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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 99GE
Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245342**

2. STATE VENDOR OR MEDICAID NO. (L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - GREELEY**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

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 **06/14/2016** (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 **74** (L18)

13. Total Certified Beds **74** (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
	74			
(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):

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 06/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/29/2016 (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 **08/01/1986** (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 07/11/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/02/2016** (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245342
June 29, 2016

Mr. Kurtis Rollin, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

Dear Mr. Rollin:

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 June 7, 2016 the above facility is certified for or recommended for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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
June 29, 2016

Mr. Kurtis Rollin, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

RE: Project Number S5342025 & H5342040

Dear Mr. Rollin:

On May 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 April 28, 2016 that included an investigation of complaint number H5342040. 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 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 20, 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 April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 28, 2016, effective June 7, 2016 and therefore remedies outlined in our letter to you dated May 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245342	A. Building B. Wing	6/14/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

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 F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/07/2016	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 06/07/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/07/2016
ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	Correction Completed 06/07/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/07/2016	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 06/29/2016	SIGNATURE OF SURVEYOR 16022	DATE 06/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/28/2016	☐ 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)
245342	A. Building 01 - MAIN BUILDING 01 B. Wing	6/20/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

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 K0011	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 06/07/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 06/07/2016
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/07/2016	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 06/29/2016	SIGNATURE OF SURVEYOR 16022	DATE 06/20/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 99GE
Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245342**

2. STATE VENDOR OR MEDICAID NO. (L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - GREELEY**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

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 **04/28/2016** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X 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: **B*** (L12)

12. Total Facility Beds **74** (L18)

13. Total Certified Beds **74** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/01/2016 (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 **08/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 12, 2016

Mr. Kurtis Rollin, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

RE: Project Number S5342025

Dear Mr. Rollin:

On April 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.

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 April 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5342040 that was found to be substantiated.

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 June 7, 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 June 7, 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 July 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 October 28, 2016 (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
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
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
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. H5342040 was completed. The complaint was substantiated. Deficiencies issued at F315 and F364.	F 000		
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 provide services according to the plan of care for 1 of 1 resident (R117) reviewed for ambulation and 1 of 1	F 282	Resident R 1117, and R 123 care plans and care guides were reviewed and updated on 5/6/2016 All residents have the potential to be	6/7/16

