### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8E8N

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE					Facility ID: 00915		
MEDICARE/MEDICAID PROVIDER     (L1) 245386  2.STATE VENDOR OR MEDICAID NO.     (L2) 660385800	NO.	3. NAME AND AD (L3) <b>GOLDEN LI</b> (L4) <b>2957 REDW</b> (L5) <b>SLAYTON</b> , 1	IVINGCENTE OOD AVENUE	R - SLAYT	ON (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		
5. EFFECTIVE DATE CHANGE OF OV (L9) <b>04/01/2006</b>	VNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	ORY 09 ESRD	<u>O2</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 10/24/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	55 (L18) 55 (L17)	Complian1. A B. Not in Cor		gram	And/Or Approved Waivers Of TI 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code  * Code: A*	6. Scope of Services Limit 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOV  18 SNF 18/19 SNF  55  (L37) (L38)	VN 19 SNF (L39)	ICF (L42)	IID (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 to Certification Regulations. Please refer to the CMS 2567B. Effective October 4, 201  17. SURVEYOR SIGNATURE  Date:  Kathryn Serie, Unit Supervisor 11/1/2013  (L19)					*			
19. DETERMINATION OF ELIGIBILIT  _X	Y	20. COM	BY HCFA R  MPLIANCE WITH GHTS 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)  25. LTC EXTENSION DATE:  (L27)	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI A. Suspension B. Rescind Sus	DATE  /E SANCTIONS of Admissions:	4. LTC AGREEM ENDING DATE (L25)		26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement		
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C		(L31)	30. REMARKS Posted 1/6/2014	ML 8E8N		
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION ( 12/04/2013	OF APPROVAL D	DATE (L33)	DETERMINATION APPR	OVAI		



#### 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 B. Leach, Program Specialist

Colleen Feach

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



#### 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

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245386	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/24/2013
Name of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - SLAYTO	N	2957 REDWOOD AVENUE SO	UTH

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	F0329	Correction Completed 10/04/2013	ID Prefix	F0428	Correction Completed 10/04/2013		ID Prefix		Correction Completed
Reg. # LSC	483.25(I)		Reg. # LSC	483.60(c)	-		Reg. # LSC		
ID Prefix Reg. # LSC			Reg. #		Correction Completed				
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #		
ID Prefix Reg. # LSC					Correction Completed		Б "		
Reg. #			Reg. #				D #		
Reviewed E	WC/VI	ІВу	Date: 11/01/201	Signature of Sur 03048	rveyor:			<b>Dat</b> 11	e: /01/2013
Reviewed E	By Reviewed	I Ву	Date:	Signature of Sui	rveyor:			Dat	e:
Followup t	o Survey Completed or 9/5/2013	1:		Check for any Unco Uncorrected Defice					S NO

**GOLDEN LIVINGCENTER - SLAYTON** 

requirement on the survey report form).

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245386	( <b>Y2) Multiple Con</b> A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 10/23/2013
Name	of Facility		Street Address, City, State, Zip Code	
GC	OLDEN LIVINGCENTER - SLAVTON		2957 REDWOOD AVENUE SOL	JTH

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 09/24/2013	ID Prefix		Correction Completed			
Ū	NFPA 101 K0050		Reg. #			Reg. # LSC		
Reg. #			Reg. #		Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #			Reg. #		Correction Completed	D "		Correction Completed
			Reg. #		Correction Completed			
Reviewed E		iewed By Q/KJ	Date: 11/01/2013	Signature of Sur	veyor:		Date: 11/0	1/2013
Reviewed E	-	iewed By	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Comple 9/6/2013			theck for any Uncor Uncorrected Defic	rected Deficiencies (CMS	iencies. Was a Si S-2567) Sent to th	ummary of ee Facility? YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8E8N

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMI	PLETED BY TH	IE STAT	E SURVEY AGENCY	Facili	ity ID: 00915
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245386  2.STATE VENDOR OR MEDICAID NO.     (L2) 660385800	3. NAME AND ADE (L3) GOLDEN LIV (L4) 2957 REDWC (L5) SLAYTON, M	VINGCENTER - S OOD AVENUE SO	SLAYTO	(L6) <b>56172</b>	3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006	7. PROVIDER/SUP	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey After Compla	9. Other nint
6. DATE OF SURVEY 09/05/2013  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	L34) 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DAT	TE: (L35)
	(L17) X B. Not in Comp	ce With quirements	'aivers:	And/Or Approved Waivers Of The  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code  * Code: B*	6. Scope of Services I 7. Medical Director	- Limit
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  55  (L37) (L38)	19 SNF ICF (L39) (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLI See Attached Remarks	CABLE SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE	Date :	09/24/2013	(L19)	18. STATE SURVEY AGENCY APP		Date: 12/04/2013 (L20)
PART	II - TO BE COMPLETEI	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate 2. Facility is not Eligible		PLIANCE WITH CI TS ACT:	VIL	<ul><li>21. 1. Statement of Financia</li><li>2. Ownership/Control In</li><li>3. Both of the Above :</li></ul>	al Solvency (HCFA-2572)  nterest Disclosure Stmt (HCFA-15	13)
OF PARTICIPATION BEG 12/01/1986 (L24) (L41	INNING DATE	4. LTC AGREEMEN ENDING DATE (L25)	VΤ	26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	05-Fail to Meet Fail to Meet A	<u>/</u> Iealth/Safety
A. St	RNATIVE SANCTIONS spension of Admissions: scind Suspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER 07-Provider State 00-Active	us Change
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CA 00454	ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION O 12/04/2013	OF APPROVAL DATE	(L33)	DETERMINATION APPROV	VAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

