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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8H22

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00933

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245336**

2.STATE VENDOR OR MEDICAID NO.
(L2) **655371100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - DELANO**
(L4) **433 COUNTY ROAD 30**
(L5) **DELANO, MN** (L6) **55328**

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

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

6. DATE OF SURVEY **09/29/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Facility's request for a continuing waiver involving K067 is recommended.

17. SURVEYOR SIGNATURE — Date :
Michelle Koch, HFE NE II — 09/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 10/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/13/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245336
October 19, 2016

Mr. Don Flack, Administrator
Golden Livingcenter - Delano
433 County Road 30
Delano, MN 55328

Dear Mr. Flack:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 6, 2016 the above facility is certified for or recommended for:

54 Skilled Nursing Facility/Nursing Facility Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K067.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 19, 2016

Mr. Don Flack, Administrator
Golden Livingcenter - Delano
433 County Road 30
Delano, MN 55328

RE: Project Number S5336025, H5336018, & H5336019

Dear Mr. Flack:

On August 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2016 that included an investigation of complaints numbered H5336018 & H5336019. 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 September 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 7, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2016, effective September 6, 2016 and therefore remedies outlined in our letter to you dated August 12, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245336 Y1	A. Building B. Wing Y2	9/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0164	Correction	ID Prefix	F0174	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.10(e), 483.75(l)(4)	Completed	Reg. #	483.10(k),(l)	Completed
LSC		09/06/2016	LSC		09/06/2016	LSC		09/06/2016
ID Prefix	F0257	Correction	ID Prefix	F0280	Correction	ID Prefix	F0282	Correction
Reg. #	483.15(h)(6)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed
LSC		09/06/2016	LSC		09/06/2016	LSC		09/06/2016
ID Prefix	F0311	Correction	ID Prefix	F0312	Correction	ID Prefix	F0314	Correction
Reg. #	483.25(a)(2)	Completed	Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(c)	Completed
LSC		09/06/2016	LSC		09/06/2016	LSC		09/06/2016
ID Prefix	F0329	Correction	ID Prefix	F0334	Correction	ID Prefix	F0353	Correction
Reg. #	483.25(l)	Completed	Reg. #	483.25(n)	Completed	Reg. #	483.30(a)	Completed
LSC		09/06/2016	LSC		09/06/2016	LSC		09/06/2016
ID Prefix	F0356	Correction	ID Prefix	F0428	Correction	ID Prefix		Correction
Reg. #	483.30(e)	Completed	Reg. #	483.60(c)	Completed	Reg. #		Completed
LSC		09/06/2016	LSC		09/06/2016	LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 35992	DATE 09/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
7/28/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245336	A. Building B. Wing	9/27/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 09/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 35992	DATE 09/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245336	A. Building 01 - MAIN BUILDING 01 B. Wing	9/7/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 09/06/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/06/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 09/06/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 34764	DATE 09/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245336	A. Building 02 - 2008 ADDITION B. Wing	9/7/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/06/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 09/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 34764	DATE 09/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8H22

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00933

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245336**
2.STATE VENDOR OR MEDICAID NO.
(L2) **655371100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - DELANO**
(L4) **433 COUNTY ROAD 30**
(L5) **DELANO, MN** (L6) **55328**

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

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

6. DATE OF SURVEY **07/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Facility's request for a continuing waiver involving K067 is recommended.

17. SURVEYOR SIGNATURE — Date :
Michelle Thompson, HFE NE II — 08/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 09/13/2016 Co.
AW K67 sent to Rochi as email notification 09/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 22, 2016

Mr. Donald Flack III, Administrator
Golden Livingcenter - Delano
433 County Road 30
Delano, MN 55328

****Updated letter addressing compliance date****

RE: Project Number S5336025, H5336018, H5336019, H5336020

Dear Mr. Flack:

On July 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5336018, H5336019, H5336020.

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. In addition, at the time of the July 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5336020 that was found to be unsubstantiated.

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

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

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

Electronic Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 6, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 12, 2016

Mr. Donald Flack III, Administrator Administrator
Golden Livingcenter - Delano
433 County Road 30
Delano, MN 55328

RE: Project Number S5336025, H5336018, H5336019, H5336020

Dear Mr. Flack III:

On July 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5336018 & H5336019.

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. In addition, at the time of the July 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5336020 that was found to be unsubstantiated.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 6, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

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Original deficiencies not corrected and new deficiencies found during the revisit

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Original deficiencies corrected but new deficiencies found during the revisit

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Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint H5336018, H5336019 investigation was also completed at the time of the standard survey and was substantiated. In addition H5336020 investigated and was completed and unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the	F 156		9/6/16

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

Electronically Signed | 08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1	F 156		

resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification

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F 156	Continued From page 2 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notices of Medicare non-coverage, Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), upon the termination of benefits for 2 of 3 residents (R34, R31) reviewed for liability notices. Findings include: R34's Notice of Medicare Non-Coverage dated 3/29/16, identified R34's covered services would end on 4/1/16. R34's Admission Record dated 7/29/16, identified R34 was discharged from the	F 156	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 156 a. R 34 was discharged from the facility. R 31 was issued a SNFABN	

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F 156	Continued From page 3 facility on 5/31/16. R34's medical record had no indication a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) was provided to R34 upon the termination of Medicare benefits, even though they remained in the facility after Medicare services were terminated. R31's Notice of Medicare Non-Coverage dated 5/27/16, identified R31's covered services would end on 5/30/16. R31's Admission Record dated 7/29/16, identified R31 currently remained in the facility. R31's medical record had no indication a SNFABN had been provided to R31 upon termination of Medicare benefits, even though R31 remained in the facility after Medicare services terminated. During interview on 7/27/16, at 11:20 a.m. business office manager (BOM)-A stated R34 and R31 were admitted to the facility for therapy services under Medicare, but remained in the facility after their therapy services had ended. BOM-A stated she had spoken with the nurse in charge of providing liability notices, and they were unable to locate any documentation or evidence R34 or R31 had been provided a SNFABN as required. Further, BOM-A stated R34 and R31 should have been provided a SNFABN upon termination of their Medicare benefit. A facility policy on liability notices was requested, but none was provided.	F 156	b. Audit of all residents that admitted on a Medicare benefit to ensure a SNFABN was issued c. Staff members that issue SNFABN letters educated on Medicare guidelines for issuing Denial letters d. ED or designee to complete a weekly audit on all residents that were issued denial letters and remained in facility for SNFABN letters issued per Medicare regulations. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 164 SS=D	Continued From page 4 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained during cares for 1 of 4 residents (R54) whose cares were observed.	F 164	F 164 a. R 54□s room was audited to ensure proper equipment is present to provide privacy during cares	9/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 5 Findings include: R54's quarterly Minimum Data Set (MDS) dated 5/20/16, identified R54 had severe cognitive impairment, was frequently incontinent of urine, and required extensive assistance with bed mobility, transfers, and toileting. During observation on 7/27/16, at 7:22 a.m. R54 was laying in bed. Nursing assistant (NA)-A entered R54's room and began to help R54 with morning cares. A privacy curtain was attached to the ceiling in the room bunch in the corner of the room, and was not pulled in front of the doorway, allowing anyone who entered the room to have a direct line of sight to R54's bed. NA-A removed the blankets from R54 exposing a soiled incontinence brief, then placed a pair of clean pants on R54 as he lay in bed. At 7:33 a.m. nursing assistant (NA)-B suddenly opened the door to R54's room, knocking on it as it was being opened. NA-B stood in the fully opened doorway to the hall, and stated she needed help with a transfer when NA-A had time, then looked at the surveyor and stated, "Sorry," then turned and left the room closing the door. NA-A then finished providing cares to R54. When interviewed on 7/27/16, at 7:51 a.m. NA-A stated NA-B should have knocked and waited for a response before suddenly entering R54's room and seeing him exposed in a soiled incontinence product. Further, NA-A stated she had lately noticed other NA staff just entering rooms without knocking and waiting for a response adding, "We all get in a rush getting people up." During interview on 7/27/16, at 7:57 a.m. R54 stated he did not like it when people just entered	F 164	b. Audit of all residents to identify those that need assistance with cares have proper equipment to provide privacy c. All staff that assist with cares educated to the Preservation of Rights Policy d. DNS or Designee t o complete weekly audit of 5 residents receiving assistance with cares for Privacy. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 164	Continued From page 6 his room without knocking and waiting for a response adding staff, "Should be more careful." When interviewed on 7/27/16, at 11:57 a.m. NA-B stated she suddenly opened R54's door without waiting for a response because she was rushed for time and, "Wasn't logically thinking." NA-B stated staff should be waiting for a response from the resident before entering their room, "For privacy and dignity" of the resident. During interview on 7/27/16, at 12:17 p.m. registered nurse (RN)-A stated NA-B should have waited for a response from inside the room instead of suddenly opening R54's door as she knocked because people passing by in the hallway could have seen R54 exposed in the bed. Further, RN-A stated if NA staff are noticing incidents of this, they should of told management, "We need to do further education."	F 164		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 174	F174	9/6/16