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

Electronically Signed | | 05/20/2016

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
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 282	Continued From page 1 resident (R123) reviewed for toileting. Findings include: R117's plan of care dated 4/7/16, read; "I have a physical functioning deficit related to Mobility impairment. I am weak and my gait is unsteady. I need encouragement to get out of bed and participate with therapies and my self cares. The approach directed Transfer/ambulation assistance of one assist, gait belt and 4 WW (wheel walker)." Restorative ambulation program plan of care dated 4/22/16, read, "Report any complaints of pain, refusals or changes in ability to amb (ambulate) to the nurse." The undated aide assignment sheet directed, walk to dine. The admission progress note dated 3/29/16, addressed R117 ambulated into the facility using a 4 WW and ambulated to room. During observation of the evening meal 4/25/16, R117 was wheeled in the wheel chair to the dining room. During observation of breakfast and lunch on 4/26/16 and 4/27/16, R117 was wheeled into the dining room for meals. When interviewed on 4/28/16, nursing assistant (NA)-A verified R117 did not walk on the unit or to the dining room for meals because therapy walks R117. Document review of the therapy notes dated 4/19/16, titled, Discharge Summary, read: "Ambulates 250 feet with 4 WW on even surfaces with caregiver assistance. Discharge Plans and instructions, Pt to remain in the facility LTC (long term care) to ambulate 2 x/day (two times per day) 100-200 feet with assist of 1 and 4 WW.	F 282	affected. Staff training was scheduled and completed on 5/20/2016. The training included how to access resident care guide/plan. Clinical staff trained on the expectation of following resident plan of care. Care Plan Audits will begin the week of 5/23/2016. We will have all current resident Care Plans reviewed and audited by 6/7/2016 – with observations to validate that residents are receiving cares according to their individualized plan of care. Once all residents are audited once, at that time we will begin re-monitoring two residents a week ongoing, by wing – so that compliance will be maintained. Negative findings will be corrected immediately with re-education provided. The Administrator and Director of Nursing will summarize the results of the audits. This summary shall be taken to the monthly QAPI meeting, and discussed. The QAPI team will determine how long Auditing shall continue based on the results of the audits. Ongoing monitoring will continue until such time as improvement is maintained. Compliance will be completed by 6/7/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 282	Continued From page 2 Recommendation for patient to also ambulate with staff and 4 WW to and from meals." R123 was not offered to toilet and did not receive the necessary care and services to manage incontinence. R123 was admitted from independent living on 4/20/16, following a fall and left shoulder fracture. The temporary plan of care dated 4/22/16, indicated urinary incontinence risk related to incontinent 2+ times a week, check and change every two hours and bedside commode whenever necessary. During observation of morning cares on 4/27/16, at 7:18 a.m. R123 was incontinent of urine in the brief and there was no offer to toilet. At 11:00 a.m. R123 was put to bed and remained in bed until 2:55 p.m. without a check and change until surveyor asked the NA-C to check the brief. R123 was incontinent with a large amount of urine. R123 who is cognitively intact, verified there had been no offer to use the commode or the toilet today, and the brief has not been changed since getting up this morning. R123 verified using the toilet at independent living prior to coming to the facility but stated, "They are so busy here, it is just easier if I go in my brief." When interviewed on 4/28/16, at 8:33 a.m. NA-A verified not checking/changing for incontinence and not offering to use the commode because R123 would ask the staff if R123 needed to go to the bathroom.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 311	Continued From page 3 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 observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain each resident's ability to ambulate for 1 of 1 resident (R117) reviewed for activities of daily living (ADL). Findings include: During observation of the evening meal on 4/25/16, R117 was wheeled in the wheel chair to the dining room. During observation of breakfast and lunch on 4/26/16 and 4/27/16, R117 was wheeled into the dining room for meals. When interviewed on 4/25/16. at 6:30 p.m. R117 indicated having an alarm on the wheel chair and the staff did not want R117 to stand up without help because the alarm would go off. Document review of the form titled, Care Area Assessment (CAA) dated, 4/11/16, indicated R117 was assessed as moderately impaired cognition. Document review of the admission note dated, 2/25/16, indicated R117 ambulated to the room with the use of a walker. R117's plan of care dated 4/7/16, read; "I have a physical functioning deficit related to Mobility impairment. I am weak and my gait is unsteady. I	F 311	Resident R 117's Restorative Program was reviewed, and resident care guide was updated. The update included two items, #1 – now indicates resident 117 is on a restorative program, and #2 – what the restorative program is – walk to dine – ambulate to and from meals. In addition to review of resident 117, there were an additional 15 residents who were on a restorative program – their programs, and care guides were also reviewed for accuracy and updated as indicated. All residents have the potential to be affected. The following system change was made to ensure the deficient practice was corrected and will not recur is: #1. The care guide will now have a place for "Date", so that staff will know if they have a current care guide. The Care Guide will indicate "Restorative" if resident is on a restorative program. #2. The Care Guide will be reviewed and updated daily (M-F) and placed at Nurses Station each evening by ADNS, or Unit Manager. On Saturday and Sunday evening – the PM Charge Nurse will review care guides for changes and print and place updated care guide at Nurses station. An audit tool was developed – that allows	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 311	Continued From page 4 need encouragement to get out of bed and participate with therapies and my self cares. The approach directed Transfer/ambulation assistance of one assist, gait belt and 4 WW (wheel walker)." Restorative ambulation program plan of care dated 4/22/16, read, "Report any complaints of pain, refusals or changes in ability to amb (ambulate) to the nurse." The undated aide assignment sheet directed, Walk to dine. The admission progress note 3/29/16, addressed R117 ambulated into the facility using a 4 WW and ambulated to the bed room. When interviewed on 4/27/16, at 2:00 p.m. NA-D verified R117 did not walk to meals or in the hallway during breakfast and lunch 4/27/16. NA-D stated generally works another unit and is not familiar with R117. When interviewed on 4/28/16, nursing assistant (NA)-A verified R117 did not walk on the unit or to the dining room for breakfast and lunch meals on 4/27/16 because NA-A said therapy walks R117. Furthermore, NA-A verified R117 did not walk to breakfast 4/28/16. Document review of the therapy notes dated 4/19/16, titled, Discharge Summary, read; "Ambulates 250 feet with 4 WW on even surfaces with caregiver assistance. Discharge Plans and instructions, Pt to remain in the facility LTC (long term care) to ambulate 2 x/day (two times per day) 100-200 feet with assist of 1 and 4 WW. Recommendation for patient to also ambulate with staff and 4 WW to and from meals."	F 311	us to ensure staff receive updated care guide, with resident (s) indication who is on restorative program – and audit to ensure the resident restorative program was carried out. The In-Service training will be held on 5/20/2016. The training shall include the process by which the updated care guides will be made available to staff. The Administrator and Director of Nursing will review and summarize the results of the audits. This summary shall be taken to the monthly QAPI meeting, and discussed. The QAPI team will determine how long Auditing shall continue based on the results of the audits. Audits for this deficient practice will begin on 5/23/2016, and full compliance by 6/7/2016.	
