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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9JEN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00948

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245337**

2.STATE VENDOR OR MEDICAID NO.
(L2) **248627000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LINDEN**
(L4) **105 WEST LINDEN 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 **04/26/2016** (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 **67** (L18)

13.Total Certified Beds **67** (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
	67			
(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 Heim, HPR Social Work Specialist 04/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/28/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245337
May 10, 2016

Mr. Eric Andersen, Administrator
Golden Livingcenter - Linden
105 West Linden Street
Stillwater, MN 55082

Dear Mr. Andersen:

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 April 8, 2016 the above facility is certified for or recommended for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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

Certified Mail # 7015 0640 0003 5695 5965
May 10, 2016

Mr. Eric Andersen, Administrator
Golden Livingcenter - Linden
105 West Linden Street
Stillwater, Minnesota 55082

RE: Project Number S5337025

Dear Mr. Andersen:

On March 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 10, 2016. 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 April 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 12, 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 March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 10, 2016, effective April 8, 2016 and therefore remedies outlined in our letter to you dated March 28, 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.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245337 Y1	A. Building B. Wing Y2	4/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN 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	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0272	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.20(b)(1)	Completed
LSC		04/08/2016	LSC		04/08/2016	LSC		04/08/2016
ID Prefix	F0279	Correction	ID Prefix	F0309	Correction	ID Prefix	F0412	Correction
Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.25	Completed	Reg. #	483.55(b)	Completed
LSC		04/08/2016	LSC		04/08/2016	LSC		04/08/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 05/10/2016	SIGNATURE OF SURVEYOR 30922	DATE 04/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245337 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	04/08/2016	LSC K0062	04/08/2016	LSC K0143	04/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	04/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/10/2016	SIGNATURE OF SURVEYOR 12424	DATE 04/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/15/2016	☐ YES ☐ NO

MDH L&C 3201 **PLEASE DATE** 1

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

Mr. Eric Andersen, Administrator
Golden Livingcenter - Linden
105 W Linden St
Stillwater, MN 55082

9590 9403 0954 5223 2833 45

7015 0640 0003 5695 5965

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x Michele Langer ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Michele Langer C. Date of Delivery 5/5/13/16

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

UC

3. Service Type
- ☒ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Mail
- ☐ Mail Restricted Delivery
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7530-02-000-9053 **PLEASE RETURN IN 5 DAYS** Return Receipt

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9JEN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00948

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245337**

2.STATE VENDOR OR MEDICAID NO.
(L2) **248627000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LINDEN**
(L4) **105 WEST LINDEN 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 **03/10/2016** (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 **67** (L18)

13.Total Certified Beds **67** (L17)

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)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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 — 04/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 04/28/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2922
March 28, 2016

Mr. Chad Ketcham, Administrator
Golden Livingcenter - Linden
105 West Linden Street
Stillwater, Minnesota 55082

RE: Project Numbers S5337025 & H5337026

Dear Mr. Ketcham:

On March 15, 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 March 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5337026 that was found to be unsubstantiated.

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

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

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

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 April 19, 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 April 19, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 10, 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 September 10, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

Received via email 4/11/16

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

PRINTED: 03/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN 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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 SER 4/11/16	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the law. Submission of this Response and Plan of Correction is <u>not</u> a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also <u>not</u> to be construed as an admission against interest of the Facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		04/08/16

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

3/31/16

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

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F 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations of mistreatment, neglect and abuse are thoroughly investigated and reported to the administrator and to the state agency immediately for 2 of 5 residents (R16 and R69) reviewed for abuse. Findings include: R16 expressed neglect of care and rough treatment which was not reported to the state agency. According to the annual Minimum Data Set (MDS) document dated 1/15/16, R16 was cognitively intact with a diagnosis of cerebral vascular disease (CVA) and expressive communication difficulty.	F 225	This Plan of Correction shall constitute this facility's credible allegation of compliance. All deficiencies shall be corrected on or before 04/08/16. **F225, D** F225 S/S=D 483.13 (c)(1)(ii)-(iii), (c)(2)-(4), Investigate/Report Allegations/Individuals The Facility does develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of residents, and misappropriation of resident property. The Facility does ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown origin and misappropriation are reported to the Executive Director and to other officials in accordance with law through established procedures. The Facility did present evidence that all alleged violations were investigated.	