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	245336	A. BUILDING _____ B. WING _____	07/28/2016

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F 174	Continued From page 7 review the facility failed to allow residents to keep personal mini fridges in their rooms for 1 of 1 resident (R17), reviewed for personal belongings. Findings include: During interview on 7/25/16, at 11:01 a.m. R17 stated she was upset that she was not allowed to have a mini fridge in her room. R17 explained that her daughter had purchased a fridge and was able to keep it in her room for some time. Then management came and asked her and her family to remove the refrigerator from her room. R17 did not know the reason management had her family remove her fridge. At the time, R17 did not have a mini fridge observed in her room as identified. A progress note dated 10/20/16, at 4:49 p.m., noted as a late entry, indicated R17's daughter was very upset that R17 could not keep the mini fridge in her room, the daughter had bought for R17. The progress noted indicated all residents would be asked to remove their mini fridges because they were a fire hazard. When interviewed on 7/26/16, at 5:29 p.m. the licensed social worker (LSW) stated the facility suggests residents not to use a mini fridges in their rooms. The LSW stated residents are allowed to have them, if the facility policy on dating food items and maintaining and checking temperatures of the refrigerators were adhered to. The LSW stated currently there were no residents in the facility that had mini fridges in their rooms. The LSW stated the previous environmental services director had requested all mini fridges be removed from resident room as they were a fire hazard. The LSW stated that	F 174	a. R 17 was encouraged to have family return the mini Fridge to her room, which was completed during survey b. Residents educated during Resident Council on their rights and responsibilities of having a mini fridge in their room c. All staff was educated to the Patient□s Personal Refrigerator Policy. Care Conference Sheet will be updated to reflect review of resident□s preference of having a personal refrigerator in their room, as well as a review of responsibilities of family if refrigerator is present. d. SS or Designee will complete a weekly Audit of residents scheduled for a care conference for preference regarding personal refrigerator use. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 174	Continued From page 8 R17's mini fridge was in working order and she had not revisited the issue of the mini fridges with R17, after it was removed. When interviewed on 7/26/16, at 5:38 p.m. the maintenance supervisor (MS) stated the mini fridge in a residents room was not a fire hazard as long as it was in good working condition. The MS also stated that it would be a good thing for residents to be able to have mini fridges in their rooms. When interviewed on 7/26/16, at 5:56 p.m. the administrator stated he was not aware of the facility's current policy on residents having mini fridges in their rooms, and as long as they were in good working order he didn't see a problem with it and would check on the facility policy. Review of the facility policy Patient's Personal Refrigerators dated 7/20/16, directed the staff on how to obtain temperatures, storing food items and frequency of cleaning the fridges. The policy did not forbid personal mini fridges in residents rooms.	F 174		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable	F 257	F 257	9/6/16

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F 257	Continued From page 9 room temperatures were maintained for 1 of 1 residents (R30) who complained about their room temperature. Findings include: R30's annual Minimum Data Set (MDS), dated 5/26/16, identified R30 had intact cognition. During interview on 7/25/16, at 10:39 a.m. R30 was seated in her room wrapped in a blanket. When questioned about the temperature in her (R30's) room, she stated, "this is the coldest room in the building" as the air conditioner unit is outside my door and the air "flows into my room". When interviewed on 7/27/16, at 2:09 p.m. trained medication aid (TMA)-A stated R30 was "always cold" and was covered in blankets when in her room to stay warm. Further, TMA-A stated (R30) would always ask staff to keep her door partially shut to block out the cold air which was coming from the air conditioner unit outside of her room. TMA-A was unsure if maintenance had been notified about the cold room temperature in R30's room. During interview on 7/27/16, at 2:03 p.m., maintenance director (MD) stated he never received any notification R30 was to cold in her room. If staff were notified of any concerns they should have contacted maintenance to have it addressed. Futher, MD stated he did not have a system for monitoring room temperatures within the facility because he had never had any issues with it in the past. A facility policy on room temperature adjustment was requested, but none was provided.	F 257	a. R 30 was moved to a different room within the facility away from air conditioning unit in hallway b. Preventative maintenance program for monitoring room temperatures created. c. Educate staff to notify maintenance with complaints of room temperature from any resident. d. MD or designee to complete weekly audit of 5 rooms for room temperature and resident comfort. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the care plan to include specific interventions recommended by the psychiatrist for 1 of 5 residents (R61) reviewed for unnecessary medications. Findings include: R61's annual MDS dated 5/3/16, indicated R61 had moderate cognitive impairments included a diagnosis of depression. R61's psychiatric physician progress note dated	F 280	F 280 a. The care plan for R61 was modified to reflect interventions recommended by psych services. b. Audit of all care plans for residents that have psych services involvement to ensure recommendations are reflected and implemented. c. Education of staff responsible for completion of care plan updates of psych recommendations. All staff education related to behavior, and utilization of	9/6/16

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F 280	Continued From page 11 6/13/16, indicated R61 had cut himself on 6/12/16, and reported feeling depressed. The note included the following recommendations for interventions: - Encourage R61 to discontinue contact with his family member (FM)- X at this time as she is a trigger for him and seek help from his brother and staff instead - Encourage R61 to consider alternatives to cutting, as it is not serving a purpose, by getting out of his room, even if he is not interacting with anyone. - Continue to work on adding a long term roommate to his room, which would limit isolation and potentially lower the risk of cutting, as he tends to cut when alone. - Staff to continue checking on him periodically and she how he is doing. The noted mentioned a specific staff member that R61 had a good rapport with. - Remove any potentially harmful item from his room, which has been done. Staff to periodically check R61's room to make sure no harmful items have resurfaced. R61's psychiatric physician progress note dated 7/7/16, indicated R61 had been feeling so-so and reported that smiling makes him feel better. Staff reported to FM-X had visited recently and did not trigger R61. Education was provided to R61 on smiling and upright posture can improve mood. The note also included the following recommendations for interventions: - Encourage R61 to attend an activity he can tolerate, knowing that he doesn't have to like it or have fun. Just being around others can help him get outside himself. Framing things in terms of	F 280	non-pharmological intervention utilization and documentation in the medical record. d. ED or designee will complete weekly audit of 5 care plans for reflection of interventions recommended by psych services. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 280	Continued From page 12 what he can tolerate worked well for him. - Staff to reinforce smiling and sitting in an upright position with his head up, by asking to see a smile or encouraging him to sit upright. - R61 shared that Mary Poppins music makes him feel happy. This was shared with the licensed social worker, to see if there is a way he can have access to the movie or soundtrack as it could be greatly beneficial for him. - As well as previously mentioned recommendations of continuing to look for a roommate, staff to check on him periodically and check the room periodically for harmful items. R61's care plan (undated), did not include the target behavior of cutting, and did not contain the interventions the psychiatrist had recommended to improve R61's mood, even though these were recommendations made by the psychiatrist. When interviewed on 7/28/16, at 11:51 a.m. the director of nursing (DON) stated that R61's care plan should have been revised to include the recommended interventions suggested by the psychiatrist	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plan	F 282	F 282	9/6/16

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F 282	Continued From page 13 interventions for turning and repositioning were followed by staff for 1 of 2 residents (R84) reviewed for pressure ulcers. Findings include: R84's facility face sheet (undated) identified they were admitted to the facility July 2016, and an Minimum Data Set (MDS) had not been completed yet. R84's Immediate Plan of Care dated 7/25/16, indicated she had problems with mobility, and pressure ulcers. The care plan directed staff to assist R84 to turn and reposition every hour. R84's most recent Weekly Skin Review dated 7/23/16, indicated she had three stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) to her coccyx and buttocks. During interview 7/26/16, at 7:11 p.m. R84 stated she has had her pressure ulcers for over one years was was recently admitted to the facility. She states she usually gets repositioned at 4:00 a.m. and then was not repositioned again until around 8:00 a.m. or later. R84 stated "this happens to me all of the time." During continuous observation on 7/27/16, from 7:00 a.m. to 8:32 a.m. (1 hour and 32 minutes) R84 was observed lying in bed without being repositioned. At 7:00 a.m. R84 was on her left side facing the window. At 7:10 a.m. R84 stated she was last repositioned at 4:00 a.m. and at 6:00 a.m. she placed her call light on and asked the	F 282	a. R 84 care plan updated to reflect resident□s turning and repositioning to every 2 hours per resident request. b. All residents assessments for repositioning will be reviewed at next scheduled care conference. c. Policy and procedure for alteration in skin integrity reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for timely repositioning. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 282	Continued From page 14	F 282		

night nurse (unidentified) to help her reposition. The night nurse told her she would inform the day shift nursing assistants who was just starting her shift but the day shift nursing assistant never came to help her reposition and she has been lying in the same position since 4:00 a.m., over 3 hours and 10 minutes. At 7:20 a.m. R84 continued to lay in the same positron, no one entered her room. At 7:41 a.m. resident was still in the same position, on her left side facing the window, no staff had entered her room. At 7:54 a.m. R84's position remained unchanged. At 7:57 a.m. the facility registered dietician (RD) had entered her room, the residents room door remained opened and RD discussed supplements with her while she remained on her left side facing the window. Again at 8:13 a.m. and at 8:32 a.m. R84 remained in the same position as she was at 7:00 a.m., and had not been repositioned, since 4:00 a.m. for a total of 4 hours and 13 minutes.

