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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 94CQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

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

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

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

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

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

6. DATE OF SURVEY **06/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (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
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/10/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5306

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 2, 2014. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been requested.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245306

June 11, 2014

Mr. Shane Roche, Administrator
Golden Livingcenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

Dear Mr. Roche:

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 May 27, 2014 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4967

June 10, 2014

Ms. Jana Cates, Administrator
Golden Livingcenter - Rochester West
2215 Highway 52 North
Rochester, Minnesota 55901

RE: Project Number S5306024

Dear Ms. Cates:

On May 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 17, 2014. 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 June 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 28, 2014 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 April 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2001. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 17, 2014, effective May 28, 2014 and therefore remedies outlined in our letter to you dated May 8, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the April 17, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245306	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0246 Reg. # 483.15(e)(1) LSC	05/27/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	05/27/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GN/kfd	Date: 06/10/2014	Signature of Surveyor: 10160	Date: 06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/17/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245306	01 - MAIN BUILDING 01	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0147	05/27/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	06/10/2014	25822	05/28/2014
CMS RO				

Followup to Survey Completed on: 4/15/2014

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: 94CQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

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

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

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

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

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

6. DATE OF SURVEY **04/17/2014** (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: * Code: **A5*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NE II 05/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
AW K67 Emailed to CMS 06/10/2014 co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5306

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the Facility¿s plan of correction. Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded. Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4875

May 8, 2014

Ms. Jana Cates, Administrator
Golden Livingcenter - Rochester West
2215 Highway 52 North
Rochester, Minnesota 55901

RE: Project Number S5306024

Dear Ms. Cates:

On April 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 27, 2014, 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 May 27, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 17, 2014 (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 October 17, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
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
	245306	A. BUILDING _____ B. WING _____ MAY 20 2014 MN Dept of Health Rochester	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate resident preferences for bathing for 2 of 3 residents (R18, R60) reviewed for choices. Findings include: R18 did not receive more than one shower per week and was not offered the option of a bath based on her bathing preferences. On 4/14/14 at 4:23 p.m. R18 stated that she has	F 246	5/23/14 GPM	

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

Executive Director | 5-19-14

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.

MAY 20 2014
MN Dept of Health
Rochester

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 a shower on Sunday, and would like another one on Wednesday. R18 also stated that she would like a bath but it has never been offered. The quarterly Minimum Data Set (MDS) dated 2/5/14 indicated R18 has no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS also indicates R18 requires physical help in part of bathing activity and one person assist. Care plan was reviewed and bathing was not addressed. During an interview with R18 on 4/17/14 at 10:45 a.m. when asked what her preference was regarding a bath or shower, R18 stated, "I don't think they have a tub. But I will be getting 2 showers a week now; the DON [Director of Nursing] just told me that." When R18 was asked if she had ever requested more showers, she stated, "Yes, but the nursing assistant [NA] just did like this [R18 shrugged her shoulders to demonstrate that is how the NA answered R18 ' s question.] " On 4/16/14 at 3:10 p.m. NA-A stated R18 gets a shower once a week and could have a bath instead of a shower but R18 has never asked. NA-A further stated that they only find a time and day to give the residents a shower or bath. On 4/17/14 at 8:48 a.m. NA-B stated that R18 gets a shower in the evening and it has always been that way. We should use the whirlpool more. I've never given a whirlpool here and I have been here for over a year. It would feel good for the residents to soak. On 4/17/14 at 9:35 a.m. The DON stated that residents are told upon admission which day was	F 246	F246 Resident R18 will be given bathing options based on her preferences. All residents will be reviewed and asked for bathing options based on their preferences. All nursing staff have been educated on the residents right to receive services in the facility based on individual needs and preferences. Weekly audits will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. DNS or designee is the responsible party. Corrective Action will be completed by May 27th,2014	5-27-14