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.



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;

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

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

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

### **DEPARTMENT CONTACT**

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

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.

Golden Livingcenter - Slayton September 12, 2013 Page 3 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

SEP 24 2013

PRINTED: 09/12/2013 **FORM APPROVED** 

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		Annestoa Department o	f Health	FORM APPROVED <u>MB NO. 09</u> 38-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į.	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		245386	B. WING			09/05/2013
NAME OF	PROVIDER OR SUPPLIER		L	STREET ADDRESS, C	ITY, STATE, ZIP CODE	09/09/2013
GOLDEN	I LIVINGCENTER - SL	AYTON		2957 REDWOOD AV SLAYTON, MN 56	ENUE SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 000	as your allegation on Department's accept bottom of the first pube used as verificate.  Upon receipt of an arevisit of your facility.	of correction (POC) will serve for compliance upon the obtance. Your signature at the age of the CMS-2567 form will ion of compliance.  Acceptable POC an on-site or may be conducted to	FO	Preparation implement Correction an admission with the factor of the court Plant of the quality the quality implements to the quality implements the quality	on, submission and tation of this Plan of a does not constitute sion of or agreement acts and conclusions on the survey report. of Correction is and executed as a continuously improve of care and to comp	ly
F 329 SS≃D	regulations has bee your verification. 483.25(I) DRUG RE UNNECESSARY DI Each resident's drug unnecessary drugs. drug when used in eduplicate therapy); of	ntial compliance with the n attained in accordance with GIMEN IS FREE FROM RUGS  g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate	F3: approv approv	F329: Medication been review for use ha from phys	e applicable state and gulatory requirements in for resident R1 has swed and parameters we been requested ician.	3.
	indications for its us adverse consequents should be reduced of combinations of the Based on a comprehensident, the facility who have not used a given these drugs up therapy is necessary as diagnosed and derecord; and resident drugs receive gradus behavioral interventic contraindicated, in a drugs.	e; or in the presence of ces which indicate the dose or discontinued; or any reasons above.  The ensive assessment of a must ensure that residents antipsychotic drugs are not enless antipsychotic drug or to treat a specific condition occumented in the clinical s who use antipsychotic all dose reductions, and ons, unless clinically in effort to discontinue these	Har	been revier reduction from physics Residents psychophic medication to be affect indicators not identificators as well as behaviors	ewed and dosage has been requested ician.  receiving armacologic as have the potential for continued use are ed as well as seeing identified.  been re-educated on to identify clinical for use of medications identify the targeted on the Behavior log.	6
BORATORY,	DIRECTOR'S OR PROVIDE	RISUPPLIER REPRESENTATIVE'S SIGNA	ATURE	лт	E	/ (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.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING\_ B. WING 245386 09/05/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH **GOLDEN LIVINGCENTER - SLAYTON** SLAYTON, MN 56172 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 329 Continued From page 1 F 329 DRA/designee will audit 2-4 charts weekly for 60 days to ensure clinical indicators and This REQUIREMENT is not met as evidenced parameters are addressed for bv: all medications. Negative Based on interview and document review the outcomes will be reviewed at facility failed to ensure that 2 of 5 residents (R59 QA&A. 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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Event ID: 8E8N11