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 315 SS=D	Continued From page 5 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R123) in the sample, who was identified as incontinent of urine. Findings include: R123 was admitted from independent living on 4/20/16, for rehabilitation following a fall at home which resulted in a left shoulder fracture. When interviewed on 4/26/16, at 9:30 a.m., R123 indicated the toilet was used in independent living but also used a brief because of "dribbling". Document review of the form titled, Bladder and Bowel Record/3-Day Consecutive Assessment, indicated on 4/21/16, no use of the toilet, bedpan or commode and episodes of incontinence at 12:00 p.m., 1:00 a.m. and 5:00 a.m. The assessment indicated on 4/22/16, from 6:00 a.m. to 7:00 p.m. continent but did not indicate if toileted on the toilet. bed pan or commode. On	F 315	R 123's toileting plan was reviewed and subsequently updated. R 123 is now being offered assistance to use the bedside commode or bathroom – on a regular schedule, and also when she uses her call light to request. In addition – a list was generated of all residents in the facility who are incontinent; these care guides were also reviewed and updated accordingly. All residents who are incontinent have the potential to be affected. System changes we completed to ensure that deficient practice does not recur are: #1. Care plans and care guides were reviewed and updated. #2. We are in the process of re-educating all CNA's – Incontinence Competency. Begin 1:1 Training and pass off beginning 5/23/2016. Re-education will be completed by 6/7/2016. #3. All staff plan of correction In-service held on 5/20/2016, to train verbally, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 315	Continued From page 6 4/23/16, the assessment indicated R123 was incontinent at 8:00 a.m. and 9:00 p.m.. Furthermore, the assessment indicated R123 was toileted at 8:00 a.m. 11:00 a.m. 2:00 p.m. and 9:00 p.m.. The temporary plan of care dated 4/22/16, indicated urinary incontinence risk related to incontinent 2+ times a week, check and change every two hours and bedside commode whenever necessary. During observation of morning cares on 4/27/16, at 7:18 a.m. R123 was incontinent of urine in the brief and there was no offer to toilet. At 11:00 a.m. R123 was put to bed and remained in bed until 2:55 p.m. without a check and change or offer to toilet until surveyor asked the nursing assistant NA-C to check the brief. R123 was incontinent of a large amount of urine. R123 was assessed as cognitively intact, verified there had been no offer to use the commode or the toilet today, and the brief had not been changed since getting up this morning. R123 verified using the toilet at independent living prior to coming to the facility but stated, "They are so busy here, it is just easier if I go in my brief." When interviewed on 4/28/16, at 8:33 a.m. NA-A verified not checking/changing for incontinence on 4/27/16, and not offering to use the commode because R123 had not asked the staff to be taken to the toilet.	F 315	expectation of incontinence care. #4. We have developed an Incontinence audit – that will be initiated beginning 5/23/2016. Eighteen residents will be audited over all shifts, in a 24 hour period. The audit tool is designed to provide prompt feedback to staff if requirement not met. The Incontinence audits will be reviewed by the Administrator/Director of Nursing or designee, for additional follow up as indicated. #5. The incontinence audit (s) – will continue daily until June, 2016 QAPI Meeting. The results of the May, and June, 2016 audits will be discussed. Based on findings – the QAPI team will determine the frequency in which the audits will be required ongoing, and if frequency can be reduced. Compliance will be achieved by 6/7/2016.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 364	Continued From page 7 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food at an appropriate temperature for 10 of 17 resident's (R50, R59, R61, R65, R81, R117, R121, R122, R123, R124) interviewed in the sample who complained about the unpalatable temperature of food. Findings include: During observation of the evening meal on 4/25/16, at 6:00 p.m. in the south dining room, R122 expressed concern about the consistency of the food and complained of the luke warm temperature. R122 voiced was new to the facility and noticed the evening and weekend meals were served on the cool side. R124 and R81 expressed agreement that sometimes the food comes cold but they do not send it back to be re-heated because they do not want to bother the already busy staff. During an observation of the breakfast meal in the south dining room on 4/27/16, at 8:18 a.m., R50, R65 and R122 were seated at the table and no fluids were available while they waited for the food cart to arrive. The expectation was for the meal to be served at 8:15 a.m. R50, R65 and R122 expressed concern that the food was sometimes cold, but they do not send the food back to be re-heated because everyone is so	F 364	A. Dietary Staff will be re-educated on the following items: 1. Plate warmer will be stored with plates and turned on prior to meal service to assure plates are warm for meal service. 2. Temperatures will be taken before meals and logged in kitchen to ensure proper serving temperature. 3. Dietary staff to plate room trays first from the steam table, according to meal ticket. Dining room trays to be plated secondly, per meal ticket. 4. Announcing when meal cart has left kitchen and is ready for meal pass. B. Nursing staff will be re-educated on the following items: 1. Procedure for passing meal trays in order to assure food is served at appropriate temperature. 2. Customer service during meals to assure food is appropriate temperature and respond accordingly when resident identifies that their food is not at their preferred temperature. C. Dietary to set up beverage carts to go out prior to meal service. Beverage carts will include enough glasses and mugs for residents who prefer room service.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 364	Continued From page 8 busy. On 4/27/16, at 8:27 a.m. the administrator and dietary manager were observed moving the food cart down the hallway and stopping to pass room meal trays out to residents. At 8:30 a.m. registered nurse RN-C and RN-D came to assist with passing the meal trays out in the dining room. At 8:41 a.m. RN-A assisted with passing the meal trays in the dining room. When interviewed regarding the work schedule for RN-A, RN-C and RN-D revealed they typically work Monday through Friday 8 a.m. to 4:30 p.m. and came to help out as they saw the staff were later than usual with the meal delivery. The last meal tray was delivered at 8:48 a.m. and the scheduled meal time is 8:15 a.m.. At 8:41 a.m. R123 received the meal tray with french toast. R123 complained the french toast was cold. R123 confided others complain about the cold food but if they ask to have it re-heated it just slows everyone else up, so they just eat it cold. R117 verified sometimes the food is cold but did not want to say anymore than that because the food tasted good. When interviewed on 4/27/16, at 11:52 a.m. R59 expressed eating in the North dining room and experienced cold food often. Family members FA-A and FA-B were present during the interview and verified hearing frequent complaints of cold food by numerous residents for a very long time. When interviewed on 4/27/16, at 12:06 p.m. R121 said the food was always cold, there were too many people here to serve, and everyone was so busy. If you stop them to heat up your cold food	F 364	1. Nursing staff may pass beverages to residents in rooms and dining rooms once beverage cart is delivered. D. Dietary purchased 8 ¾" diameter divided plates that can be warmed on Lowerator and fit on insulated base with insulated dome. E. Test tray audits will be performed by Dining Services Manager or Designee. Random audits will be conducted on evenings and weekends to ensure food is being served at proper temperature. F. Monthly Food Council Meetings held. The next council meeting will be held on 5/26/2016. The meeting will address food temperatures and any concerns residents have regarding food temperatures. Results will be presented to the QAPI committee for review and further action. Corrective action will be completed by June 7th.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 364	Continued From page 9 then it slowed everyone else from getting their food. R121 used a divided plate for all meals. When interviewed on 4/27/16, at 12:18 p.m., R61 expressed the food is often cold and many times will ask to have the food warmed up, expressed frustration about getting the food out and providing hot food without having to ask staff to re-heat the food. R61 verified the staff was aware because the residents told them all the time. R61 expressed cold food was worse in the evening and weekends because there were less people around to help. The South food cart, 16 trays were dished up in the kitchen at 12:22 p.m., left the kitchen at 12:28 p.m.. Observation of the south food cart delivery on 4/27/16, at 12:29 p.m., revealed the dietitian rounded up the staff to start passing the meal trays to the rooms on the South wing. Licensed practical nurse (LPN-A), and RN-C were observed passing room trays. At 12:38 p.m. RN-A assisted with passing meal trays in the dining room. Nursing assistant (NA)-A started to pass fluids out to the residents in the dining room at 12:38 p.m. At 12:48 p.m. all meals trays had been passed to the residents. At 12:48 p.m. food temps were taken of the test tray pureed lasagna by the dietitian, which revealed 119 degrees Fahrenheit (F) The regular serving of lasagna was 138 degrees F. The taste of the pureed lasagna at 119 degrees was bland and the palatability appeared dough like. When interviewed on 4/27/16, at 1:00 p.m., the dietician verified the expectation would be to	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 364	Continued From page 10	F 364		