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 246	Continued From page 2 their bath day and offered a tub bath or shower. Stated the residents can have multiple showers if they want them and also bed baths are offered. Preference goes on the facility bath schedule. On 4/17/14 at 10:40 a.m. after the DON met with R18, she stated that she asked R18 if she had issues related to her bathing and stated that the resident had said no. DON stated that R18 had been very sleepy during their talk but told the DON when asked that she would enjoy having an additional shower. Surveyor asked DON if she had offered R18 a bath instead of a shower and she stated that R18 is not a candidate for a bath per the Nurse Practitioner due to skin excoriations but can have as many showers as she chooses plus bed baths. Surveyor asked DON if R18 is aware of why she cannot have tub baths and she said, "Yes, I just told her." DON stated resident was ok with that. DON also indicated that R18 was in bed a lot, but was alert and oriented. On 4/17/14 at 11:15 a.m. the Administrator stated that every single day the nursing assistants are supposed to ask whether the resident wants to take a bath or a shower. On 4/17/14 at 1:51 p.m. the DON stated that the nursing assistants don't document bathing preferences anywhere, but do ask the residents if they want a bath or shower and said most people want a shower. If someone wanted a bath only, it would be documented on the bath sheet. DON stated that currently there are no residents receiving a bath. DON also told surveyor that she had contacted the nurse practitioner and R18 will now be able to have a bath instead of a shower as long as the water is not deep enough to touch	F 246		

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F 246	Continued From page 3 the suprapubic catheter. A policy and procedure for bathing choices was requested and not provided. R60 was interviewed on 4/14/14 at 5:15 p.m., regarding choosing how many times a week she could take a bath or shower. R60 responded by saying that the staff had never asked her, just told her it was time to take her bath. On 4/15/2014 at 4:00 p.m. R60 was interviewed again regarding the bathing issue. The resident indicated she didn't like the shower she gets but they never offered her a bath in place of the shower. So she took the shower. R60 also said that she did not have a choice of how many times she wanted to have a shower. R60's admission Minimum Data Set dated 3/12/2014 was reviewed. It identified the resident with cognitive status as alert and oriented, required total dependence for bathing and customary routine was identified as very important to choose bath. The resident's bathing schedule identified the resident was to receive a bath on Thursday p.m. shift only. R60's care plan dated 3/20/2014 did not address choice of tub or shower for bathing or frequency. On 4/17/2014 at 8:45 a.m., nurse aide (NA)-D was interviewed. She gave R60 a shower which the resident didn't like. She had not offered the tub and she didn't know if there was any reason the resident couldn't be in the tub. On 4/17/2014 at 11:10 a.m., NA-C was	F 246		

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MAY 20 2014
MN Dept of Health
Rochester

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F 246	Continued From page 4 interviewed. She indicated she didn't give R60 a bath but R60 got a shower. She went on to say "they all get a shower." NA-C couldn't tell the surveyor why they didn't use the tub for bathing.	F 246		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the food contact surface which was of a quality to maintain a sanitary surface for food preparation. This had the potential to affect all 37 residents who ate foods prepared on this counter surface. Findings include: During the kitchen tour observations on 4/16/14, at 10:20 a.m., with dietary services manager, there was a Formica counter top which had worn finish, long and deep cuts through the finish to the wood base. Beneath the counter top were ten drawers, which contained various utensils. Although the utensils lay on mats inserted into the drawers, the outside, inside and top edges of the drawers had multiple chipped and missing paint	F 371	F371 A stainless steel prep station will be ordered to maintain a cleanable and sanitary surface for food preparation. All food contact surfaces will maintain a sanitary surface for food preparations. All dietary staff have been educated on preparing food on a sanitary contact surface. Weekly audits will be conducted to monitor compliance. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. Dining Services Manager or designee is the responsible party. Corrective Action will be completed by May 27th, 2014	5-27-14

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 371	Continued From page 5 areas. Beneath the drawers were four cupboard doors which were painted inside and outside, which had chipped and missing paint. During interview at that time, dietary services manager stated the counter, drawers, and doors were a unit referred to as the "cook prep station." Dietary services manager verified chipped paint could land on utensils and verified the worn finish and chipped, missing paint were not a surface that could be sanitized thoroughly. During interview on 4/17/14, at 2:00 p.m., dietary services manager stated he expected staff to wipe down the cook prep station at the end of each shift. Dietary services manager stated the facility had no dietary cleaning written policy but staff knew to wipe down the area at the end of each shift. Although dietary department cleaning logs indicated the cook prep station had been cleaned daily, there was no way to determine if an effective sanitation was achieved due to the multiple cuts and worn areas observed on the food preparation surface. During interview on 4/17/14, at 3:15 p.m., director of nursing verified all residents in the facility ate food prepared in the facility kitchen.	F 371		