During interview 7/27/16, at 8:32 a.m. nursing assistant (NA)-K stated R84 was to be repositioned every 1 hour but she got busy with breakfast and had not assisted (R82) to reposition since she began her shift. NA-K stated "there just isn't enough staff to get her work done." NA-K further stated she was not told by the night nurse that R84 wanted to be repositioned and was not sure when she was last repositioned. If the resident said she was last repositioned at 4:00 a.m. she was probably correct.

During interview 7/27/16, at 8:39 a.m. director of nursing (DON) stated since she had stage 4 pressure ulcers she should have been repositioned after one hour, as identified by the

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F 282	Continued From page 15 care plan.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R85) reviewed for activities of daily living (ADLs) was provided assistance with bathing. Findings include: R85's entry tracking Minimum Data Set (MDS) dated 7/8/16, identified R85 had admitted to the facility on 7/3/16. R85's care plan dated 7/16/16, identified R85 was at the facility for rehabilitation therapy with a goal of returning back to the community, and was, "Alert and oriented." R85 was identified to have, "A physical functioning deficit," and required, "Personal Hygiene assistance of 1." The care plan did not identify how much assistance from staff R85 required with bathing. During interview on 7/25/16, at 1:57 p.m. R85 stated she had been at the facility for several weeks, and had not been offered or helped with taking a bath since she came, "I haven't had one since I've been here." Further, R85 stated she would like to get help to take a bath, but nobody from the facility had ever spoken to her about it.	F 311	F 311 a. R 85 was provided assistance with bathing b. All residents preferences for bathing will be reviewed at next scheduled care conference. c. Policy and procedure for bath, shower reviewed and remains current. Education to staff on bath, shower completion as care planned utilizing care sheets. Education on documentation of bathing, shower completed with staff that give showers/baths d. DNS or designee complete weekly audit of 5 residents for bath/shower completion. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	9/6/16

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F 311	Continued From page 16	F 311		

An undated facility Group A care sheet identified R85 was scheduled to receive a, "Thursday AM" bath, and required assist of one for ADLs.

During interview on 7/26/16, at 5:10 p.m. nursing assistant (NA)-E stated R85 should be getting a weekly bath, "Thursdays in the morning." NA-E stated staff document baths on the bath list sheets after they are completed, however staff had been having trouble getting baths completed for all the residents, "Because were short staffed," and "Can only do so much."

The facility Bath List(s) (the forms used to document completed baths identified by NA-E dated 7/3/16, to 7/26/16, identified columns to write a residents name, then spacing for staff to, "Initial & [and] date" when a bath is completed. However, R85 was not identified to have received a bath since her admission to the facility in early July 2015, nor was R85's name identified on any of the listings to show any bathing had been completed for her.

When interviewed on 7/27/16, at 10:54 a.m. NA-G stated R85 should have assistance with bathing, "At least once a week," and added staff had been struggling to get baths done recently because, "We're so swamped [with work]."

On 7/27/16, at 1:18 p.m. the director of nursing (DON and field service clinical director registered nurse (RN)-B were interviewed. The DON stated the facility had recently changed the NA staff to new resident assignment sheets as bathing and other cares weren't being completed, "To the level I wanted them to." Further, the DON stated she was not aware that bathing was still not being

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F 311	Continued From page 17 completed, and would see what information she could locate concerning R85's bathing in the facility. During subsequent interview on 7/27/16, at 2:17 p.m. the DON stated she had been unable to locate any documentation to show R85 had received a bath since admitting to the facility. Further, the DON stated her expectation was for every resident to receive a bath at least once a week and for staff to document this, "Everything should be documented." A review of the facility Bath, Tub policy dated 12/7/15, identified bathing was completed to, "Cleanse the skin," and, "Provide comfort to the resident." Further, the policy provided, "Documentation Guidelines" which included documenting the, "Amount of assistance resident required with bathing," and a, "Signature and title."	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided to 1 of 5 residents (R45) reviewed and activities of daily living and whom was dependent on staff for care.	F 312	F 312 e. R 54 nails were trimmed and cleaned. f. All residents nails were examined for trimming and cleanliness. Nails	9/6/16

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F 312	Continued From page 18 Findings include: R45's Brief Interview for Mental Status (BIMS, a screening tool used to determine cognition) dated 7/16/16, identified R45 had moderate cognitive impairment. During observation on 7/25/16, at 2:23 p.m. R45 was seated in his wheelchair in his room. R45 had several long fingernails on both of his hands, with several nails having a dark colored substance underneath them. R45 stated he liked his nails kept shorter and they, "Could be cleaned up," however he was was not able to do this on his own adding staff help him cut his nails, "Periodically." On 7/26/16, at 1:02 p.m. R45 was observed in his room watching a game show on television. R45 continued to have long, fingernails with a dark colored substance underneath them. During interview on 7/27/16, at 10:49 a.m. nursing assistant (NA)-G stated R45 is compliant with cares, typically never refusing to have care completed. NA-G stated R45 required staff to cut his fingernails. At 10:51 a.m. NA-G observed R45's fingernails and stated they needed to be trimmed and cleaned because, "A couple of them are dirty underneath." R45's care plan dated 7/15/15, identified R45 had a, "Physical functioning deficit" and directed R45 required, "Nail care PRN [as needed]." R45's Treatment Administration Record (TAR) dated 7/2016, identified a treatment of, "Nurse to trim nails Q [every] week for Diabetes." The TAR	F 312	trimmed and cleaned as indicated. g. Policy and procedure for fingernail maintenance reviewed and remains current. Education to staff on assistance provided as care planned. h. DNS or designee complete weekly audit of 5 residents for nail care. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 312	Continued From page 19 identified staff last completed this on 7/22/16 (5 days prior). When interviewed on 7/27/16, at 11:27 a.m. licensed practical nurse (LPN)-A stated R45 was, "Newly diabetic" and nail care should be completed by the nurses. LPN-A observed R45's nails and stated there was, "Dirt under the nails," and they had not been trimmed despite being signed off in R45's TAR. A facility policy on grooming and nail care was requested, but none was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning to promote healing of pressure ulcers for 1 of 2 residents (R84) who had pressure ulcers. Findings include: R84 undated face sheet identified she was	F 314	F 314 a. R 84 care plan updated to reflect resident□s turning and repositioning to every 2 hours per resident request. b. All residents assessments for skin integrity will be reviewed at next scheduled care conference. c. Policy and procedure for skin integrity,	9/6/16

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F 314	Continued From page 20 admitted July 2016, there was no admission Minimum Data Set (MDS) completed to date. R84's Braden Scale for Prediction Pressure Ulcer Risk (undated), a scale used to determine a residents risk for development of pressure ulcers, identified R84 was at high risk for pressure ulcer development. R84's Immediate Plan of Care dated 7/25/16, indicated she had problems with mobility, bowel incontinence and pressure ulcers. The Care Plan indicated for staff to reposition her every 1 hour and as needed, and to use proper techniques to avoid friction and shear. R84's Weekly Skin Review dated 7/23/16, indicated she had three stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) on her coccyx and buttocks. She received wet to dry dressing changes twice a day. The Skin Review sheet indicated she had one coccyx wound that measured 1.5 centimeter (cm) x 3 cm x 5 cm deep, one under left buttock 7 cm x 3 cm x 4 cm deep, and one under her right buttock measured 2 cm x 1.5 cm and 2 cm deep. During interview 7/26/16, at 7:11 p.m. R84 stated she had the pressure ulcers for over a year, and was recently admitted to the nursing home. She stated she usually gets repositioned at 4:00 a.m. but then doesn't get repositioned again until around 8:00 a.m. or later. R84 stated, "This happens to me all of the time". During interview 7/27/16, at 7:10 a.m. R84 stated she was last repositioned at 4:00 a.m. and at 6:00	F 314	and skin integrity reviewed and remains current. Education to staff on assistance provided as care planned utilizing care sheets. d. DNS or designee complete weekly audit of 5 residents for repositioning. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 314	Continued From page 21	F 314		

a.m. she placed her call light on and asked the night nurse to be repositioned. R84 stated the night nurse told her she would inform the day shift nursing assistant who was just starting her shift. R84 stated the day shift nursing assistant never came in to reposition her.