serve the food at 135 degrees to the residents. Furthermore, the dietitian verified the divided plates used for 6 residents did not fit into a dome food warmer and may be the reason for the food becoming colder, sooner, than the plates that are placed on a food warmer.

On 4/25/16, at 12:38 p.m., R81 was observed in room eating lunch. R81 stated the food was cold "just about every day." R81 further explained does not ask staff to warm it up because they are "busy enough" and doesn't want to bother them.

At 12:10 p.m., preparation for the north hallway meal trays began with a test tray mechanical soft diet was placed on a glass plate, covered with a lid dome and put into the food cart. The temperature registered 130 degrees Fahrenheit. The cart left the kitchen at 12:21 p.m.

When interviewed on 4/27/16, at 2:21 p.m. the director of therapeutic recreation (TR) revealed minutes of the Resident Council minutes were not available and explained, "Honestly, if I have to be truthful, I don't believe they wrote anything down. I witnessed the previous administrator take the Resident Council minutes, flip to the last page and sign without even looking at it."

When interviewed on 4/27/16, at 2:30 p.m., the dietary manager (DM) stated the food carts used to transport trays to the dining rooms and resident rooms were insulated but not warmed. The DM stated the insulated bases that fit the entree domes were insulated but not wax-based and were expected to keep food hot during delivery for up to 45 minutes. Furthermore, the DM explained a food council meeting was not conducted since the last director left over 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ____ B. WING ____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 364	Continued From page 11 months ago. When asked for any food council minutes within the last year the DM could not provide them.	F 364		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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 441	Continued From page 12 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper handwashing for 2 of 2 residents (R117 and R123) observed with cares and soiled linen and soiled brief placed on the floor during cares. Findings include: During an observation on 4/27/16, at 7:18 a.m., nursing assistant (NA)-B was observed donning gloves without hand hygiene, to assist R117 with blankets to cover up while in bed, moved the tray table closer, offered water to drink, adjusted the privacy curtain, clipped the call light on the covers and turned on the overhead bed light. Without changing gloves or washing hands, NA-B proceeded to R123 and got linen for morning cares, placing the washcloth in the sink and running the water. NA-B did not use a basin to wash R123 and walked back and forth to the bathroom (BR) leaving the water running in the BR. NA-B raised up the bed for cares, obtained clothing from the closet, then proceeded to remove the incontinence brief from R123, which was saturated with urine. NA-B threw the brief on the floor, and removed linen which NA-B placed on the floor in the BR under the sink. NA-B took the wash cloth from the sink, ran water on the washcloth, took soap from the dispenser and placed soap on the wash cloth. NA-B proceeded to the bedside and performed perineal cleansing without rinsing off the soap. NA-B proceeded to	F 441	Resident Rooms and bathrooms 344 and 346 were deep cleaned. All residents have the potential to be affected. The In-Service training will be held on 5/20/2016. The training shall include lecture style in-service on hand hygiene (rub/handwashing); incontinence care; handling of soiled linens; handling of soiled briefs, when and how to use a wash basin. Hand washing competency, hand cleanser, antiseptic competency, and incontinence care competency to be completed by clinical staff. Handwashing and hand cleanser competency to be completed by all staff that have contact with residents. An Audit tool was created to address the areas of concern: #1. Hand hygiene, #2. Incontinence care, #3. Proper handling of linen, #4. Proper handling of garbage. We will conduct daily audits across all shifts, and all wings. The audits will be completed daily, and reviewed by the Administrator or Director of Nursing. The Audits may be delegated to staff, Managers, Department Heads to conduct. The audit tool was designed to give immediate feedback and re-education if protocol is broken. The results of the audits will be taken to the QAPI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 441	Continued From page 13 turn R123 from side to side to position the brief and adjust the linen. Then, NA-B picked up the soiled brief from the floor and placed in the trash receptacle, removed contaminated gloves and discarded in the trash. NA-B then proceeded to dress R123 while lying in bed. NA-B left the room to get help with transferring R123. NA-B did not do hand hygiene. At 7:50 a.m. NA-A and NA-B came back to the room to use the mechanical device to assist R117 to get up. No hand hygiene performed by NA-A or NA-B prior to adjusting the sling and using the remote control to raise the device to position R117 in the wheelchair. NA-A put on R117's shoes and then performed hand hygiene for thirteen seconds. At 7:58 a.m. NA-B assisted R123 to complete cares and did not perform hand hygiene between cares to R117 and R123. NA-A and NA-B finished dressing R123, sat up on the side of the bed and transferred into the wheel chair. NA-A provided hair care, then left the room to find an alarm that would work. NA-A and NA-B left the room without performing hand hygiene. When interviewed on 4/28/16, at 8:37 a.m. NA-A verified handwashing was to be performed under running water for 20 seconds. Furthermore, NA-A verified wash cloths were not to be put in the bathroom sink and that a basin was to be used for resident cares. When interviewed on 4/28/16, at 8:41 a.m. registered nurse (RN)-E verified the facility expectation was to perform hand hygiene between residents, after taking care of body fluids, and a basin was to be used so that the washcloth was not put in the sink. Furthermore, RN-E verified contaminated linen was never to be put on the floor unless in a liner.	F 441	and discussed by the team. Based upon the results of the audits – the frequency and duration will be determined to ensure ongoing compliance. Compliance will be achieved by 6/7/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 441	Continued From page 14 A review of the facility policy dated, 3/29/16, titled; Handwashing, directed, "Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water." A review of the facility policy dated, 4/14/15, titled; Laundry and linens, read, "All soiled linens must be bagged at the location where they are used."	F 441		