Facility ID: 00915

If continuation sheet Page 2 of 7

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245386	B. WING			09	/05/2013
	PROVIDER OR SUPPLIER	AYTON		295	REET ADDRESS, CITY, STATE, ZIP CODE 17 REDWOOD AVENUE SOUTH AYTON, MN 56172		
(X4) ID PREFIX TAG	- (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Lorazepam".  Documentation was to indicate the ration antipsychotic medic rationale for not attereduction of the menot evident in the resystem had not bee response and/or on Risperdal.  R59 was admitted to had diagnoses that disease, altered medepression, and der regimen included the milligrams (mg) daily 0.25 mg daily, and F.  Documentation in a 1/28/13 listed R59 diagnoses and utilizand Aricept.  On 2/15/13 the licent documented in the pazero (0) on her PH scale) demonstrating depression.  On 7/9/13 the consumer commendation to on Risperdal from 0.5 m.  7/10/13 documentation and get back with the rational standing and get back with the rational standing medications at the randing standing to the retain of the page of the retained and get back with the rational standing the retained to	meters for the use of the PRN s lacking in the record of R59 hale for the use of the hation, Risperdal. The hampting a gradual dose dication, Risperdal, was also hord of R59. Further, a had developed to monitor R59's going need for the use of  the facility on 1/21/13 and included: peripheral vascular hat status, anxiety state, mentia. R59's medication he medications: Aricept 10 hy; Celexa 30 mg daily; Ativan has Risperdal 0.5 mg everyday.  Physician progress note on hiagnoses as: dementia and hated Risperdal, Lorazepam,  sed social worker (LSW) hrogress note that R59 score had accompany assessment (depression had R59 had no symptoms of  that pharmacist made a had had hor want to reduce hat time but would discuss it had did not want to reduce hat time but would discuss it had facility. The physician had only assessing for the family had accomplished the family	f F3	329			

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Event ID: 8E8N11

Facility ID: 00915

If continuation sheet Page 3 of 7

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI			(X3) DATE SURVEY COMPLETED	
		245386	B. WING	·		nc	0/05/2013
	PROVIDER OR SUPPLIER	_AYTON	<u> </u>	295	REET ADDRESS, CITY, STATE, ZIP CODE 57 REDWOOD AVENUE SOUTH AYTON, MN 58172		103/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	he/she would order R59's mood /behavidentified R59 with looking for her familidentified," [R59] is reports resident with on something, becover it, with initiation Has diagnoses anxiconfusion, demential scale] score is zero  Staff documented of Observation" log/shidentified that R59 with following: anxious and tearfulness. The psychotic episodes behavior logs identified in September 2013 behaviors document in August 2013 R59 has and four (4) episode in May 2013 R59 has anxiety and one (1) of And in April 2013 R5 wandering and (1) of The record lacked armonitored for and/or psychotic behaviors.  On 9/4/13 at 1:39 p.r	duction of the medications it to continue the same.  ior care plan, dated 7/15/13, a history of wandering and ly. The care plan also easily redirected. Family also ha [history] of getting fixated ming very anxious or agitated of Risperdal and Lorazepam. ety, depression, current PHQ-9[depression (0)."  In a "Daily Behavior eet on each shift. The logs would be tracked each shift for ety, restlessness, wandering ere were no indicators for noted on the logs. The fied the following notes: through 9/5/13 there were no ted.  In was noted to have one (1) g. d one(1) episode of anxiety. In a six (6) episodes of anxiety and six (6) episodes of episode of wandering.  In a track of the following notes: through 9/5/13 there were noted.  In a six (6) episode of anxiety and six (6) episode of anxiety and three (3) episodes of episode of wandering.  In a six to continue the same.	F	229			

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Event ID: 8E8N11

Facility ID: 00915

If continuation sheet Page 4 of 7

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	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245386	B. WING				
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COR 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	DE 1 09/	05/2013	
(X4) ID PREFIX TAG	( EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428 SS≂D	consultant pharmac family did not want restated R59 had a his verified there was lated education had occur concerning the use of medication in absential and/or manifestation diagnosis R59 had for The DON stated R59 psychosis disorder at manifested. The DO no clear indication for and the behavior modevidence of tracking R59 medical record late would be contraindictly lacked as psychotic behaviors in the medical record late would be contraindictly gradual dose reduction Risperdal.  483.60(c) DRUG REGIRREGULAR, ACT Of The drug regimen of reviewed at least once pharmacist.	uction recommendation by the ist the DON verified R59's medications reduced and story of behaviors. The DON lock of any evidence that tred with the family of the antipsychotic ce of a psychotic diagnosis is. The DON was asked what or the use of the Risperdal? 9 had an unspecified and was unsure how it was in further verified there were or the use of the Risperdal and into logs lacked any of any psychotic behaviors. If acked clear indication for the potic medication Risperdal and existent to monitor any manifested by R59. Further, lacked any evidence there ations for an attempted, on of the medication, GIMEN REVIEW, REPORT in the each resident must be ear month by a licensed report any irregularities to	F 32		for		