During continuous observation on 7/27/16, from 7:00 a.m. to 8:32 a.m. (1 hour and 32 minutes) R84 was observed lying in bed without being repositioned. At 7:00 a.m. R84 was on her left side facing the window. At 7:10 a.m. R84 stated she was last repositioned at 4:00 a.m. and at 6:00 a.m. she placed her call light on and asked the night nurse (unidentified) to help her reposition. The night nurse told her she would inform the day shift nursing assistants who was just starting her shift but the day shift nursing assistant never came to help her reposition and she has been lying in the same position since 4:00 a.m., over 3 hours and 10 minutes. At 7:20 a.m. R84 continued to lay in the same positron, no one entered her room. At 7:41 a.m. resident was still in the same position, on her left side facing the window, no staff had entered her room. At 7:54 a.m. R84's position remained unchanged. At 7:57 a.m. the facility registered dietician (RD) had entered her room, the residents room door remained opened and RD discussed supplements with her while she remained on her left side facing the window. Again at 8:13 a.m. and at 8:32 a.m. R84 remained in the same position as she was at 7:00 a.m., and had not been repositioned, since 4:00 a.m. for a total of 4 hours and 13 minutes.

During interview 7/27/16, at 8:32 a.m. nursing assistant (NA)-K stated R84 was to be repositioned every 1 hour but she got busy with

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F 314	Continued From page 22 breakfast and had not assisted (R82) to reposition since she began her shift. NA-K stated "there just isn't enough staff to get her work done." NA-K further stated she was not told by the night nurse that R84 wanted to be repositioned and was not sure when she was last repositioned. If the resident said she was last repositioned at 4:00 a.m. she was probably correct. During interview 7/27/16, at 8:39 a.m. director of nursing (DON) stated since she had stage 4 pressure ulcers she should have been repositioned after one hour. During observation of R84's pressure ulcers with the DON and assistant DON (ADON) on 7/27/16, at 11:47 a.m. R84's pressure ulcers dressing were removed and measured. R84's coccyx pressure ulcer measured 3 cm x 1.2 cm and depth 1.9 cm, right ischial tuberosity (IT) measured 2 cm x 1.2 cm and depth 1.2 cm, and the left IT 1.4 cm x 6.2 cm and depth 1.1. cm. The ADON stated she had just changed her dressings two days ago, which showed improvement from the Weekly Skin Review of 7/23/16. ADON continued to stated the resident (R84) recently went to the wound specialist and was told they were improving as well. The DON and ADON both concurred R84 should have timely repositioning to assist in pressure ulcer healing, as identified in their assessment. A Skin Care Protocol undated indicated the objective is to "Provide a guideline for optimal care to promote healing to patients/residents with all identified alterations in skin integrity."	F 314		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		9/6/16

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F 329 SS=D	Continued From page 23 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to effectively monitor psychotropic medications, including target behavior monitoring for 3 of 5 residents (R16, R61,R39). In addition, the facility failed to provide a gradual dose reduction or justification for use of the medicaiton at that specific dose for 3 of 5 residents (R16, R39 and R2) reviewed for unnecessary medication use.	F 329	F 329 a. R 16, R 61, and R 39 were reviewed by Clinical Pharmacist for Gradual Dose Reductions. R2□s Risperdone was discontinued b. Target behavior, and non-pharmological intervention monitoring implemented for all residents receiving	

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F 329	Continued From page 24 Findings include: R16's significant change Minimum Data Set (MDS) dated 4/19/16, indicated R16 was cognitively impaired, scored a zero on the depression scale and did not display any behaviors, and had no changes with behaviors since the previous assessment period dated 2/24/16 . The MDS included diagnoses of dementia, and depression. R16 was observed on 7/26/16, at 4:33 p.m. with her husband pushing her in the hallway via wheelchair, R16 displayed no signs or symptoms of anxiety or depression and was not displaying any behaviors. During a subsequent observation on 7/26/16, at 4:39 p.m. R16 spontaneously started crying, however her husband patted her hand and told her she would be okay. R16 stopped crying and her husband continued to walk her in the hallways via wheelchair. R16's psychotropic medication Care Area Assessment (CAA) dated 4/28/16, indicated R16 was taking antipsychotic, antidepressant and antianxiety medications. The CAA indicated a care plan would be developed to avoid complications and minimize risks. The CAA summary indicated R16 had been discharge from hospice on 4/15/16 and the pharmacy was reviewing her medications monthly and R16 had no side effects from her current medications. The CAA however, did not address the reasons why R16 was taking the psychotropic medications, what was being monitored and if they were	F 329	psychotropic medications. Gradual dose reductions and continued antipsychotic medication need will be reviewed at next scheduled care conference. c. Policy and procedure for Antipsychotic medication reviewed and remains current. Education to staff on Antipsychotic Medication. d. SS or designee to complete weekly audit of 5 residents on antipsychotic medication for target behavior monitoring, non-pharmological intervention utilization, and gradual dose reductions. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 329	Continued From page 25 effective. R16's physician orders signed 6/15/16, included the following medication orders: Haldol (an antipsychotic)1 milliliters (mL) sublingually every evening for agitation with a start date of 2/23/16. Ativan (antianxiety medication) 2 mg/mL every 24 hours as needed (PRN) for agitation with a start date of 3/29/16. R16's care plan dated 6/18/15, addressed a potential for drug related complications associated with the use of psychotropic medications. The care plan directed staff to provide non-pharmalogical interventions of talking, being aware of non-verbal cues and use spouse involvement to decrease target behaviors, anxiety or depression. The care plan did not address what R61's target behaviors were or what individualized interventions were to be implemented for these target behaviors, for the use of Haldol. The facility form, for R16 titled, Clinical Pharmacist Letter to Physician Services dated 2/2/16, 3/16/16, and 5/4/16, asked the physician to provided an appropriate indication for use for Haldol. Each time the physician rejected the recommendation, and did not justify why R16 needed this medication at the current dose. Also, R16 was given PRN Ativan without consistently identifying the indication for administration or documentation on non-pharmalogical interventions attempted prior to the administration of the Ativan, for the following dates:	F 329		

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F 329	Continued From page 26 - 5/23/16, at 11:58 a.m. 1 mg of Ativan was given with no indication of why the Ativan was given or what non- pharmalogical interventions were tried prior to the administration. - 5/28/16, at 12:50 a.m. 10mg of Ativan was given for yelling and calling out non stop. Non-pharmalogical interventions tried prior to the administration were not documented - 6/1/16, at 1:56 a.m. 1 mg of Ativan was given for restlessness and calling out, there was not description on how R61 was restless. Also, non-pharmalogical interventions tried prior to the administration were not documented. - 6/3/16, at 10:45 p.m. 1 mg of Ativan was given with no indication of why the Ativan was given or what non- pharmalogical interventions were tried prior to the administration. - 6/8/16, at 12:29 a.m. 1 mg of Ativan was given for agitation, there was not a description on how R61 was agitated. Also, non- pharmalogical interventions tried prior to the administration were not documented. - 6/10/16, at 2:59 p.m. 1 mg of Ativan was given for R16 calling out loudly, however, non-pharmalogical interventions tried prior to the administration were not documented. - 7/21/16, at 4:00 p.m. 1 mg of Ativan was given with no indication of why the Ativan was given or what non- pharmalogical interventions were tried prior to the administration. - 7/26/16, at 11:31 a.m. 1 mg of Ativan was given	F 329		

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with no indication of why the Ativan was given or what non- pharmalogical interventions were tried prior to the administration.

The medical record lacked a quarterly ,at minimum, assessment of the use, effectiveness and continued need of of R16's use of Haldol and Ativan. medications.

When interviewed on 7/27/16, at 10:50 a.m. nursing assistant (NA)- C stated that R16 did not have any hallucinations or delusions that she was aware of. NA-C also stated that R16 has never been aggressive with staff, however does frequently holler out and cry. NA-C stated she was not aware of interventions that work for R16 to try and calm her as R16 has a difficult time expressing herself vocally. NA-C further stated the staff had an area in the kiosk to chart behaviors however, the behaviors were generalized and were the same for all residents and lacked an option for interventions.