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

F5306023

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/15/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Rochester West was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok w/AW for K67 5-20-14 RECEIVED MAY 20 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Do: 5-27-14

EXIT: 4-17-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 5-19-14

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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GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester West is a 1-story building, with a partial basement. The facility was built in 1963 and was determined to be of Type II(111) construction The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 38 beds at the time of the survey.	K 000		
K 067 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067	K067 A waiver for the deficiency has been submitted. See attached waiver.	

AW
5-27-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 2 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 staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed and tested in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 38 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 04/15/2014, observation revealed, that the ventilation system utilizes the egress corridor as the supply air for the resident rooms. Date of building construction is 1963. There was no balance report available. HVAC system shut down upon activation of the fire alarm system. This deficient practice was confirmed by the Director of Maintenance (LW) at the time of discovery.	K 067		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 The electrical supply will meet NFPA Guidelines. The circuit breakers in the mattress storage room will be removed. The boiler room identified during survey will be remain clear and unblocked. Weekly random audits will be completed to ensure compliance with the circuit breakers. Audit results will be reviewed during the QAA process to provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance. Corrective Action will be completed by May 27th, 2014 Maintenance Director will be responsible party.	5-27-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 10 out of 38 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 04/15/2014, observation revealed, that the following circuit breaker panels were block: 1. Basement - mattress storage room 2. Basement - boiler room by entrance door NOTE: Check the entire facility for this deficiency These deficient practices were confirmed by the Facility Maintenance Director (LW) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, May 20, 2014 2:31 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: gary.schroeder@state.mn.us; 'jana.cates@goldenliving.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Golden LivingCenter Rochester West (245306) 2014 K67 Annual Wavier Request - Previously Approved - No Changes

This is to inform you that GLC Rochester West is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 4-17-14.

I am recommending that CMS approve this waive r request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility		2000 CODE
	Golden Living Center West 2215 Hwy 52 North, Rochester MN, 55901 507-288-1818	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K067 HVAC Equipment Shall comply with Sec. 9.2and NFPA 90A	A waiver is requested for K067 for the following reasons: A. There will be no adverse effect on the health and safety of the facility's residents and staff since: 1. The building is equipped with an approved full corridor smoked detection system. 2. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm and or sprinkler system. 3. Annual service and maintenance contracts exist to service all the facility's fire protection systems. (for example; fire alarm, sprinkler system, portable extinguishers) 4. The building fire alarm system is monitored to provide automatic fire department notification. 5. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 6. Fire drills are conducted at least quarterly on each shift. 7. The facility is protected by a supervised automatic sprinkler system. B. Compliance with this provision would impose an unreasonable hardship on the facility since: 1. It would cost an estimated $126,200 to upgrade the facilities HVAC system to comply with NFPA 90A 2. It would be a hardship during construction. Residents would need to be moved and dust would lead to infection control issues.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature]	Fire Safety Supervisor	State Fire Marshal	5-20-14

HiMEC MECHANICAL®

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

April 15, 2014

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

RE: Ducting Both Wings

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

Total.....$126,200.00

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

Sincerely,

Bryce Beckel
Project Manager Service Division

Acceptance_____ Date:_____

Proposal Guaranteed For 30 Days

Leadership through innovative and responsible solutions.

Winona Heating & Ventilating, Inc.

Winona Office
974 East Second St
P. O. Box 77
Winona, MN 55987
Phone: 507.452.2064
Fax: 507.452.6320

Rochester Office
1712 Third Ave. SE
Rochester, MN 55904
Phone: 507.280.4201
Fax: 507.281.7694

La Crosse Office
1202 Caledonia St.
La Crosse, WI 54603
Phone: 608.782.6550
Fax: 608.782.1219

Des Moines Office
2400 86th St., Suite 10
Des Moines, IA 50322
Phone: 515.270.4811
Fax: 515.331.8037

ESTABLISHED IN 1902

• HVAC Design/Build • Roofing • Service/Controls • Testing & Balancing • Specialty Metals • Architectural Sheet Metal

April 16, 2013

Golden Living
2215 Highway 52 North
Rochester, MN 55901

Attn: Larry Wood
Re: Ventilation System Modifications

Larry, pursuant to our previous conversations, this budget proposal addresses the item on your deficiency list that states that the ventilation system utilizes the egress corridor as the supply air for the resident rooms. To clarify, it is the return air that passes through the egress corridor, not the supply air.