F5342024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING 01 - MAIN BUILDING 01 B. WING _______	05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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. At the time of this survey, Greeley Healthcare Center 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 TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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. Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type 2(111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. Also system smoke detection is in all resident rooms. The facility has a licensed capacity of 70 beds and had a census of 67 at the time of the survey.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: A K-067 has been written in past surveys. The facility has corrected this deficiency and it was approved by MDH.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations, and staff interview revealed that there is 1 of 5 fire barriers located throughout the facility that did not meet the opening protective requirements for a 2 hour fire barrier and is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1, 8.2.3.2.3.1. Findings include: On facility tour between 09:00 AM and 12:00 PM on 05/03/2016 observations revealed that the 2 hour fire barrier located at the separation of the nursing home had a 4" X6" hole in the 2 hour fire wall going to the rehab area. This deficiency was verified by the facility Director of Maintenance (RB) at the time of discovery.	K 011	4" x 6" hole was covered with metal plate covering and sealed with fire caulk around plate by facility Maintenance Director. Task was completed 5/4. Facility Maintenance Director will audit fire barriers to ensure they meet the opening protective requirements. Results will be brought to QAPI committer for review and further action as necessary.	6/7/16
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		6/7/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 027	Continued From page 3 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. Findings include: On facility tour between 09:00 AM and 12:00 PM on 05/03/2016 observations revealed that the smoke barrier doors 7E do not fully close when tested, caused by a door coordinator malfunction. This deficiency was verified by the facility Director of Maintenance (RB) at the time of discovery.	K 027	Door coordinator was adjusted by facility Maintenance Director to ensure that smoke barrier doors close properly. Task was completed 5/5. Facility Maintenance Director or designee will conduct door checks to ensure they fully close. Executive Director will audit all smoke barrier doors to ensure doors close properly on a weekly basis starting immediately. Results will be brought to QAPI committee for review and further action as necessary.	6/7/16
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 029	Door closure bracket was adjusted by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

(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 029	Continued From page 4 failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect all residents, guests and staff within the smoke compartments. Findings include: On facility tour between 09:00 AM and 12:00 PM on 05/03/2016 observations revealed that the door to soiled linen/laundry room did not self close and latch when tested. This deficiency was verified by the facility Director of Maintenance (RB) at the time of discovery.	K 029	facility Maintenance Director to ensure door self closed and latched properly. Task was completed 5/5 Facility Maintenance Director or designee will audit all doors to provide protection of hazardous areas on a weekly basis starting immediately. Results will be brought to the QAPI committee for review and further action as necessary.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 12:00 PM on 05/03/2016, based on review of available	K 050	Fire drills will be conducted on each shift quarterly by the facility Maintenance Director or designee. The fire drills will be conducted at unexpected varying times on each shift throughout the year. Executive Director will audit fire drills monthly. Facility Maintenance Director will present	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 5 documentation it was reveled that the facility had no documentation for fire drills conducted: 1) No night shift fire drills conducted during the 1st quarter of 2016. 2) No evening fire drills conducted during 3rd quarter of 2015. 3) No night shift fire drills conducted during the 2nd quarter of 2015. 4) fire drills on night shift during last 12 months are all conducted during the 5:00 am hour. This deficiency was verified by the facility Director of Maintenance (RB) at the time of discovery.	K 050	the fire drills to the QAPI committee for review and further action as necessary. Task will be completed by 6/7.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
May 12, 2016

Mr. Kurtis Rollin, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5342025

Dear Mr. Rollin:

The above facility was surveyed on April 25, 2016 through April 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5342040 that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston