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F 225	Continued From page 2 Document review of the form titled, Grievance/Concern, dated 12/5/15, addressed R16 being upset with nursing assistant (NA)-A for taking away the television remote control and not getting R16 up for supper on 12/4/15. The summary of findings indicated NA-A was "annoyed" with R16 because of being frustrated caring for R16. There were no investigative details or interviews of co-workers or other residents regarding R16's complaint of neglect of care. Document review of the form titled Grievance/Concern, dated 1/1/16, indicated NA-A came into the bedroom of R16 as witnessed by NA-B, when R16 began shaking fist at NA-A stating, "rough, rough." NA-B asked R16 is NA-A rough with you to which R16 stated,"Yes." Although the document indicated the aide was warned to be cautious and respectful of this resident, there was no report immediately to the administrator or to the state agency, and there were no documents to indicate an investigation of the incident had occurred. Furthermore, there was no documentation of a resolution for R16 regarding concerns with NA-A neglecting care. The facility's current policy and procedure dated, 1/14/15, titled Reporting Alleged Abuse Violation, read, "It is the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reporting immediately to the executive director of the center. Such violations are also reported to state agencies in accordance with existing state law. The center	F 225	The Facility does listen to and act upon the concerns regarding resident care and life in the Facility. In accordance with Facility policy and the law, the Executive Director or designee will report alleged violations as appropriate. Background checks are completed in a timely manner and all employees have completed background checks. The allegations included in the statement of deficiencies involving R16 and R69 have been reported to the appropriate state agency. The investigations will be reported in a timely fashion. The employees, E1, E2, and E5 references have been submitted and have been completed. Employee, E3 has a completed facility background study. The Executive Director will review each alleged violation to assure thorough investigation and appropriate documentation are completed. Upon any concern, the	

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F 225	Continued From page 3 investigates each such alleged violation thoroughly. The attached Verification of Investigation form is completed after the investigation is complete" During an interview with the director of nursing on 3/10/16, at 11:00 a.m. verified both incidents with R16 should have been reported to the state agency pending investigation. Furthermore, the DON verified the resident should have been interviewed and followed up with concerning this allegation of neglect. The DON verified a verification of investigation was not completed for the 12/5/15 or 1/1/16 allegation of abuse. R69 reported an allegation of abuse which was not reported immediately to the administrator or state agency. According to the document titled Verification of Investigation, dated 11/14/15, R69 was denied access to spouses room by the staff, and referred to the nursing assistant as, "whipping" her around in the hallway and prying her fingers off the hand rail in the hallway and pushing R69 in the wheelchair against her will into her bedroom. The administrator and state agency were not informed of the incident until 11/17/15 according to the Verification of Investigation form. During an interview with the director of nursing on 3/10/16, at 2:40 p.m. verified the incident with R69 should have been reported immediately to the administrator and state agency pending investigation. Furthermore, the DON verified other residents and staff should have been interviewed and followed up with concerning this allegation of abuse.	F 225	Executive Director will consult with the Golden Living Center – Linden's Area Vice President to review investigative findings and discrepancies. Upon discrepancies the Executive Director will coach direct reports on proper investigative procedures and the process of identifying and reporting alleged violations. To ensure alleged violations are identified, the Director of Nursing Services and/or Assistant Director of Nursing will review nurse documentation the following business day to report discrepancies to the Interdisciplinary Team for appropriate follow-up. All staff training on facility abuse and neglect is assigned to be completed via new employee orientation, as well as annually. Abuse and neglect training is to be complete before any staff member or volunteer is to have direct contact with residents. Timely completion will be verified by the Executive Director or designee.	