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Event ID: 8E8N11

Facility ID: 00915

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED	
		245386	B. WING	;		00	//05/2013
GOLDEI (X4) ID PREFIX	(EACH DEFICIENC)	LAYTON  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	290 SL	REET ADDRESS, CITY, STATE, ZIP CODE  67 REDWOOD AVENUE SOUTH  AYTON, MN 56172  PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL)	DN D BE	(X5)
PRÉFIX TAG	Continued From participations of the sample who a medications,  Findings include: Redication Lorazep clear parameters id medication.  R1 was admitted to diagnoses that includisorder and schizo The current physicia anti-anxiety medication parameters for when received the medication when the sample who a medication.  R1 was admitted to diagnoses that includisorder and schizo The current physicia anti-anxiety medication.	y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  age 5  NT is not met as evidenced wand document review the ure the consultant pharmacist ameters for use of a cation for 1 of 5 residents (R1) utilized psychoactive  R1 received the anti-anxiety pam as needed (PRN) with not entified for the use of the the facility 4/27/10 with uded anxiety state, bipolar			provider's Plan of Correction (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE PRIATE	COMPLETION DATE
:	time thus far in Sept lacking in the medica (MAR) to indicate the PRN medication, Lo by the licensed staff, pharmacist reports mot been addressed during the monthly reDuring interview with 9/4/13 at 2:40 p.m.	tember. Documentation was ation administration record e rationale for the use of the razepam, when administered. Review of the consultant evealed this irregularity had by the consultant pharmacist					

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Event ID: 8E8N11

Facility ID: 00915

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245386	B. WING	·		n	9/05/2013
	PROVIDER OR SUPPLIER			2957	ET ADDRESS, CITY, STATE, ZIP CODE REDWOOD AVENUE SOUTH YTON, MN 56172	1	000/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	Continued From pay recommendations, if the PRN Lorazepan documentation for F	that parameters for the use of had been missing in the	F 4	128			
							İ

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Event ID: 8E8N11

Facility ID: 00915

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

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245386 B. WING 09/06/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH **GOLDEN LIVINGCENTER - SLAYTON** SLAYTON, MN 56172 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) SEP 2 3 2013 K 000 INITIAL COMMENTS K 000 MILITERE CEPTIBLIC SAFETY FIRE SAFETY STATE FINE MALE HALDING TO THE FACILITY'S POC WILL SERVE AS YOUR Preparation, submission and ALLEGATION OF COMPLIANCE UPON THE implementation of this Plan of DEPARTMENT'S ACCEPTANCE. YOUR Correction does not constitute SIGNATURE AT THE BOTTOM OF THE FIRST an admission of or agreement PAGE OF THE CMS-2567 FORM WILL BE with the facts and conclusions USED AS VERIFICATION OF COMPLIANCE. set forth on the survey report. Our Plan of Correction is UPON RECEIPT OF AN ACCEPTABLE POC, AN prepared and executed as a ONSITE REVISIT OF YOUR FACILITY MAY BE means to continuously improve CONDUCTED TO VALIDATE THAT the quality of care and to comply SUBSTANTIAL COMPLIANCE WITH THE with all the applicable state and REGULATIONS HAS BEEN ATTAINED IN federal regulatory requirements. 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 K 050 was found not in substantial compliance with the m requirements for participation in O Medicare/Medicaid at 42 CFR, Subpart Golden LivingCenter - Slayton N 483.70(a), Life Safety from Fire, and the 2000 has implemented a tracking tool to ensure that fire drills are edition of National Fire Protection Association scheduled at vary times on each (NFPA) 101 Life Safety Code (LSC), Chapter 19 POCOK

39-24-13 shift in accordance with NFPA Existing Health Care Occupancies. 101 LSC (00) Section 19.7.1.2. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division The Maintenance Director is 444 Cedar St., Suite 145 responsible to monitor for St Paul, MN 55101-5145, or compliance with K 050 By email to: Barbara.Lundberg@state.mn.us and, Marian.Whitney@state.mn.us

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

e institution may be excused from correcting providing it is determined that

TITLE

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.

(X6) DATE

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

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION AIN BUILDING 01	(X3) D	O: 0938-038 ATE SURVEY OMPLETED
e		245386	B. WING				0/00/0040
	PROVIDER OR SUPPLIER  N LIVINGCENTER - SL	W.A. Landson, Co.		2957 REI	ADDRESS, CITY, STATE, ZIP CO DWOOD AVENUE SOUTH DN, MN 56172	DE	9/06/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CI	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From page	ge 1	K 00	00			
	THE PLAN OF COR DEFICIENCY MUST FOLLOWING INFO	RRECTION FOR EACH FINCLUDE ALL OF THE RMATION:					
	A description of w     to correct the deficie	hat has been, or will be, done ency.		A.			1
	2. The actual, or pro	posed, completion date.					4
	Golden LivingCenter	ction and monitoring to					
	fully fire sprinkler pro construction.	tected and is Type II(111)					
To go pool of	detection in the corridors which is modepartment notification	alarm system with smoke dors and spaces open to the initored for automatic fire on. The facility has a and had a census of 52 at		1 1 11 11 11			
	NOT MET as evidend	2 CFR, Subpart 483.70(a) is ed by: ETY CODE STANDARD	K 050				
SS=F	Fire drills are held at a varying conditions, at The staff is familiar wi that drills are part of e Responsibility for plan assigned only to comp	unexpected times under least quarterly on each shift. th procedures and is aware	K 050				