When interviewed on 7/27/16, at 11:22 a.m. licensed practical nurse (LPN)-A stated that the nurses monitor for side effects every shift and it is documented on the EMAR. LPN-A stated that behaviors are charted by exception and that she was not aware of any target behaviors for the use of Haldol or non-pharmalogical interventions for R16. LPN-A also stated that non- pharmalogical interventions were not documented prior to administering PRN Ativan.

When interviewed on 7/27/16, at 2:31 p.m. registered nurse (RN)-A stated there wasn't any behavior tracking sheets with individualized behaviors for R16 related to the use of Haldol. RN-A stated that to complete the MDS

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assessment she just skims the resident notes to see if there had been any behaviors, and marks the MDS accordingly. RN-A stated that she had never completed a quarterly assessment for the continued use of Haldol or Ativan to be to determine the effectiveness of the medications.

When interviewed on 7/28/16, at 11:51 a.m. the director of nursing (DON) stated that R16 had recently come off of hospice care and that the pharmacist had addressed with the physician multiple times for an adequate indication for use for R16's Haldol and agitation was not an acceptable diagnoses for the use of this medication. The DON stated that she had not brought this to the medical directions attention as the facility just hired a new medical director. The DON verified that there were not any specific target behaviors or individualized interventions for R16 in the care plan, for the use of Haldol. The DON reviewed R16's medical record including the EMAR and progress notes and stated the nursing staff had not been documenting non-pharmalogical interventions utilized prior to the administration of PRN Ativan. The DON also verified the facility is not currently assessing for the ongoing use and continued need for R16's Haldol and Ativan.

When interviewed via telephone on 7/28/16, at 2:44 p.m. the consultant pharmacist (CP) stated he expected the facility to document non-pharmalogical interventions prior to the administration of PRN Ativan. The CP also stated he continues to address the inadequate use for Haldol for R16, with her physician.

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R61's annual MDS dated 5/3/16, indicated R61 had moderate cognitive impairments and had no behaviors. There also had not been a change in behaviors since the prior assessment period dated 2/3/16. The MDS included a diagnosis of depression.

R61's psychotropic medication CAA dated 5/13/16, did not identify the use of an antipsychotic medication, as the assessment was completed prior to the physician prescribing the medication.

R61's physician orders dated 7/28/16, indicated R61 was prescribed risperidone (an antipsychotic medication)1 mg po at bedtime for a thought and mood disorder, with a start date of 6/25/16, per the EMAR.

R61 was observed on 7/26/16, at 7:16 p.m. sitting in the hallway outside his room. R61 had a sad look on his face and was slummed over in his wheelchair.

R61's psychiatric physician progress note dated 6/13/16, indicated R61 had cut himself on 6/12/16, and reported feeling depressed. The note included the following recommendations for interventions:
- Encourage R61 to discontinue contact with his ex-wife at this time as she is a trigger for him and seek help from his brother and staff instead
- Encourage R61 to consider alternatives to cutting, as it is not serving a purpose, by getting out of his room, even if he is not interacting with anyone.
- Continue to work on adding a long term roommate to his room, which would limit isolation and potentially lower the risk of cutting, as he

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tends to cut when alone.
- Staff to continue checking on him periodically and she how he is doing. The noted mentioned a specific staff member that R61 had a good rapport with.
- Remove any potentially harmful item from his room, which has been done. Staff to periodically check R61's room to make sure no harmful items have resurfaced.

A progress note dated 6/2/16, at 11:17 a.m. included documentation that R61 was observed scratching his left arm and poking himself with a pen cap. R61 stated at the time that he would not quit until he was covered with blood. The resident was placed on continuous observations.

A progress note dated 6/12/16, at 2:50 p.m. included documentation that R61 was found in his room cutting himself with a broken plastic hanger. The sheriff department was called and the resident was transferred to the hospital.

A progress note dated 6/20/16, included documentation that R61 was pulling push pins off the bulletin board and was poking himself repeatedly with them. The pins were taken away from him.

R61's psychiatric physician progress note dated 7/7/16, indicated R61 had been feeling so-so and reported that smiling makes him feel better. Staff reported his ex- wife had visited recently and did not trigger R61. Education was provided to R61 on smiling and upright posture can improve mood. The note also included the following recommendations for interventions:
- Encourage R61 to attend an activity he can tolerate, knowing that he doesn't have to like it or

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have fun. Just being around others can help him get outside himself. Framing things in terms of what he can tolerate worked well for him.
- Staff to reinforce smiling and sitting in an upright position with his head up, by asking to see a smile or encouraging him to sit upright.
- R61 shared that Mary Poppins music makes him feel happy. This was shared with the licensed social worker, to see if there is a way he can have access to the movie or soundtrack as it could be greatly beneficial for him.
- As well as previously mentioned recommendations of continuing to look for a roommate, staff to check on him periodically and check the room periodically for harmful items.

R61 was prescribed Risperidone for his altered thought process and self injurious behaviors and although the psychiatrist and progress notes identified R61 had a history of self injurious behaviors the care plan dated 9/1/15, did not include the target behavior of cutting, and did not contain the interventions the psychiatrist had recommended to improve R61's mood.

The medical record also lacked a quarterly ,at minimum, assessment of the use, effectiveness and continued need of Risperidone.

When interviewed on 7/27/16, at 10:57 a.m. NA-C stated that R61 had been having more suicidal thoughts recently and the staff check on him more. NA-C stated that the facility had removed sharp objects or things that could be broken from his room. NA-C stated that he seemed depressed a lot and isolates himself. NA-C mentioned that R61 liked John Wayne movies, and was not sure if other staff knew that. NA-C further stated the staff had an area in the

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kiosk to chart behaviors however, the behaviors were generalized and were the same for all residents and lacked an option to document any interventions.

When interviewed on 7/27/16, at 11:22 a.m. LPN-A stated that behaviors are charted by exception and that she was not aware of any target behaviors or non-pharmalogical interventions, for R61, listed on the care plan or anywhere else in the medical record.

When interviewed on 7/27/16, at 2:31 p.m. RN-A stated there wasn't any behavior tracking sheets with individualized behaviors for R61. RN-A stated to complete her MDS assessments she just skims the resident notes to see if there had been any behaviors, and marks the MDS accordingly. RN-A stated that she had never completed a quarterly assessment for the continued use of Risperidone to determine the effectiveness of the medication.

When interviewed on 7/28/16, at 11:51 a.m. he DON verified there were no target behaviors or individualized interventions for R61 The DON stated that the interventions suggested by the psychiatrist should have been placed R61's care plan. The DON confirmed the facility is not currently doing an assessment for ongoing use and continued need for R61's Risperidone.

R39's quarterly Minimum Data Set (MDS). dated 5/13/16, identified R39 had diagnosis of dementia, anxiety, depression and past history of delusional disorder. The MDS identified R39 had significant cognitive impairment, had no behaviors, wandering or rejection of cares and received a anti-psychotic medication on a daily

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basis.

R39's signed physician orders dated 7/13/16, identified R39 was on Risperdal (anti-psychotic medication) 0.5 mg by mouth one time a day related to DELUSIONAL DISORDER which was started on 5/15/15, then discontinued on 5/5/16 and restarted on 5/7/16, two days later.

R39's physician progress note dated 5/18/16, identified R39 had "Dementia- no significant change in status". The physician did not identify that R39 was exhibiting any behaviors or rational why R39 was taken off the medication, then restarted and then remained on the antipsychotic medication.

R39's care plan dated 2/7/16, identified R39 had behaviors related to dementia/depression. R39's goal as listed on his care plan was to interact appropriately with others and to have no episodes of wandering. The care plan did not identify the use of Risperdal, or list any target behaviors for the continues use of the antipsychotic medication.

There was no indication in the medical record, that identified what R39's target behaviors were, what behavior monitoring was being completed, what non pharmacological interventions were implemented and the results of these interventions prior to the use of the antipsychotic medication for R39.

When interviewed with nursing assistant (NA)-G and trained medicaiton aid (TMA)-B on 726/16, at 7:49 p.m. NA-G stated R39 had "good and bad days." TMA-B stated on the "bad days" he (R39) would become agitated and yell at staff, but did not exhibit any physical aggression with patients

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F 329	Continued From page 34 or staff. When interviewed on 7/27/16, at 10:55 a.m. the director of nursing (DON) stated she had reviewed R39's medical record and was unable to identify why R39's Risperdal was restarted, or what if any target behaviors the resident exhibited to justify the continued use of R39's antipsychotic medication. During interview with consulting pharmacist (CP) on 7/28/16, at 2:55 p.m. stated R39's Risperdal was discontinued on 5/5/16, and was restarted again on 5/7/16. Further, CP stated he did not see the rational for why the antipsychotic was restarted nor did he see any behaviors for the continued justification for the use of Risperdal. R2's quarterly MDS dated 4/18/16, indicated he had severe cognitive impairment and had no behavioral or mood indicators. The MDS further indicated he received a anti-psychotic medication. R2's Care Area Assessment (CAA) dated 10/27/15, indicated R2 received antipsychotic medications. R2's care plan dated 5/28/15, indicated he had dementia and psychosis. The care plan identified he received anti-psychotic medications and sometimes had behaviors of calling out or yelling and history of urinating on the floor. The care plan listed interventions to assess the need for psychiatric services, attempt to redirect, be specific and firm, set limits, do not argue with the resident if refuses to walk try again later and to set limits on inappropriate harmful behaviors.	F 329		

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R2's physician orders signed 4/13/16, indicated R2's received risperdone (anti-psychotic medication) 0.125 milligrams (mg) at HS.