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F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations of mistreatment, neglect and abuse were thoroughly investigated, reported to the administrator and to the state agency immediately for 2 of 5 residents (R16 and R69) reviewed for abuse. The facility also failed to complete background checks on 1 of 5 newly hired employees, (E)3, check professional references for 4 of 5 newly hired employees E1, E2, E3, E5 and failed to provide education on abuse and abuse prevention for 4 of 5 newly hired employees, E1, E2, E3 and E5. Findings include: The facility policy titled, Reporting Alleged Abuse Violation, dated 1/14/15, read, "It is the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reporting [sic] immediately to the executive director of the center. Such violations are also reported to state agencies in accordance with	F 226	An All Staff Meeting was conducted on 04/06/16 to educate on the Facilities Abuse and Neglect policy and procedure. Education emphasis was placed on immediate reporting of allegations to the Executive Director and Director of Nursing. Policy/procedure was educated to all staff on notification of Executive Director and Director of Nursing. All staff will review these policies with the Executive Director or designee prior to working their shift and in conjunction with the date of compliance. The Business Office Manager will ensure each employee has completed reference checks and appropriate documentation. Background checks are completed in a timely manner. All employees have completed background checks. Education was completed with the Business Office Manager in regards to background checks and submission of employee references. The Executive	04/08/16

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F 226	Continued From page 5 existing state law. The center investigates each such alleged violation thoroughly. The attached Verification of Investigation form is completed after the investigation is complete" Under the policy definition of abuse read, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. This presumes that instances of abuse of all residents even those in a coma, cause [physical harm or pain or mental anguish. Under the police section titled, Investigation, directed the investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident. The procedure for employee screening directed reference checks with the current and/or past employer, appropriate licensing board or registry check, and criminal background check pursuant to center policy or state law. Staff and volunteer training directed upon hire, each new employee is informed of the obligation to report alleged violations. Training includes appropriate interventions to deal with aggressive and/or catastrophic reactions of residents, definitions of alleged violations and caregiver stress. Training also includes examples of reportable incidents to assist staff in detection of such incidents. R16 expressed neglect of care and rough treatment which was not reported to the state agency.	F 226	Director will review each new employee's personnel file to ensure background checks and references are submitted in a timely manner before employees have direct contact with residents. The Executive Director will randomly question staff during daily rounds twice per week for six weeks and weekly for four months regarding staff knowledge of misconduct definitions and immediate reporting requirements. The Executive Director will monitor for compliance and report any negative findings to the QAPI committee for four months. **F226, E** F226, S/S=E 483.13 (c) Develop/ Implement Abuse/Neglect, Etc. Policies The Facility does develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of residents, and misappropriation of resident	

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F 226	Continued From page 6 According to the annual Minimum Data Set (MDS) document dated 1/15/16, R16 was cognitively intact with a diagnosis of cerebral vascular disease (CVA) and expressive communication difficulty. Document review of the form titled, Grievance/Concern, dated 12/5/15, addressed R16 being upset with nursing assistant (NA)-A for taking away the television remote control and not getting R16 up for supper on 12/4/15. The summary of findings indicated NA-A was "annoyed" with R16 because of being frustrated caring for R16. There were no investigative details or interviews of co-workers or other residents regarding R16's complaint of neglect of care. Document review of the form titled Grievance/Concern, dated 1/1/16, indicated NA-A came into the bedroom of R16 as witnessed by NA-B, when R16 began shaking fist at NA-A stating, "rough, rough." NA-B asked R16 is NA-A rough with you to which R16 stated,"Yes." Although the document indicated the aide was warned to be cautious and respectful of this resident, there was no report immediately to the administrator or to the state agency, and there were no documents to indicate an investigation of the incident had occurred. Furthermore, there was no documentation of a resolution for R16 regarding concerns with NA-A neglecting care. During an interview with the director of nursing on 3/10/16, at 11:00 a.m. verified both incidents with R16 should have been reported to the state agency pending investigation. Furthermore, the DON verified the resident should have been	F 226	property. The Facility does ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown origin and misappropriation are reported to the Executive Director and to other officials in accordance with law through established procedures. The Facility did present evidence that all alleged violations were investigated. The Facility does listen to and act upon the concerns regarding resident care and life in the Facility. In accordance with faciiity policy and the law, the Executive Director or designee will report alleged violations as appropriate. The allegations included in the 2567 involving R16 and R69 have been reported to the appropriate state agency. The investigation will reported in a timely fashion. The Business Office Manager will ensure each employee has completed reference checks	