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

CENTE	13 FUR WIEDICARE	E & MEDICAID SERVICES			O	MB NO	0.0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DAT	TE SURVEY MPLETED
		245386	B WING	_		09	/06/2013
	PROVIDER OR SUPPLIER  N LIVINGCENTER - SL			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	1 00.	100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE	(X5) COMPLETION DATE
co	conducted between	n 9 PM and 6 AM a coded y be used instead of audible	K 08	50			1 0 0
	Based on review of determined that the for the required num in the last 12-month NFPA 101 LSC (00) deficient practice co the event of a fire. In	s not met as evidenced by: If reports and records, it was If facility failed to vary the times If period in accordance with If Section 19.7.1.2. This If pould affect how staff react in If mproper reaction by staff If the section is the section of all 52 residents, visitors					
i	Findings include:					4	
	on 9/06/2013, a revier reports revealed that fire drills in 2012 and between the hours or PM, 4:40 PM, and the between 11:10 PM, 1	reen 8:30 AM and 11:30 AM iew of the available fire drill at the facility's Evening-shift d 2013 were conducted of 9:30 PM, 3:30 PM, 3:40 the Night-shift fire drills 11:05 PM, 11:10 PM, 5:32 tes as required by Section	25 a 100 a 1	**************************************			
f ×	This deficient practice facility 's Maintenance	ce was confirmed by the ce Supervisor.					
8							

3.25

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#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number		Provider/Supplier Name						
245386		GOI	DEN LIVINGCEN	NTER SLAYTON				
Type of Survey (sele	ct all that a	apply):	A Complaint	Investigatio	n E Initia	l Certifica	tion I Rec	certification
I			B Dumping In	vestigation	F Inspec	tion of Car	e J Sano	ction/Hearing
			C Federal Mo	nitoring	G Valida	tion	K Stat	e License
			D Follow-up	Visit	H Life s	afety Code	L Chov	Į.
xtent of Survey (Se	lect all that	apply):						
A				andard (all	-			
				urvey (HHA o	_	care facil	ity)	
				tended Surve	y (HHA)			
			D Other Surv	rey				
			SURVEY TEAM A	ND WORKLOAD I	DATA			
lease enter the wor			-	Use the sur	veyor's info			
	First	Last	Pre-Survey	On-Site	On-Site	On-Site	Travel (	ff-Site Report
Surveyor Id Number	Date Arrived	Date	Preparation	Hours	Hours	Hours	Hours	Preparation Hours
(A)	(B)	Departed	Hours (D)	12am-8am (E)	8am-6pm (F)	6pm-12am (G)	(H)	(I)
	(=)	(C)	(D)	(2)	( f )	(-/		(1)
Team Leader 1. 22113	09-03-2013	09-05-2013	1.00	1.00	17.00	2.00	3.00	1.00
1. 22113	03 03 2013	03 03 2013	1.00	1.00	17.00	2.00	3.00	1.00
<sup>2</sup> . <sub>28651</sub>	09-03-2013	09-05-2013	0.00	1.00	16.50	2.00	3.25	1.00
2								
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. <sub>32978</sub>	09-03-2013	09-05-2013	0.00	5.00	8.00	8.00	2.25	0.00
	09-03-2013	09-03-2013	0.00	3.00	8.00	0.00	2.23	0.00
6.								
7.								
,								
8.								
9.								
J.								
10.								

Total Clerical/Data Entry Hours.....

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

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245386			Provider/Supplier Name GOLDEN LIVINGCENTER SLAYTON						
Type of Survey (sele			A Complaint B Dumping In C Federal Mo	nvestigation onitoring	F Inspec G Valida	tion of Car	e J Sand	certification ction/Hearing te License w	
xtent of Survey (Se	lect all that	apply):	B Extended S	andard (all Survey (HHA o stended Surve	r long term		ity)		
			SURVEY TEAM A	ND WORKLOAD	DATA				
Please enter the wor 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)		Off-Site Report Preparation Hours (I)	
Team Leader 1. 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.									
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10.									
otal Supervisory Re	view Hours							0.25	
otal Clerical/Data									