In general, each wing has a Rooftop Air Handling Unit that serves both the corridor and the resident rooms. The supply air is ducted to sidewall supply grilles in each resident room and also serves the corridor with ceiling supply diffusers. The return air is all returned through two return grilles in the corridor ceiling only. Currently, there are no returns from the resident rooms. This proposal eliminates the passage of return air through the egress corridor, and provides a mechanical separation between the corridor and the resident rooms as follows:

- Disconnect and remove existing return air grilles in corridor ceilings directly below the drops from the existing RTU to make room for return ductwork.
- Fabricate and install new insulated return air ductwork above the corridor ceiling. This shall be a continuous hard-ducted return system and shall run the entire length of the corridor to serve each resident room, and also the corridor.
- Furnish and install new hard-ducted return duct into each resident room.
- Furnish and install new Combination Smoke/ Fire Damper in each return air duct penetration into resident room. This will provide a mechanical separation in the ventilation system that serves both the resident rooms and the corridor.
- Furnish and install new ducted ceiling return air grill in each resident room.
- Disconnect and modifiy each supply duct penetration into resident rooms and furnish and install new Combination Smoke/Fire Damper in each supply duct penetration into resident room. This will provide a mechanical separation in the ventilation system that serves both the resident rooms and corridor.
- Reconnect return air duct to ceiling grilles in corridor to provide a hard-ducted return.
- Furnish and install temporary plastic partition in corridor to enclose the work areas. We propose to partition off a portion of the corridor parallel to the corridor walls. This would allow us an enclosed work area and would also allow continuous passage through the corridor during construction.

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April 17, 2013

Golden Living
2215 Highway 52 North
Rochester, MN 55901

Attn: Larry Wood
Re: Ventilation System Modifications
Rated Corridor Walls

Larry, pursuant to your request and our discussions, WHV is pleased to quote the modifications to the corridor walls. This is based on utilizing 5/8" sheetrock per our previous phone call.

- Extend corridor walls above the ceilings all the way to the roof deck.
- Sheetrock both sides of the extended walls above the ceilings with 5/8" sheet rock.
- Tape both sides of the extended walls.
- All work figured during normal daytime working hours.
- Not Included: Overtime.

North Wing:

$16,300.00
Sixteen Thousand Three Hundred Dollars.

South Wing:

$32,600.00
Thirty Two Thousand Six Hundred Dollars.

Thank you for the opportunity to quote on this project. If you have any questions, please contact me.

Anthony Shirek, LEED AP
Project Manager
WHV Inc.

- Extend supply and return in South Wing to include the rooms at the far south end.
- Remove and then reinstall ceiling tiles after construction.
- Permits.
- Duct insulation.
- Existing RTU's to remain.
- Testing and Balancing.
- All work figured during normal daytime working hours.
- Electrical connections to provide 120 V power to each Combination Smoke/Fire Damper and connect to new contactor in existing fire alarm panel/system.
- Not Included: New RTU's, Modification of corridor walls (see below), Overtime.

North Wing:

$49,750.00
Forty Nine Thousand Seven Hundred and Fifty Dollars.

South Wing:

$70,600.00
Seventy Thousand Six Hundred Dollars.

PLEASE NOTE: The above quotes do not include the modification to the corridor wall construction below or above the ceiling. We need more information and would like to have more dialogue with your group as to what type of rating is required between the corridor ceiling and the resident rooms before this can be confidently quoted. We will gladly provide you with a separate quote for this scope of work.

Thank you for the opportunity to provide you with this budget proposal. If you have any questions, please contact me.

Anthony Shirek, LEED AP
Project Manager
WHV Inc.