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F 226	Continued From page 7 interviewed and followed up with concerning this allegation of neglect. The DON verified a verification of investigation was not completed for the 12/5/15 or 1/1/16 allegation of abuse. R69 reported an allegation of abuse which was not reported immediately to the administrator or state agency. According to the document titled Verification of Investigation, dated 11/14/15, R69 was denied access to spouses room by the staff, and referred to the nursing assistant as, "whipping" her around in the hallway and prying her fingers off the hand rail in the hallway and pushing R69 in the wheelchair against her will into her bedroom. The administrator and state agency were not informed of the incident until 11/17/15 according to the Verification of Investigation form. During an interview with the director of nursing on 3/10/16, at 2:40 p.m. verified the incident with R69 should have been reported immediately to the administrator and state agency pending investigation. Furthermore, the DON verified other residents and staff should have been interviewed and followed up with concerning this allegation of abuse. Review of employee roster revealed E1, E2, E3 and E5 had all been hired between May 1st 2015 and November 1st 2015. Review of E3's employee record revealed no background study completed by the facility and no professional references. E3's background check had been completed by another facility. E1, E2, and E5's	F 226	and appropriate documentation. Background checks are completed in a timely manner. All employees have completed background checks. Education was completed with the Business Office Manager in regards to background checks and submission of employee references. The Executive Director will review each new employee's personnel file to ensure background checks and references are submitted in a timely manner before employees have direct contact with residents. The Director of Nursing and/or Assisted Director of Nursing will review all nurse charting from the previous business day to review for any charting that may reflect any reportable incident. Any reportable instances will be reviewed with the Interdisciplinary Team. The Executive Director will review each alleged violation to assure thorough investigation and appropriate	

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F 226	Continued From page 8 employee files were reviewed. No professional references were found. On 3/10/15 at 9:48 a.m. the business office manager (BOM) reported the facility did not run a background check for E3. BOM reported she thought the background check completed at a nearby facility, which was run by the same company was sufficient. BOM reported employee records for the two facilities were stored separately at each facility and not in a central storage location. On 3/10/16 at 12:49 p.m. the director of nursing (DON) reported he was unable to locate professional references for E1, E2, E3 and E5. A review of E1, E2, E3 and E5's education transcript, dated 1/1/15 to 12/31/15, revealed no training on abuse and abuse prevention. On 3/10/16 at 12:49 p.m.. the DON confirmed E1, E2, E3 and E5 had no documentation to confirm training on abuse and abuse prevention was completed on hire.	F 226	documentation are completed. Upon any concern, the Executive Director will consult with the Golden Living Center – Linden's Area Vice President to review investigative findings and discrepancies. Upon discrepancies the Executive Director will coach direct reports on proper investigative procedures and the process of identifying and reporting alleged violations. To ensure alleged violations are identified, the Director of Nursing Services will review nurse documentation the following business day to report discrepancies to the Interdisciplinary Team for appropriate follow-up. All staff training on facility abuse and neglect is assigned to be completed via new employee orientation, as well as annually. Abuse/neglect training is to be complete before any employee has direct contact with residents. Completion will be verified by the Executive Director or designee. An All Staff Meeting was	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		04/08/16

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F 272	Continued From page 9 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess dental status for 1 of 1 resident reviewed, R66. Findings include: Review of R66's admission Minimum Data Set (MDS), dated 10/12/15 and quarterly MDS, dated	F 272	conducted on 04/06/16 to train on the Facilities Abuse and Neglect policy and procedure. Education emphasis was placed on immediate reporting of allegations to the Executive Director and Director of Nursing. A policy/procedure was educated to all staff on notification of Executive Director and Director of Nursing. All staff will review the policy with the Executive Director or designee prior to working their shift. The Executive Director will randomly question staff during daily rounds twice per week for six weeks and weekly for four months regarding staff knowledge of misconduct definitions and immediate reporting requirements. The Executive Director will monitor for compliance and report any negative findings to the QAPI committee for four months. **F272, D** F272, S/S=D 483.20 (b)(1) Comprehensive Assessments	