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

PROVIDER NUMBER	FACILITY NAME			SURVEY DATE
K1 245386	GOLDEN LIVINGCENTE	R - SLAYTON		*K4 09/06/2013
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONS TOTAL NUMBER OF BU NUMBER OF THIS BUIL	JILDINGS	1 A	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR			MPLETE IF ICF/MR IS SURVEYED UNDER	
He	ealth Care Form	SMA	ALL (16 BEDS O	R LESS)
12 2786 R	2000 EXISTING		1 PROMPT	
13 2786 R	2000 NEW		K8: 2 SLOW 3 IMPRAC	TICAI
-	ACCE	<b></b>	3 IIVII RAC	HCAL
14 2786 U	ASC Form 2000 EXISTING	<del> </del>   , , ,		
15 2786 U	2000 EXISTING 2000 NEW	LAF	4 PROMPT	
13 2700 0	2000 NEW		K8: 5 SLOW 6 IMPRAC	TICAL
	CF/MR Form		K8: 6 IMPRAC	HCAL
16 2786 V, W, X		$\sqcup$		
17 2786 V, W, X	2000 NEW	APA	ARTMENT HOUSE	
	FORM USED FROM ABOVE		K8: 7 PROMPT 8 SLOW 9 IMPRAC	
(Cneck tj K29 or K36 are ma 2786 M, R, T, U, V, W, X, Y	arked as not applicable in the and Z.)	ENT	TER E-SCORE HERE	
K29:	K56:		K5: e.g 2.5	
*K9 : FACILITY MEETS LSC BA	ASED ON: (Check all that apply)			
(COMP. WITH ALL PROVISIONS)	A2 X (ACCEPTABLE POC)	(WAIVERS)	A4 FSES)	A5 PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET LSO  B. *MANDATORY	FUL	A. X  LY SPRINKLERED quired areas are sprinklered)	B. PARTIALLY SPRINKLERED (Not all required areas are sprinklere	

September 26, 2013

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

Dear Mr. Fischgrabe:

7 Sheehan

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

# 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:  National Provider Identifier (NPI) Number:  One facility may have multiple NPI Numbers. Please provider type for this survey, i.e. for a nursing home the Nursing Home.	survey, the NPI number associated with survey, the NPI Number will be associated with
OWNERSHIP INFORMATION AT THE TIME O	OF SURVEY
Name of Facility: GOLDEN LIVINGCENTER SLA	YTON City: SLAYTON
Name of Legal Entity Operating Provider: GGNSC S	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 deprovide the information below.	
Name of Facility:	City:
Name of Legal Entity Operating Provider:	
Name and Address of Governing Board President:	•
Name:	<u> </u>
Address:	·
City/State/Zip:	
SIGNATURE Completed by:	)
Title: EXECTIVE DIROCPOR	)
Data: S/c/13	

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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 mailplece, or on the front if space permits.  Article Addressed to:  Mr. Wayman Fischgrabe, Administrator	A. Signature  X. A. Signature  B. Bacelved by (Printed Name)  C. Date of Delivery  D. Is delivery address different from Item 1?  If YES, enter delivery address below:
Golden Living Center-Slayton 2957 Redwood Avenue S. Slayton, MN 56172	3. Service Type  Certified Mail
	4. Restricted Delivery? (Extra Fee)
7011 2000 0002 5148 2838	Please return 5 days
PS Form 3811, February 2004 245386 Domestic Retu	

CMS-671 Page 1 of 4



Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be

Would you like to go to the CMS-672 form for data entry?

required to complete the process.



Print this Page

Go to CMS-672

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

	<u>Exit</u>		
Standard Sur	vey Date Format: mm/dd/yy	Extanded Survey De	te Format: mm/dd/yy
	/03/13 To F2: 09/05/13	From F3: To F4:	tte Format. mm/dd/yy
Name of Fac GOLDEN L	ility: IVINGCENTER - SLAYTO	Provider Number: 245386	Fiscal Year ending:
Address: <b>2957 REDW</b>	OOD AVENUE SOUTH, S	LAYTON, MURRAY, MN 50	6172
Telephone N <b>507-836-613</b>		State/County Code: MN / MURRAY	State/Region Code: MN / 05
B. Is this fac	NF/NF - Medicare/Medicaid ility hospital based? F10 No licate Hopsital Provider Numb	per: <mark>F11 n/a</mark>	
Ownership: 1	F12 03 - For Profit - Corpora	ation	
	ased by Multi-Facility Organiz lti-Facility Organization: F14		
Name of Mu		Golden Living	
Name of Mu	lti-Facility Organization: F14  pecial Care Units (show numb	Golden Living	
Name of Mu  Dedicated Sp	lti-Facility Organization: F14  pecial Care Units (show numb	er of beds for all that apply)	18 0
Name of Mu  Dedicated Sp  AIDS F1  Dialysis I  Head Tra	lti-Facility Organization: F14  pecial Care Units (show numb  5 0  F17 0  ma F19 0	er of beds for all that apply)  Alzheimer's Disease F16 0  Disabled Child Young Adult F  Hospice F20 0	
Dedicated Sp  AIDS F1  Dialysis I  Head Tra  Huntington	lti-Facility Organization: F14  pecial Care Units (show numb  5 0  F17 0  ma F19 0	er of beds for all that apply)  Alzheimer's Disease F16 0  Disabled Child Young Adult F	
Dedicated Sp AIDS F1 Dialysis I Head Tra Huntingto Other Spo	lti-Facility Organization: F14  pecial Care Units (show numb  5 0  F17 0  ma F19 0  pon's Disease F21 0	er of beds for all that apply)  Alzheimer's Disease F16 0  Disabled Child Young Adult F  Hospice F20 0  Ventilator/Respiratory Care F2	
Dedicated Sp  AIDS F1  Dialysis I  Head Tra  Huntingto  Other Spo	lti-Facility Organization: F14  Decial Care Units (show numb  5 0  F17 0  ma F19 0  on's Disease F21 0  ec Rehab. F23 0  flity currently have an organiz	er of beds for all that apply)  Alzheimer's Disease F16 0  Disabled Child Young Adult F  Hospice F20 0  Ventilator/Respiratory Care F2	Yes

CMS-671 Page 2 of 4

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. Hours waived per week:

Date: mm/dd/yy Waiver of seven day RN requirement. F28 n/a F29 n/a

Date: mm/dd/yy Hours waived per week: Waiver of 24 hr licensed nursing requirement.