R2's Clinical Pharmacist Letter To Physician Services dated 4/13/16, indicated please consider reducing the current medication dose of risperdone from 0.25 mg to 0.125 mg. The physician order on 4/13/16 identified they decrease the medication to 0.125 milligrams (mg) at hour of of sleep.

Review of R2's Progress Notes for Behavior And Psychotropic Committee Summary for the last three months indicated only one note dated 5/3/16, "Behavior And Psychotropic Committee Summary: [R2] Current Psychotropic Medications (and diagnoses) , .125 RisperiDONE Tablet Target Behaviors: Calling out for pop, and help." The summary of mood and behaviors since last assessment (including any hallucinations and delusions) identified the resident was not having any changes in behavior, since the reduction of the risperdone on 4/13/16 and the dose reduction was appropriate. The note further identified (R2) calls out when he needs something and was easily redirected by meeting his needs. The committee summary recommendations were to continue,"monitor for effectiveness of dose reduction." There was no plan identified to continue to reduce R2's risperdone even though R2 had no behaviors after the April 2016 reduction.

Review of C2's MAR which directed staff to document and monitor "Effectiveness of Antipsychotic medicaiton. Observe for yelling out, demanding with cares at staff, impatient at times. If these behaviors are noted, document # of

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episodes and outcomes every shift." There was no indication what interventions were completed and if they were effective.

Review of the MAR indicated the following:
May 2016- no behaviors documented
June 2016-no behaviors documented
July 2016- no behaviors documented

During interview 7/28/16, at 11:16 a.m. the DON stated they do not have any specific target behaviors or interventions they are monitoring for R2, besides what is identified on the MAR.

During interview 7/28/16, at 12:23 p.m. licensed social worker (LSW) stated R2 does some yelling out and digs into his pants. He does not have any hallucinations and delusions. He has in the past picked on other residents but I haven't seen him do that in along time and he really doesn't have a lot of behaviors. He had a dose reduction of his risperdone in April and hasn't had any behaviors since then. The LSW stated they had a behavior committee meeting in May 2016 and he (R2) was probably due for another dose reduction.

During interview 7/28/16, at 2:45 p.m. with the facility pharmacist consultant stated he had recommended at dose reduction of his risperdone in April 2016. The consultant pharmacist stated R2 has not been physically aggressive or violent with staff or any other behaviors, so he probably should not be on the risperdone. We need to look at decreasing or discontinuing the medication.

Although R2 was on an anti-psychotic medication, there was no specific target behavior identified, or

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F 329	Continued From page 37 any interventions and if these interventions were effective. A dose reduction was completed in April 2016 with risperidone, and R2 continued to have no behaviors. There was no indication the facility had a plan to continue to reduce the risperidone, despite R2's not having any identified behaviors.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		9/6/16

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F 334	Continued From page 38 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy related to	F 334	Revised 8-24-2016	

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F 334	Continued From page 39 pneumococcal conjugate vaccine (PCV13) for 5 of 5 residents (R17, R27, R35, R38, R39) whose vaccination histories were reviewed. Findings include: Center for Disease Control and Prevention identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R17's Clinical Immunizations report undated indicated the 85 year old had received the 23-valent pneumococcal vaccine (PPSV23) on 10/08/2007, but was never offered the PCV13 according to the center for disease control (CDC) guidelines. R27's Clinical Immunizations report undated indicated the 86 year old had received the pneumococcal vaccine (PPSV23) on 04/16/2011, but was never offered the PCV13 according to the center for disease control (CDC) guidelines. R35's Clinical Immunizations report undated indicated the 83 year old had declined the pneumococcal vaccine (PPSV-13) prior to admission, but had not been offered the vaccination since his admission to the facility on 06/24/2015. R38's Clinical Immunizations report undated indicated the 90 year old had received the pneumococcal vaccine (PPSV23) on 10/15/1998, but was never offered the PCV13 according to	F 334	F 334 a. R 17, R 27, R 35, R 38, and R 39 to be given the PCV13. b. All residents' charts will be audited for pneumonia immunization status. Residents in need of PCV 13 and their families will be educated on vaccination, consent obtained, and given as consented, unless contraindicated. c. Policy and procedure for Influenza/ Pneumococcal Immunization Guideline reviewed and remains current. Education to staff on Influenza/ Pneumococcal Immunization Guideline. d. DNS or designee to complete weekly audit of 5 residents for Pneumonia immunization status. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 334	Continued From page 40 the center for disease control (CDC) guidelines. R39's Clinical Immunizations report undated indicated the 92 year old had received the pneumococcal vaccine (PPSV23) on 2/09/2011, but was never offered the PCV13 according to the center for disease control (CDC) guidelines. During interview 7/26/16, at 1:13 p.m. the facility director of nursing (DON) stated they currently are not been offering the PCV13 and were in the beginning stages of implementing a policy for pneumococcal vaccinations according to CDC guidelines. Review of the facility policy Influenza/Pneumococcal Immunization Guideline dated 06/2015, indicated LivingCenters will offer and encourage that each resident receive lifetime immunization against Pneumococcal disease. This immunization will be administered unless it is contraindicated, the resident has already been immunized or the resident and/or the responsible party refuses the immunization."	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident	F 353		9/6/16

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F 353	Continued From page 41 care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient staffing to ensure the assessed cares were provided for 1 of 2 residents (R84) reviewed for pressure ulcers; and for 1 of 1 residents (R85) who had not received a bath since admission. Additionally, lack of staffing concerns and residents cares not being completed or completed timely along with long call light waits were expressed by 3 of 3 residents (R30, R77 and R45), 1 of 4 family members (FM)-A; and 3 of 3 nursing assistant (NA-E, NA-G and NA-K) interviewed. The lack of staffing had the potential to affect all 38 residents who resided in the facility. Findings include: CARES NOT PROVIDED R84 was not provide with timely repositioning to promote healing of 3 stage four pressure ulcers, a full thickness tissue loss with exposed bone, tendon or muscle and often includes undermining and tunneling.	F 353	F 353 a. R 84 care plan updated to reflect resident□s turning and repositioning to every 2 hours per resident request. R 85, R 30, R 27, and R 45 assessments reviewed and updated accordingly to reflect care needs. R 77 has discharged from facility. b. Facility will provide sufficient staffing to provide nursing and related services according to the residents assessments and plans of care. c. Education provided to all staff relating to provision of sufficient nursing staffing to meet the residents needs according to assessments and plan of care. Interviews will be completed with sample of residents and staff to help determine opportunities for improvement relating to nursing staffing. Action plans will be implemented based on opportunities identified. d. DNS or designee to complete call light audit and care observations of 5 residents weekly. DNS or designee to interview 5	

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F 353	Continued From page 42 During interview 7/26/16, at 7:11 p.m. R84 stated she has had her wounds for over a year now. R84 stated she recently admitted to the facility and that she usually gets repositioned at 4 a.m. and doesn't not get repositioned again until around 8:00 a.m. or later. R84 stated "this happens to me all of the time" they don't have enough staff. During interview 7/27/16, at 7:10 a.m. R84 stated she was last repositioned at 4:00 a.m. and at 6:00 a.m. she placed her call light on and asked the night nurse to be repositioned. R84 stated the night nurse told her she would inform the day shift nursing assistant who was just starting her shift. She stated the day shift nursing assistant never came in to reposition her. During continuous observation on 7/27/16, from 7:00 a.m. to 8:32 a.m. (1 hour and 32 minutes) R84 was observed lying in bed without being repositioned. At 7:00 a.m. R84 was on her left side facing the window. At 7:10 a.m. R84 stated she was last repositioned at 4:00 a.m. and at 6:00 a.m. she placed her call light on and asked the night nurse (unidentified) to help her reposition. The night nurse told her she would inform the day shift nursing assistants who was just starting her shift but the day shift nursing assistant never came to help her reposition and she has been lying in the same position since 4:00 a.m., over 3 hours and 10 minutes. At 7:20 a.m. R84 continued to lay in the same positron, no one entered her room. At 7:41 a.m. resident was still in the same position, on her left side facing the window, no staff had entered her room. At 7:54 a.m. R84's position remained unchanged. At 7:57 a.m. the facility registered dietician (RD) had entered her room, the residents room door	F 353	nursing staff weekly regarding areas of opportunity for sufficient nursing staffing. DNS or designee to interview 5 residents weekly regarding areas of opportunities for sufficient nursing staffing. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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remained opened and RD discussed supplements with her while she remained on her left side facing the window. Again at 8:13 a.m. and at 8:32 a.m. R84 remained in the same position as she was at 7:00 a.m., and had not been repositioned, since 4:00 a.m. for a total of 4 hours and 13 minutes.