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F 272	Continued From page 10 1/8/16 revealed R66 had no broken or loosely fitting dentures, On the 10/12/15 admission MDS R66 was noted as moderately cognitively impaired. On the 1/8/16 quarterly MDS, R66 was noted as cognitively intact. An assessment, titled MDS 3.0 Oral/Dental Assessment Form, dated 10/22/15, the RDH identified "teeth have broken off of [lower] partial-but partial is still stable and functional." and "Routine Dental Referral. Resident has non-urgent dental care needs. repair [lower] partials (?)" During observation and interview on 3/9/16 at 9:08 a.m. with the MDS registered nurse, (RN)-A, R66 took the partial dentures out of his mouth and pointed out where two prosthetic teeth were missing in his partial dentures. R66 reported the prosthetic teeth in his partial dentures had been missing since prior to admission. On 3/9/16 at 7:50 a.m. RN-A reported she was unaware of R66 missing prosthetic teeth in his partial dentures. RN-A reported she did not use the MDS 3.0 Oral/Dental Assessment to verify the accuracy of the submitted admission MDS and complete any needed modifications. RN-A reported she also failed to use the MDS 3.0 Oral/Dental Assessment for the quarterly MDS. RN-A reported she did not look into R66's mouth, except what she could see during normal conversation, and did not ask him to take out his partials for examination. RN-A reported R66 did not say anything to her about his partials but could not recall if she asked him about his partial dentures. R66's care area assessment, dated 10/12/15,	F 272	Facility assessments do reflect residents' status and conditions, and care plans are appropriate. MDS assessments are completed and individualized care plans are developed. Facility systems/protocols for MDS and care plan completion have been reviewed and are appropriate. Resident 66 has a completed dental assessment. Resident 66 was referred to the facility contract Dentist and has fixed and properly fitted dentures. No other residents were identified. MDS Coordinator or designee will audit records for appropriate complete assessments. Results of the audits will be monitored at QAPI and systems will be reviewed if necessary. There were no other missed dental assessments that were identified. The dental referral process has been reviewed and communicated to the Interdisciplinary Team. During monthly dental hygienist visits for all	

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	245337	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN STREET STILLWATER, MN 55082

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F 272	Continued From page 11 revealed no assessment of R66's broken partial dentures. R66's care plan, last revised 1/5/16, revealed no directions related to dental needs. Section L of the Resident Assessment Instrument Version 3.0, dated October 2015, directed staff "If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment."	F 272	residents the hygienist will compile notes to reflect any needs for a dentist referral. The hygienist notes will be reviewed by the Assisted Director of Nursing and the Health Information Coordinator. Per the review, the Health Information Coordinator will communicate any prompt or emergency referrals to Golden Living Center – Linden's contract Dentist. Any follow up Dentist visits will be reviewed by the Assisted Director of Nursing and/or designee. The Director of Nursing will audit for appropriateness and quality assurance. Upon admission, a nurse will assess, in person a resident's dentures to reveal broken or loosely fitting dentures. Any negative findings will be communicated to the Health Information Coordinator to request and schedule a visit with Golden Living Center – Linden's contract Dentist. The Assisted Director of Nursing and/or Director of Nursing will report any	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		04/08/16

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F 279	Continued From page 12 Based on interview and document review, the facility failed to develop a comprehensive care plan to manage cardiac and pain concerns for 1 of 1 resident reviewed, R13. Findings include: Review of R13's most recent Minimum Data Set (MDS), dated 1/13/16, revealed R13 was cognitively intact and had frequent moderate to severe pain. On 3/9/16 at 2:50 p.m. R13 reported she experienced pain in her lower back and headaches. R66 reported it helped to rest in bed and take medications when she was in pain. Review of R13's medication orders revealed an order for Midodrine HCL (Antihypotensive) Tablet 10 mg (milligrams) daily, Aspirin 81 mg daily and Atorvastatin 40 mg daily for Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Hearth Failure. R13's diagnoses list included Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Hearth Failure, unspecified atrial fibrillation and pure hypercholesterolemia. A review of progress notes, dated 2/11/16, revealed R13 was experiencing hypotension episodes and had a recent increase in Midodrine HCL. A 2/16/16 note indicated R13 was experiencing syncope episodes. R13 was also ordered Tylenol (acetaminophen) Extra Strength twice daily for chronic headaches; Acetaminophen 500 mg as needed every four hours for pain, and Hydromorphone HCL 4 mg as needed every six hours for moderate to severe pain. R13's diagnoses list included headache and pain in thoracic spine. Review of the February and March 2016 Medication and Treatment Administration revealed R13 used	F 279	negative findings to the Facility QAPI meeting for the next six months. **F279, D** F279, S/S=D 483.20 (d), 483.20 (k)(1), Develop Comprehensive Care Plans Facility assessments do reflect residents' status and conditions, and care plans are appropriate. MDS assessments are completed and individualized care plans are developed. Facility systems/protocols for MDS and care plan completion have been reviewed and are appropriate. The Facility has completed a comprehensive plan of care for pain and heart issues for the identified, Resident 13. No other residents were identified. Education has been completed with the MDS Coordinator, ADON, and DON on timely and effective care planning.	