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(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An investigation of complaint H5342040 was completed. The complaint was substantiated. Correction orders issued at State Licensing Rule 4658.0525 Subp 5 A. B and State Licensing Rule 4658.0600 Subp. 1. You have agreed to participate in the electronic	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ____ B. WING ____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 000	Continued From page 1 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 04/25/16 through 04/28/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include:	2 302		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 302	Continued From page 2 (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 60 residents residing in the facility and resident representatives/families. Findings Include: On 4/28/16, at 11:43 a.m., the Director of Nursing (DON) confirmed the facility did not have any consumer education or information related to dementia/Alzheimer's training. The DON indicated she thought information was posted in the facility and would find it. At 1:00 p.m., the DON indicated she had called the previous administrator and the information was not posted anywhere, nor was it provided in the admission package given to new residents and/or the	2 302	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 302	Continued From page 3 residents representative/families. SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide the information describing the staff training program, categories of employees trained and the frequency of the training, as required. The administrator or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the plan of care for 1 of 1 resident (R117) reviewed for ambulation and 1 of 1 resident (R123) reviewed for toileting. Findings include: R117's plan of care dated 4/7/16, read; "I have a physical functioning deficit related to Mobility impairment. I am weak and my gait is unsteady. I need encouragement to get out of bed and participate with therapies and my self cares. The	2 565	Corrected	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 565	Continued From page 4	2 565		

approach directed Transfer/ambulation assistance of one assist, gait belt and 4 WW (wheel walker)." Restorative ambulation program plan of care dated 4/22/16, read, "Report any complaints of pain, refusals or changes in ability to amb (ambulate) to the nurse."

The undated aide assignment sheet directed, walk to dine. The admission progress note dated 3/29/16, addressed R117 ambulated into the facility using a 4 WW and ambulated to room.

During observation of the evening meal 4/25/16, R117 was wheeled in the wheel chair to the dining room. During observation of breakfast and lunch on 4/26/16 and 4/27/16, R117 was wheeled into the dining room for meals.

When interviewed on 4/28/16, nursing assistant (NA)-A verified R117 did not walk on the unit or to the dining room for meals because therapy walks R117.

Document review of the therapy notes dated 4/19/16, titled, Discharge Summary, read: "Ambulates 250 feet with 4 WW on even surfaces with caregiver assistance. Discharge Plans and instructions, Pt to remain in the facility LTC (long term care) to ambulate 2 x/day (two times per day) 100-200 feet with assist of 1 and 4 WW. Recommendation for patient to also ambulate with staff and 4 WW to and from meals."

R123 was not offered to toilet and did not receive the necessary care and services to manage incontinence.

R123 was admitted from independent living on 4/20/16, following a fall and left shoulder fracture. The temporary plan of care dated 4/22/16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 565	Continued From page 5 indicated urinary incontinence risk related to incontinent 2+ times a week, check and change every two hours and bedside commode whenever necessary. During observation of morning cares on 4/27/16, at 7:18 a.m. R123 was incontinent of urine in the brief and there was no offer to toilet. At 11:00 a.m. R123 was put to bed and remained in bed until 2:55 p.m. without a check and change until surveyor asked the NA-C to check the brief. R123 was incontinent with a large amount of urine. R123 who is cognitively intact, verified there had been no offer to use the commode or the toilet today, and the brief has not been changed since getting up this morning. R123 verified using the toilet at independent living prior to coming to the facility but stated, "They are so busy here, it is just easier if I go in my brief." When interviewed on 4/28/16, at 8:33 a.m. NA-A verified not checking/changing for incontinence and not offering to use the commode because R123 would ask the staff if R123 needed to go to the bathroom. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 910	Continued From page 6	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R123) in the sample, who was identified as incontinent of urine. Findings include: R123 was admitted from independent living on 4/20/16, for rehabilitation following a fall at home which resulted in a left shoulder fracture. When interviewed on 4/26/16, at 9:30 a.m., R123 indicated the toilet was used in independent living but also used a brief because of "dribbling". Document review of the form titled, Bladder and	2 910	Corrected	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 910	Continued From page 7	2 910		

Bowel Record/3-Day Consecutive Assessment, indicated on 4/21/16, no use of the toilet, bedpan or commode and episodes of incontinence at 12:00 p.m., 1:00 a.m. and 5:00 a.m. The assessment indicated on 4/22/16, from 6:00 a.m. to 7:00 p.m. continent but did not indicate if toileted on the toilet. bed pan or commode. On 4/23/16, the assessment indicated R123 was incontinent at 8:00 a.m. and 9:00 p.m.. Furthermore, the assessment indicated R123 was toileted at 8:00 a.m. 11:00 a.m. 2:00 p.m. and 9:00 p.m..

The temporary plan of care dated 4/22/16, indicated urinary incontinence risk related to incontinent 2+ times a week, check and change every two hours and bedside commode whenever necessary.

During observation of morning cares on 4/27/16, at 7:18 a.m. R123 was incontinent of urine in the brief and there was no offer to toilet. At 11:00 a.m. R123 was put to bed and remained in bed until 2:55 p.m. without a check and change or offer to toilet until surveyor asked the nursing assistant NA-C to check the brief. R123 was incontinent of a large amount of urine.

R123 was assessed as cognitively intact, verified there had been no offer to use the commode or the toilet today, and the brief had not been changed since getting up this morning. R123 verified using the toilet at independent living prior to coming to the facility but stated, "They are so busy here, it is just easier if I go in my brief."