During interview 7/27/16, at 8:32 a.m. with nursing assistant (NA)-K who stated R84 should be repositioned every 1 hour but she got busy with breakfast and had not been in on her shift to reposition her. NA-K stated, "There just isn't enough staff to get her work done." NA-K further stated she was not informed by the night nurse that R84 wanted to be repositioned and was not sure when she was repositioned last, if R84 said she was last repositioned at 4:00 a.m. she was probably correct.

During interview 7/27/16, at 8:39 a.m. director of nursing (DON) stated since she had 3 stage four pressure ulcers she should have been repositioned after one hour, to assist in pressure ulcer healing.

R85 was not provided assistance with bathing since admission to the facility in early July, because of limited staffing.

R85's care plan dated 7/16/16, identified R85 was "Alert and oriented," and needed "Personal Hygiene assistance of 1."

During interview on 7/25/16, at 1:57 p.m. R85 stated she had been at the facility for several weeks, and had not been offered or helped with taking a bath since she came, "I haven't had one

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	245336	A. BUILDING _____ B. WING _____	07/28/2016

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GOLDEN LIVINGCENTER - DELANO	433 COUNTY ROAD 30 DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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since I've been here." Further, R85 stated she would like to get help to take a bath, but nobody from the facility had ever spoken to her about it.

An undated facility Group A care sheet identified R85 was scheduled to receive a, "Thursday AM" bath, and required assist of one for ADLs.

During interview on 7/26/16, at 5:10 p.m. nursing assistant (NA)-E stated R85 should be getting a weekly bath, "Thursdays in the morning." NA-E stated staff document baths on the bath list sheets after they are completed, however staff had been having trouble getting baths completed for all the residents, "Because were short staffed," and staff, "Can only do so much."

The facility Bath List(s) (the forms used to document completed baths identified by NA-E) dated 7/3/16, to 7/26/16, identified columns to write a residents name, then spacing for staff to, "Initial & [and] date" when a bath is completed. However, R85 was not identified to have received a bath since her admission to the facility in early July 2015, nor was R85's name identified on any of the listings to show any bathing had been completed for her.

When interviewed on 7/27/16, at 10:54 a.m. NA-G stated R85 should have assistance with bathing, "At least once a week," and added staff had been struggling to get baths done recently because, "We're so swamped [with work]."

On 7/27/16, at 1:18 p.m. the director of nursing (DON and field service clinical director registered nurse (RN)-B were interviewed. The DON stated the facility had recently changed the NA staff to new resident assignment sheets as bathing and

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other cares weren't being completed, "To the level I wanted them to." Further, the DON stated she was not aware the bathing was still not being completed, and would see what information she could locate concerning R85's bathing in the facility.

During subsequent interview on 7/27/16, at 2:17 p.m. the DON stated she had been unable to locate any documentation to show R85 had received a bath since admitting to the facility. Further, the DON stated her expectation was for every resident to receive a bath at least once a week and for staff to document this, "Everything should be documented."

RESIDENT COMPLAINTS

R30's annual MDS dated 5/26/16, indicated she was cognitively intact and needed extensive assist with activity of daily living (ADL's).

During interview 7/25/16, at 10:43 a.m. R30 stated she has to wait a long time for her call light to be answered some times up to "an hour" to have her call light answered and there is "never enough people on staff".

R77's admission MDS dated 6/29/16, indicated she was cognitively intact, needed total assist with ADL's and was occasionally incontinent of urine.
During interview 7/25/16 at 2:18 p.m. R77 stated she had waited up to 2-3 hours and sat in urine that long. R77 further stated the response time is often slow and they "just don't have enough staff."

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R45's quarterly MDS dated 7/1/16, indicated she was moderately cognitively intact and need assist of one to two with ADL's.
During interview 7/25/16, at 3:35 p.m. R45 stated in the mornings it takes an hour for them to answer her call light and in the evening you have to go to bed before the aides leave since there is only one aide on during the night to help us.

FAMILY COMPLAINTS
Family member (FM)-A stated stated during interview 7/25/16, at 2:19 p.m. there was not enough help on the weekends and he has noticed the building is not as clean and he doesn't see much staff around. FM-A stated when he comes in on the weekends he is concerned his father is not getting cleaned and that he has an odor which embarrasses him.

During interview 7/28/16, at 8:58 a.m. the facility executive director (ED) stated he was aware the baths were not getting done and they are working on making changes so that each aide on each shift will be giving baths. The ED stated they have enough staff but because the census is low they had to reduce the amount of staff working. He was aware the facility had some issues and they are working on systems to fix these concerns. The ED further stated they have no system in place to check call light response time and they will need to look at a system so this can be fixed.

NURSING ASSISTANT COMPLAINTS
During interview 7/27/16, at 8:32 a.m. nursing assistant (NA)-K stated R84 should be repositioned every 1 hour but she got busy with breakfast and had not been in on her shift to reposition her. NA-K stated, "There just isn't

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F 353	Continued From page 47 enough staff to get her work done." During interview on 7/26/16, at 5:10 p.m. NA-E stated R85 should be getting a weekly bath. They document on the bath list sheets after they are completed, however staff had been having trouble getting baths completed for all the residents, "Because were short staffed," and staff, "Can only do so much." During interview on 7/27/16, at 10:54 a.m. NA-G stated R85 should have assistance with bathing, "At least once a week," and added staff had been struggling to get baths done recently because, "We're so swamped [with work]." A facility policy was requested on staffing and the facility stated they do not have one.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356		9/6/16

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F 356	Continued From page 48 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the nurse staffing information as required for all residents and visitors to view. This had the potential to affect all 38 residents residing in the facility. Findings include: During the initial facility tour on 7/25/16, at 9:32 a.m. the required nurse staffing posting could not be found. The nurse staff posting should include; facility name, current date, the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shifts and the resident census. When interviewed on 7/25/16, at 9:40 a.m. the administrator stated the posting should be displayed in a plastic covering near the activity calendar. At this time the administrator identified the staffing information was not posted. When interviewed on 7/25/16, at 9:41 a.m. the staffing coordinator stated she was responsible	F 356	F 356 a. Nurse staffing information was posted prior to the exit of state surveyors. b. New plastic wall mounting was placed to ensure consistent placement of posting. c. Education provided to all nursing staff on the Nursing Staff Hours Policy d. DNS or designee will complete weekly audit to ensure nurse staffing information is posted as required. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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F 356	Continued From page 49 for making the staff posting and she was not sure where the staff posting was and it should have been posted near the activity calendar. Review of the facility policy Nursing Staff Hours dated 8/14/15, directed the following information be posted on a daily basis; center/location name, current date, total number and actual hours worked by licensed and unlicensed staff responsible for resident care and the resident census. The policy also directed the posted information should be posted in a clear and readable format and posted in a prominent place readily accessible to residents and visitors.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview,and document review, the consulting pharmacy failed to identify and report irregularities to the physician for the use of anti-psychotic medications for 2 of 5 residents (R39 and R2) reviewed for unnecessary medication use.	F 428	F 428 a. R39 reviewed for irregularities and report to the physician on the use of antipsychotic medications. R 2 Risperdone was discontinued. b. Audit of residents at next care	9/6/16

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F 428	Continued From page 50 Findings include: R39's quarterly Minimum Data Set (MDS). dated 5/13/16, identified R39 had diagnosis of dementia, anxiety, depression and past history of delusional disorder. The MDS identified R39 had significant cognitive impairment, had no behaviors, wandering or rejection of cares and received a anti-psychotic medication on a daily basis. R39's signed physician orders dated 7/13/16, identified R39 was on Risperdal [anti-psychotic medication] tablet 0.5 mg by mouth one time a day related to delusional disorder started on 5/15/15, discontinued on 5/5/16 and again restarted on 5/7/16. R39's Consultant Pharmacist Medication Reviews from 1/7/16 through 7/1/16, did not identify any recommendations until 4/7/16, when the consultant pharmacist (CP) suggested reducing current Risperdal dose to 0.25 mg at HS (hour of sleep) as there were no documented behaviors and very few episodes of wandering. The physician response to this recommendation on 4/15/16 identified, "Rejected, please continue current orders and document clinical ration below," the form was left blank, not identifying a rational for rejection of this recommendation. The monthly CP notes from May 2016 through July, 2016, made no recommendations or follow up for physician to address and justify the ongoing use of this medication. During interview with CP on 7/28/16, at 2:55 p.m. stated R39's Risperdal was discontinued on 5/5/16, for two days and then restarted on 5/7/16 and was unsure why.	F 428	conference for pharmacy reviews to identify irregularities and report to the physician on the use of antipsychotic medications. c. Clinical pharmacist to work with Medical Director on noted irregularities on the use of antipsychotic medications d. DNS or designee to complete weekly audits of 5 residents to ensure irregularities and report to the physician on the use of antipsychotic medications. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

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Although the CP identified on 4/7/16, that R2 had no behaviors, and a note was sent to the physician to consider reducing the risperidone. The physician rejected the recommendations without justification. The CP made no further attempts to have the physician justify the rational for the continued use of the risperidone medicaiton at the current dose.