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F 279	Continued From page 13 Hydromorphone HCL 4 mg seven times in February and 5 times in March. R13 used Acetaminophen 500 mg as needed every four hours one time in March. On 3/9/16 at 1:48 p.m. the MDS registered nurse (RN)-A confirmed R13 experienced pain from dialysis and sitting in her chair too long. RN-A confirmed R13 had current cardiac diagnoses and concerns. RN-A reported pain and cardiac issues were not addressed or included as part of a comprehensive care plan because they were missed. On 3/9/16 at 2:04 p.m. the director of nursing (DON) confirmed R13 had cardiac and pain diagnoses and medications. DON confirmed cardiac and pain was not addressed as part of a comprehensive care plan. DON reported he would expect pain and cardiac issues to be addressed in a comprehensive care plan.	F 279	Care plans and charts shall be reviewed on admission, quarterly, and PRN by the interdisciplinary team. The DNS or designee shall monitor for compliance by conducting resident medical record reviews three times a week for eight weeks and weekly for six months to ensure continued compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that addressed how to manage cardiac and pain concerns for 1 of 1 resident reviewed, (R13)	F 309	**F309, D** F309, S/S=D 483.25, Provide Care/ Services for Highest Well Being Each resident does receive and the Facility does provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	04/08/16

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F 309	Continued From page 14 to assure necessary care and services were provided for cardiac and pain concerns. Findings include: Review of R13's most recent Minimum Data Set (MDS), dated 1/13/16, revealed R13 was cognitively intact and had frequent moderate to severe pain. On 3/9/16 at 2:50 p.m. R13 reported she experienced pain in her lower back and headaches. R66 reported it helped to rest in bed and take medications when she was in pain. Review of R13's medication orders revealed an order for Midodrine HCL (Antihypotensive) Tablet 10 mg (milligrams) daily, Aspirin 81 mg daily and Atorvastatin 40 mg daily for Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Hearth Failure. R13's diagnoses list included Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Hearth Failure, unspecified atrial fibrillation and pure hypercholesterolemia. A review of progress notes, dated 2/11/16, revealed R13 was experiencing hypotension episodes and had a recent increase in Midodrine HCL. A 2/16/16 note indicated R13 was experiencing syncope episodes. R13 was also ordered Tylenol (acetaminophen) Extra Strength twice daily for chronic headaches; Acetaminophen 500 mg as needed every four hours for pain, and Hydromorphone HCL 4 mg as needed every six hours for moderate to severe pain. R13's diagnoses list included headache and pain in thoracic spine. Review of the February and March 2016 Medication and Treatment Administration revealed R13 used Hydromorphone HCL 4 mg seven times in	F 309	The Facility has completed a comprehensive plan of care for pain and heart issues for the identified, Resident 13. No other residents were identified. Education has been completed with the MDS Coordinator, ADON, and DON on timely and effective care planning. All residents' care plans have been reviewed. Residents at risk for pain and heart issues shall be identified by a review of physician diagnoses and resident assessments. For identified residents, care plans shall be updated to address pain and heart issues and shall include specific goals and approaches as appropriate. The facility interdisciplinary team has been reinstructed to evaluate interventions in place to determine effectiveness of care plan interventions. Care plan interventions shall be implemented in accordance with facility pain management policies and standards of practice.	