When interviewed on 4/28/16, at 8:33 a.m. NA-A verified not checking/changing for incontinence on 4/27/16, and not offering to use the commode because R123 had not asked the staff to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 910	Continued From page 8 taken to the toilet. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to prevent incontinence. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk forincontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ____ B. WING ____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 915	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain each resident's ability to ambulate for 1 of 1 resident (R117) reviewed for activities of daily living (ADL). Findings include: During observation of the evening meal on 4/25/16, R117 was wheeled in the wheel chair to the dining room. During observation of breakfast and lunch on 4/26/16 and 4/27/16, R117 was wheeled into the dining room for meals. When interviewed on 4/25/16. at 6:30 p.m. R117 indicated having an alarm on the wheel chair and the staff did not want R117 to stand up without help because the alarm would go off. Document review of the form titled, Care Area Assessment (CAA) dated, 4/11/16, indicated R117 was assessed as moderately impaired cognition. Document review of the admission note dated, 2/25/16, indicated R117 ambulated to the room with the use of a walker. R117's plan of care dated 4/7/16, read; "I have a physical functioning deficit related to Mobility impairment. I am weak and my gait is unsteady. I need encouragement to get out of bed and participate with therapies and my self cares. The approach directed Transfer/ambulation assistance of one assist, gait belt and 4 WW (wheel walker)." Restorative ambulation program plan of care dated 4/22/16, read, "Report any complaints of pain, refusals or changes in ability	2 915	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 915	Continued From page 10	2 915		

to amb (ambulate) to the nurse."

The undated aide assignment sheet directed, Walk to dine. The admission progress note 3/29/16, addressed R117 ambulated into the facility using a 4 WW and ambulated to the bed room.

When interviewed on 4/27/16, at 2:00 p.m. NA-D verified R117 did not walk to meals or in the hallway during breakfast and lunch 4/27/16. NA-D stated generally works another unit and is not familiar with R117.

When interviewed on 4/28/16, nursing assistant (NA)-A verified R117 did not walk on the unit or to the dining room for breakfast and lunch meals on 4/27/16 because NA-A said therapy walks R117. Furthermore, NA-A verified R117 did not walk to breakfast 4/28/16.

Document review of the therapy notes dated 4/19/16, titled, Discharge Summary, read; "Ambulates 250 feet with 4 WW on even surfaces with caregiver assistance. Discharge Plans and instructions, Pt to remain in the facility LTC (long term care) to ambulate 2 x/day (two times per day) 100-200 feet with assist of 1 and 4 WW. Recommendation for patient to also ambulate with staff and 4 WW to and from meals."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the resident is ambulated according to the rehabilitation plan The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing ambulation as directed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
2 915	Continued From page 11 written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food at an appropriate temperature for 10 of 17 resident's (R50, R59, R61, R65, R81, R117, R121, R122, R123, R124) interviewed in the sample who complained about the unpalatable temperature of food. Findings include: During observation of the evening meal on 4/25/16, at 6:00 p.m. in the south dining room, R122 expressed concern about the consistency of the food and complained of the luke warm temperature. R122 voiced was new to the facility and noticed the evening and weekend meals were served on the cool side. R124 and R81 expressed agreement that sometimes the food comes cold but they do not send it back to be re-heated because they do not want to bother the already busy staff. During an observation of the breakfast meal in the south dining room on 4/27/16, at 8:18 a.m.,	2 960	Corrected	6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ____ B. WING ____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 960	Continued From page 12 R50, R65 and R122 were seated at the table and no fluids were available while they waited for the food cart to arrive. The expectation was for the meal to be served at 8:15 a.m. R50, R65 and R122 expressed concern that the food was sometimes cold, but they do not send the food back to be re-heated because everyone is so busy. On 4/27/16, at 8:27 a.m. the administrator and dietary manager were observed moving the food cart down the hallway and stopping to pass room meal trays out to residents. At 8:30 a.m. registered nurse RN-C and RN-D came to assist with passing the meal trays out in the dining room. At 8:41 a.m. RN-A assisted with passing the meal trays in the dining room. When interviewed regarding the work schedule for RN-A, RN-C and RN-D revealed they typically work Monday through Friday 8 a.m. to 4:30 p.m. and came to help out as they saw the staff were later than usual with the meal delivery. The last meal tray was delivered at 8:48 a.m. and the scheduled meal time is 8:15 a.m.. At 8:41 a.m. R123 received the meal tray with french toast. R123 complained the french toast was cold. R123 confided others complain about the cold food but if they ask to have it re-heated it just slows everyone else up, so they just eat it cold. R117 verified sometimes the food is cold but did not want to say anymore than that because the food tasted good. When interviewed on 4/27/16, at 11:52 a.m. R59 expressed eating in the North dining room and experienced cold food often. Family members FA-A and FA-B were present during the interview and verified hearing frequent complaints of cold	2 960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ________ B. WING ________	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 960	Continued From page 13 food by numerous residents for a very long time. When interviewed on 4/27/16, at 12:06 p.m. R121 said the food was always cold, there were too many people here to serve, and everyone was so busy. If you stop them to heat up your cold food then it slowed everyone else from getting their food. R121 used a divided plate for all meals. When interviewed on 4/27/16, at 12:18 p.m., R61 expressed the food is often cold and many times will ask to have the food warmed up, expressed frustration about getting the food out and providing hot food without having to ask staff to re-heat the food. R61 verified the staff was aware because the residents told them all the time. R61 expressed cold food was worse in the evening and weekends because there were less people around to help. The South food cart, 16 trays were dished up in the kitchen at 12:22 p.m., left the kitchen at 12:28 p.m.. Observation of the south food cart delivery on 4/27/16, at 12:29 p.m., revealed the dietitian rounded up the staff to start passing the meal trays to the rooms on the South wing. Licensed practical nurse (LPN-A), and RN-C were observed passing room trays. At 12:38 p.m. RN-A assisted with passing meal trays in the dining room. Nursing assistant (NA)-A started to pass fluids out to the residents in the dining room at 12:38 p.m. At 12:48 p.m. all meals trays had been passed to the residents. At 12:48 p.m. food temps were taken of the test tray pureed lasagna by the dietitian, which revealed 119 degrees Fahrenheit (F) The regular serving of lasagna was 138 degrees F. The taste	2 960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 960	Continued From page 14	2 960		

of the pureed lasagna at 119 degrees was bland and the palatability appeared dough like.