R2's quarterly MDS dated 4/18/16, indicated he had severe cognitive impairment and had no behavioral or mood indicators. The MDS further indicated he received an anti-psychotic medication. R2's Care Area Assessment (CAA) dated 10/27/15, indicated Pharmacy is reviewing medication monthly and communicating with the MD as needed.

R2's Clinical Pharmacist Letter To Physician Services dated 4/13/16, indicated please consider reducing the current medication dose of risperdone from 0.25 mg to 0.125 mg. The physician order on 4/13/16 identified they decrease the medication to 0.125 milligrams (mg) at hour of of sleep.

Review of R2's Progress Notes for Behavior And Psychotropic Committee Summary for the last three months indicated only one note dated 5/3/16, identified the resident was not having any changes in behavior, since the reduction of the risperdone on 4/13/16 and the dose reduction was appropriate.

Review of C2's medication administration record (MAR) directed staff to document and monitor "Effectiveness of Antipsychotic medicaiton. Observe for yelling out, demanding with cares at

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F 428	Continued From page 52 staff, impatient at times. Review of the MAR from May 2016 to July 2016, identified no behavior occurrences. Review of the facility consulting pharmacist report from May 2016 to July 2016, made no recommendations about decreased R2's risperdone, even though R2 was not exhibiting any behaviors. During interview 7/28/16, at 2:45 p.m. with the facility pharmacist consultant stated the resident has not been physically aggressive or violent with staff or any other behaviors, so he probably should not be on the risperdone and needs to make recommendations to the physician to decrease or discontinuing the risperdone. A policy titled, "Medication Regimen Review" dated 06/2015, if a continuing irregularly is determined, the consultant pharmacist will consider whether to report the irregularity again for further clarification.	F 428		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This facility will be surveyed as two separate buildings: Golden Livingcenter Delano Main building is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (000) construction. In 1988 a single story addition was constructed to the South Wing and determined to be of Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 38 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it is revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all 38 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between the hours of 8:00AM and 11:00 AM on 07/28/2016, observations revealed that the heating, ventilation, and air conditioning systems for the building is using the corridor system as part of the air distribution system for make-up air for the bathrooms exhaust. This does not meet Exception 2 of NFPA 90A (1999 edition), Section 2-3.11.1 that allows over-pressurized corridors. This deficient practice was confirmed by the facility Maintenance Director (MT) at the time of discovery. An annual waiver was previously granted.	K 067	K 067 a. Facility has an approved hardship waiver using the corridors for heating, ventilation, and air conditioning systems a part of the air distribution system to provide make-up air for bathroom exhaust for resident sleeping and bathrooms in the facility.	9/6/16

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K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On facility tour between 8 AM to 11:00 AM on 07/28/2016, during the review of all available documentation for the emergency generator, revealed the facility did not document the monthly testing for the March 2016.	K 144	K 144 a. Generator test for March was conducted but the documentation was misplaced during transition between Maintenance Directors. b. Generator will be inspected each week and exercised under load for 30 minutes per month in accordance with NFPA 99 and NFPA 110. c. MD or designee will complete fire marshal recommended log for proper generator testing in accordance with NFPA 99 and NFPA 110. d. MD or designee to complete weekly audits of generator inspection with a monthly Audit of exercised load for 30 minutes with cool down cycle. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	9/6/16
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Findings include:	K 147	K 147 a. Microwave identified during survey inspection was immediately changed to direct power source.	9/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30** **DELANO, MN 55328**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 4 On facility tour between 8 AM to 11:00 AM on 07/28/2016, revealed the following: 1) A Microwave was not plugged into direct power.	K 147	b. Audit of facility to ensure electrical wiring and equipment is in accordance to National Electrical Code 9-1.2 (NFPA 99) 18.9.1, 19.9.1 c. Staff education on proper use of extension cords, power strips, and proper power supply. d. MD or designee to complete weekly audits of 5 resident rooms to ensure electrical wiring and equipment is in accordance to National Electrical Code 9-1.2 (NFPA 99) 18.9.1, 19.9. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30 DELANO, MN 55328**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Livingcenter Delano Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30 DELANO, MN 55328**

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

This facility will be surveyed as two separate buildings:
Golden Livingcenter Delano building # 2 is a 1-story addition with no basement. An addition was constructed in 2008 and was determined to be Type II (000) to the East Wing.

The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 54 beds and had a census of 38 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DELANO	**433 COUNTY ROAD 30 DELANO, MN 55328**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On facility tour between 8 AM to 11:00 AM on 07/28/2016, during the review of all available documentation for the emergency generator, revealed the facility did not document the monthly testing for the March 2016.	K 144	K 144 a. Generator test for March was conducted but the documentation was misplaced during transition between Maintenance Directors. b. Generator will be inspected each week and exercised under load for 30 minutes per month in accordance with NFPA 99 and NFPA 110. c. MD or designee will complete fire marshal recommended log for proper generator testing in accordance with NFPA 99 and NFPA 110. d. MD or designee to complete weekly audits of generator inspection with a monthly Audit of exercised load for 30 minutes with cool down cycle. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	9/6/16
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2	K 147	K 147	9/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 3 (NFPA 99) 18.9.1, 19.9.1 Findings include: On facility tour between 8 AM to 11:00 AM on 07/28/2016, revealed the following: 1) An extension cord is plugged into a light. 2) A power strip is plugged into another power strip for the computer and accessories.	K 147	a. Microwave identified during survey inspection was immediately changed to direct power source. b. Audit of facility to ensure electrical wiring and equipment is in accordance to National Electrical Code 9-1.2 (NFPA 99) 18.9.1, 19.9.1 c. Staff education on proper use of extension cords, power strips, and proper power supply. d. MD or designee to complete weekly audits of 5 resident rooms to ensure electrical wiring and equipment is in accordance to National Electrical Code 9-1.2 (NFPA 99) 18.9.1, 19.9. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.	

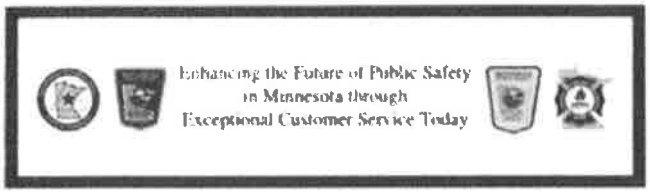
Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Thursday, September 01, 2016 10:13 AM
To: rochi_lsc@cms.hhs.gov; Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS)
Subject: RE: GLC Delano - annual waiver for K-067. Previously Approved - No Changes

This is to inform you that I am accepting the annual waiver report for Golden Livingcenter Delano 245336 regarding K-0067. No changes.
The exit date of the survey was 07/28/2016.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us



PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K067	Waiver Request for July 28, 2016 Life Safety Code Inspection. Waiver request submitted on August 31, 2016. Currently, Golden Living Center in Delano is using the corridors for both North and South wings as part of the heating, ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons: 1. There will be no adverse affect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system. 2. The facility is protected by a 24 hour supervised automatic sprinkler system. 3. The facility is smoke-free and signs are prominently posted at all major entrances/exits. 4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers. 5. The building fire alarm system is monitored to provide automatic fire department notification. 6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 7. Fire drills are conducted quarterly on each shift. 8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. In addition to that, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would potentially negatively affect the structural integrity of the building. Golden Living Center Delano is consulting with other contractors to explore other affordable and possibly more practical options of bringing the ventilation system up to code with NFPA 90A. Submitted by: Don Flack, Administrator 8-31-2016

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 09-01-2016