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F 309	Continued From page 15 February and 5 times in March. R13 used Acetaminophen 500 mg as needed every four hours one time in March. On 3/9/16 at 1:48 p.m. the MDS registered nurse (RN)-A confirmed R13 experienced pain from dialysis and sitting in her chair too long. RN-A confirmed R13 had current cardiac diagnoses and concerns. RN-A reported pain and cardiac issues were not addressed as part of a comprehensive care plan. RN-A reported pain and cardiac issues were not included in the comprehensive care plan because they were missed. On 3/9/16 at 2:04 p.m. the director of nursing (DON) confirmed R13 had cardiac and pain diagnoses and medications. DON confirmed cardiac and pain was not addressed as part of a comprehensive care plan. DON reported he would expect pain and cardiac issues to be addressed in a comprehensive care plan.	F 309	The Director of Nursing and/or Assisted Director of Nursing for the next six months will audit the care plans of all residents at risk for unresolved pain and heart issues to ensure appropriate content and appropriateness. Negative findings will be reported to the QAPI committee.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by:	F 412	**F412, D** F412, S/S=D 483.55 (b) Routine/Emergency Dental Services in NFS Facility assessments do reflect residents' status and conditions, and care plans are appropriate. MDS assessments are completed and individualized care plans are developed. Facility systems/protocols for MDS and care plan completion have been reviewed and are	04/08/16

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F 412	Continued From page 16 Based on observation, interview and document review, the facility failed to make a dental referral for broken denture partials for 1 of 1 resident reviewed for dental concerns, R66. Findings include: Review of R66's admission Minimum Data Set (MDS), dated 10/12/15 and quarterly MDS, dated 1/8/16 revealed R66 had no broken or loosely fitting dentures, On the 10/12/15 admission MDS R66 was noted as moderately cognitively impaired. On the 1/8/16 quarterly MDS, R66 was noted as cognitively intact. The 1/8/16 quarterly MDS revealed R66 was a Medicaid recipient. During observation and interview on 3/7/16 at 5:21 p.m., R66 reported he was missing front teeth in his bottom partials. R66 reported the facility knew about the concern but he was not sure how they were addressing it. R66 opened his mouth to show missing front teeth in the front area of his bottom partials. During observation and interview on 3/9/16 at 9:08 a.m. with the MDS registered nurse, (RN)-A, R66 took the partials out of his mouth and pointed out where two teeth were missing in his partials. R66 told RN-A at this time that he would like the missing teeth replaced. R66 reported the teeth in his partials had been missing since prior to admission. On 3/8/16 at 2:58 pm. the medical records manager [MRM] reported R66 was seen on 10/22/15 by a dental hygienist [RDH for an MDS assessment. On this assessment, titled MDS 3.0 Oral/Dental Assessment Form, dated 10/22/15, the RDH identified "teeth have broken off of [lower] partial-but partial is still stable and functional." and "Routine Dental Referral.	F 412	appropriate. The Facility does provide and obtain routine and emergency dental services to meet the needs of each resident. Resident 66 has a completed dental assessment. Resident 66 was referred to the facility contract Dentist and has fixed and properly fitted dentures. No other residents were identified. The MDS Coordinator or designee will audit records for appropriate complete assessments. Results of the audits will be monitored at QAPI and systems will be reviewed if necessary. There were no other missed dental assessments or dental issues that were identified. The dental referral process has been reviewed and communicated to the Interdisciplinary Team. During monthly dental hygienist visits for all residents, the hygienist will compile notes to reflect any needs for a dentist referral. The hygienist notes will be reviewed by the Assisted	