When interviewed on 4/27/16, at 1:00 p.m., the dietician verified the expectation would be to serve the food at 135 degrees to the residents. Furthermore, the dietitian verified the divided plates used for 6 residents did not fit into a dome food warmer and may be the reason for the food becoming colder, sooner, than the plates that are placed on a food warmer.

On 4/25/16, at 12:38 p.m., R81 was observed in room eating lunch. R81 stated the food was cold "just about every day." R81 further explained does not ask staff to warm it up because they are "busy enough" and doesn't want to bother them.

At 12:10 p.m., preparation for the north hallway meal trays began with a test tray mechanical soft diet was placed on a glass plate, covered with a lid dome and put into the food cart. The temperature registered 130 degrees Fahrenheit. The cart left the kitchen at 12:21 p.m.

When interviewed on 4/27/16, at 2:21 p.m. the director of therapeutic recreation (TR) revealed minutes of the Resident Council minutes were not available and explained, "Honestly, if I have to be truthful, I don't believe they wrote anything down. I witnessed the previous administrator take the Resident Council minutes, flip to the last page and sign without even looking at it."

When interviewed on 4/27/16, at 2:30 p.m., the dietary manager (DM) stated the food carts used to transport trays to the dining rooms and resident rooms were insulated but not warmed. The DM stated the insulated bases that fit the entree

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
2 960	Continued From page 15 domes were insulated but not wax-based and were expected to keep food hot during delivery for up to 45 minutes. Furthermore, the DM explained a food council meeting was not conducted since the last director left over 2 months ago. When asked for any food council minutes within the last year the DM could not provide them. SUGGESTED METHOD OF CORRECTION: The director of nutritional services or designee could develop policies and procedures to ensure food temperatures are acceptable for the resident's. The director of nutritional services or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing meals at the accepted temperatures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ____ B. WING ____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
21426	Continued From page 16 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R15) and 3 of 5 employees (NA-L, NA-M, NA-N) received the tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: R15 was admitted to the facility on 3/25/16. R15's electronic medication administration record (eMR) indicated R15's first step TST was read on 3/28/16, and the second step TST was read on 4/18/16. The eMR indicated the initials of the staff that read the TST and a "0". There was no indication what the zero meant. Interview with the medical records employee on 4/28/16, at 11:50 a.m., indicated she adds the TST to the eMR and none of the nursing staff had ever requested clarification, or asked her to add any information. Review of R15's record lacked any other forms for TB screening. Upon interview with medical records staff, a Baseline TB Screening Tool for Residents form was found. The form indicated R15 received the first step TST on 3/25/16 at 21:00. No information regard the results of the first TST. The form also lacked any information	21426	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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) COMPLETE DATE
21426	Continued From page 17 regarding the second step TST. Review of the facility policy titled, Tuberculosis, Screening Residents for , dated, 12/2/15, indicated the following: The facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of, TB and will check results of recent's (within 12 months) tuberculin skin test (TST), blood assay for Mycobacterium tuberculosis (BAMT) or chest X-rays (CXR). Any resident with documented negative TST, BAMT, or CXR with the previous 12 months will receive a baseline (two-step) TST of (one-step) BAMT upon admission. If the first TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read. The BAMT is a one-step test. Screening of new admissions or readmissions for Tuberculosis infection and disease will be in compliance with State regulations. Review of the golden living procedure #IC-406 labeled Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests directed the facility staff of the following: Interpretation Timeframe - A qualified nurse or healthcare practitioner will interpret the TST forty-eight (48) to seventy-two (72) hours after administration. All test results must be read in mm (millimeters). Reading TST - A positive reaction will be considered to be an area of induration (palpable hardness) around the injection site. Redness or erythema should not be measured. Review of Tuberculosis Screening for newly hired employees revealed NA-L and NA-M file, lacked a symptom screening for TB, and NA-N's file lacked any information on a completed	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
21426	Continued From page 18 Tuberculosis Screening. NA-L's hire date was 4-9-16. NA-L received the first step TST on 4/22/16 and was read on 4/25/16. The golden living Tuberculosis Screening Questionnaire dated 2/09 did not include symptom screening. NA-M's hire date was 3/16/16. The TST form did not have any symptom screening. Interview with the interim Director of Nursing (DON) on 4/28/16 at 11:30 a.m., verified no symptom screening was on either form and there seemed to be too many different forms. NA-N's hire date was 12/7/15. NA-N employee's file lacked any information on TB screening. The DON was continuing to look for it, and as the time of exit no information was located. Review of golden living Tuberculosis, Screening Employees and New Hires Policy #IC-414 created 8/10/15 and last reviewed on 8/14/15 indicated the following: POLICY STATEMENT: All employees shall be screen (sic) for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. Interview with the DON on 4/28/16 at 11:35 a.m. indicated all new hires are given the first step prior to orientation, and it is read before they are allowed to work with any residents. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing (DON) could review and revise policies and procedures for proper monitoring Tuberculin testing. Nursing staff could be educated as necessary to the importance of the tuberculin screening The DON	21426		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ________ B. WING ________	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	**313 SOUTH GREELEY STREET STILLWATER, MN 55082**

(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) COMPLETE DATE
21426	Continued From page 19 or designee could audit tuberculin screening on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		