F30 n/a 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.

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

1) Was this a staggered Survey? No - Not Staggered

**Surveyor to Complete** 

2) If staggered, day of the week starting? 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		

CMS-671 Page 3 of 4

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			

CMS-671 Page 4 of 4

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

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

CMS-672 Page 1 of 4





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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-671 form for data entry?	<u>Go to CMS-671</u>
I'm finished and would like to exit the application.	<u>Exit</u>

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

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

### A. Bowel/Bladder Status

F94 6 With indwelling or external catheter.

F95 Of total number of residents with catheters, 4 were present on admission.

F96 35 Occasionally or frequently incontinent of bladder.

F97 17 Occasionally or frequently incontinent of bowel.

F98 41 On individually written bladder training program.

### **B.** Mobility

F100 4 Bedfast all or most of time..

F101 42 In chair all or most of time.

F102 5 Independently ambulatory.

F103 27 Ambulation with assistance or assistive device.

F104 1 Physically restrained.

CMS-672 Page 2 of 4

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.

CMS-672 Page 3 of 4

F126 1 Receiving ostomy care.

#### F. Medication

F133 27 Receiving any psychoactive medication.

F134 10 Receiving antipsychotic medications.

F135 4 Receiving antianxiety medications.

F136 25 Receiving antidepressant medications.

F137 2 Receiving hypnotic medication.

F138 12 Receiving antibiotics.

F139 32 On pain management program.

#### G. Other

F140 6 With unplanned significant weight loss/gain.

F141 0 Who do not communicate in the dominant language of the facility (includes those who use sign language).

F142 **0** Who use non-oral communication devices.

F143 44 With advance directives.

F144 24 Received influenza immunization.

F145 42 Received pneumococcal vaccine.

