537-7158 Fax: 507-537-7194

cc: Licensing and Certification File

POCA HEALTH SURVEY.ORC