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.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245386	B. WING			09/0	05/2013
	PROVIDER OR SUPPLIER	.AYTON		STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD E		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	000			
F 329 SS=D	as your allegation of Department's accept bottom of the first pube used as verificated. Upon receipt of an revisit of your facilit validate that substate regulations has been your verification. 483.25(I) DRUG REUNNECESSARY DEACH resident's druunnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and resident drugs receive gradubehavioral intervents.	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with EGIMEN IS FREE FROM RUGS  g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any	F3	329			
LABORATOR\	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245386	B. WING _		09	/05/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON			STREET ADDRESS, CITY, STATE, ZIP COD 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 1	F 32	9			
	by: Based on interview facility failed to ens and R1) reviewed for had clear indication adequate monitoring psychoactive medication, Loraze no clear parameter medication.  R1 was admitted to diagnoses that includisorder and schizorder and schizor	cations. R1 received the anti-anxiety pam, as needed (PRN) with is identified for the use of this the facility 4/27/10 with uded anxiety state, bipolar eaffective disorder.  an orders identified that the attion, Lorazepam 1 mg by the RN had been ordered on did not have defined en to use the medication. R1 attion six (6) times in June, six e (5) times in August and one					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245386	B. WING		09	/05/2013		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON				STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 329	Lorazepam".  Documentation wa to indicate the ratio antipsychotic media rationale for not att reduction of the menot evident in the resystem had not bear response and/or or Risperdal.  R59 was admitted had diagnoses that disease, altered medepression, and deregimen included the milligrams (mg) da 0.25 mg daily, and Documentation in a 1/28/13 listed R59 depression and util and Aricept.  On 2/15/13 the lice documented in the a zero (0) on her Pscale) demonstration depression.  On 7/9/13 the considered from 0.5 7/10/13 documentation to Risperdal from 0.5 7/10/13 documentations at and get back with the series of the response of the re	age 2 Imeters for the use of the PRN Is lacking in the record of R59 Inale for the use of the Cation, Risperdal. The Imperimental a gradual dose Inale decidition, Risperdal, was also Inale decord of R59. Further, a Inale developed to monitor R59's Ingoing need for the use of Ito the facility on 1/21/13 and It included: peripheral vascular International Status, anxiety state, Immentia. R59's medication International Aricept 10 International Status, and dily; Ativan International Risperdal 0.5 mg everyday. In physician progress note on Indiagnoses as: dementia and International Status and International Status International International Status International Internatio	F 3.	29				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		245386	B. WING _		09	/05/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON				STREET ADDRESS, CITY, STATE, ZIP ( 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 329	he/she would order R59's mood /behavidentified R59 with looking for her fam identified," [R59] is reports resident wit on something, becover it, with initiatio Has diagnoses anx confusion, dementia scale] score is zero.  Staff documented of Observation" log/shidentified that R59 the following: anxiand tearfulness. The psychotic episodes behavior logs ident In September 2013 behaviors document In August 2013 R59 hand four (4) episode In July 2013 R59 hand four (4) episode In May 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) And in April 2013 R59 hanxiety and one (1) Anxiety anxiety anxiety anxiety anxiety anxiety anxiety a	duction of the medications it to continue the same.  Fior care plan, dated 7/15/13, a history of wandering and illy. The care plan also easily redirected. Family also ha [history] of getting fixated oming very anxious or agitated on of Risperdal and Lorazepam. iety, depression, a; current PHQ-9[depression o (0)."  On a "Daily Behavior neet on each shift. The logs would be tracked each shift for ety, restlessness, wandering nere were no indicators for noted on the logs. The iffied the following notes: a through 9/5/13 there were no inted.  O was noted to have one (1) ng.  and one (1) episode of anxiety. In ad six (6) episodes of anxiety es of wandering.  and three (3) episodes of episode of wandering.  So had three (3) episodes of one episode of anxiety.  any evidence R59 had been or had manifested any	F 32	29			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG		COMPLETED		
		245386	B. WING	B. WING		/05/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON				STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329	consultant pharmace family did not want stated R59 had a hiverified there was lated education had occur concerning the use medication in absert and/or manifestation diagnosis R59 had. The DON stated R5 psychosis disorder manifested. The DON oclear indication fand the behavior mevidence of tracking. R59 medical record use of the antipsych the facility lacked a psychotic behaviors the medical record would be contrained gradual dose reduce Risperdal. 483.60(c) DRUG RIRREGULAR, ACT. The drug regimen or reviewed at least or pharmacist.	uction recommendation by the sist the DON verified R59's medications reduced and story of behaviors. The DON ack of any evidence that irred with the family of the antipsychotic nce of a psychotic diagnosis ns. The DON was asked what for the use of the Risperdal? So had an unspecified and was unsure how it was DN further verified there were for the use of the Risperdal onitor logs lacked any go fany psychotic behaviors.  I lacked clear indication for the notic medication Risperdal and system to monitor any se manifested by R59. Further, lacked any evidence there cations for an attempted, tion of the medication,	F 4				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245386	B. WING _		09	/05/2013		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON				STREET ADDRESS, CITY, STATE, ZIP CO 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 428	Continued From pa	age 5	F 42	28				
	by: Based on interview facility failed to ensidentified clear parapsychoactive medicin the sample who medications, Findings include: If medication Lorazer clear parameters in medication.  R1 was admitted to diagnoses that includisorder and schizor and schizo	fan orders identified that the ation Lorazepam 1 mg by RN had been ordered on itan order had not identified the en to use the medication. R1 ation six (6) times in June,six (7) times in August and 1 otember. Documentation was cation administration record the rationale for the use of the orazepam, when administered ff. Review of the consultant revealed this irregularity had d by the consultant pharmacist reviews.						
	9/4/13 at 2:40 p.m.	she verified the consultant tidentified, during the monthly						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245386	B. WING		09/	05/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - SLAYTON				STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 428	recommendations,	that parameters for the use of m had been missing in the	F 4	28			

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 A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245386	B. WING			09/0	06/2013	
	PROVIDER OR SUPPLIER	.AYTON		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	rs	K 0	00				
	FIRE SAFETY							
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.						
	ONSITE REVISIT ( CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
	Minnesota Departm Marshal Division or time of this survey, was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 19						
	Please return the property for the Fire Safety In Health Care Fire Instate Fire Marshal 444 Cedar St., Suite St Paul, MN 55101-By email to: Barbara.Lundberg@Marian.Whitney@s	Deficiencies (K-tags) to: spections Division e 145 -5145, or  Division						

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.

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 A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245386	B. WING			09/06/2013	
	PROVIDER OR SUPPLIER	AYTON		2	TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	ΚO	000			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	1965, is one-story in	er Slayton was constructed in n height, has no basement, is rotected and is Type II(111)					
	detection in the cor corridors which is n department notifica	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a s and had a census of 52 at					
K 050	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	ΚO	)50			
SS=F	varying conditions, The staff is familiar that drills are part o Responsibility for pl assigned only to co	at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245386 B. WING 09/06/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH **GOLDEN LIVINGCENTER - SLAYTON** SLAYTON, MN 56172 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 050 | Continued From page 2 K 050 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.



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;

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

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

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

#### **DEPARTMENT CONTACT**

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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



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



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:

Kalryn Serie

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, 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