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F 412	Continued From page 17 Resident has non-urgent dental care needs. repair [lower] partials (?)" MRM noted there was no consent form signed which meant R66 was not a current patient of the onsite dental clinic or scheduled for follow up care with a dentist. The social service director [SSD] reported dental concerns are addressed as they arise and at care conferences. SSD referred surveyor to the care conference forms for 10/16/15 and 1/25/16 and electronic progress notes since R66's 10/5/15 admission. SSD reported she found nothing documented related to addressing dental concerns and preferences with R66 or his family. MRM and SSD reported the facility should have contacted R66 and his family to find out what their preferences were regarding the broken partials. On 3/8/16 at 3:52 p.m. the director of nursing, (DON) reported the nurse receiving the MDS 3.0 Oral/Dental Assessment Form, dated 10/22/15, should have made a progress note in R66's electronic record which would have notified the interdisciplinary team to follow up on the concern. DON reviewed progress notes since R66's admission and could not find a follow up note. On 3/9/16 at 7:50 a.m. RN-A reported she does not utilize the MDS 3.0 Oral/Dental Assessment Forms completed by the RDH in her role as completing the MDS annuals and quarterly and developing care plans. RN-A reported the MDS 3.0 Oral/Dental Assessment was completed for use by the MRM. RN-A reported she did not look into R66's mouth, except what she could see during normal conversation, and did not ask him to take out his partials for examination. RN-A reported R66 did not say anything to her about his partials but could not recall if she asked him	F 412	Director of Nursing and the Health Information Coordinator. Per the review, the Health Information Coordinator will communicate any prompt or emergency referrals to Golden Living Center – Linden's contract Dentist. Any follow up Dentist visits will be reviewed by the Assisted Director of Nursing and/or designee. The Director of Nursing will audit for appropriateness and quality assurance. Upon admission, a nurse will assess, in person, a resident's dentures to reveal broken or loosely fitting dentures. Any negative findings will be communicated to the Health Information Coordinator to request and schedule a visit with Golden Living Center – Linden's contract Dentist. The Assisted Director of Nursing and/or Director of Nursing will report any negative findings to the Facility QAPI meeting for the next six months.	

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F 412	Continued From page 18 about his partials. R66's care area assessment, dated 10/12/15, revealed no assessment of R66's broken dentures. R66's care plan, last revised 1/5/16, revealed no directions related to dental needs.	F 412		

F5337024

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

PRINTED: 03/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/15/2016

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Linden was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: 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 Angela.Kappenman@state.mn.us	K 000	Golden Living Center - Linden has prepared this plan of correction as a result of an annual survey completed 03/10/16. Golden Living Center - Linden has prepared and submitted this plan of correction at this time solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) calendar days following receipt of this statement of deficiencies as a condition to participate in the Title 18 and Title 19 programs. The submission of this plan of correction within this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admission by Golden Living Center - Linden that a deficiency exists. However, evidencing Golden Living Center – Linden's good faith, the facility offers the following plan of correction and will achieve substantial compliance in the following areas addressed by 04/08/16. This plan of correction should serve as the allegation of compliance.	

APPROVED
By Tom Linhoff at 11:43 am, Apr 12, 2016

RECEIVED
APR - 8 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	4/8/16

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

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	246337	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/15/2016

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2 story building was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills 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	K 050	K 050, S/S = F Executive Director has reviewed the Fire Plan with the Maintenance Director. Executive Director has reviewed standard of conducting monthly fire drills – one per Shift per Quarter in correspondence with Golden Living Center – Linden procedure, *Report of Monthly Fire Drill.*	04/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN 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 2 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 staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 22 of 22 residents. Findings include: On facility tour between 10930 AM to 12:30 PM on 03/15/2016, during the review of all available fire drill documentation no fire drill was conducted during the 2nd quarter of 2015. This deficient condition was verified by a Maintenance Supervisor.	K 050	Executive Director will audit the fire drills each month for the next six months to ensure they are being completed and documented correctly.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that the facility has failed maintain the automatic fire sprinkler system in accordance with National Fire Protection Association (NFPA) 25 The Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 1998 edition section 9.2.7.	K 062	K 062, S/S = D The ceiling tile in the second floor medication room with a 4 inch diameter hole has been replaced. No other ceiling tile penetrations were identified. Maintenance Director and Executive Director will monitor ceiling tiles for replacement during Environmental Rounds and review any negative findings during facility QAPI.	04/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	106 WEST LINDEN 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 062	Continued From page 3 Findings include: On facility tour between 10930 AM to 12:30 PM on 03/15/2016, observations and staff interview revealed the facility failed to maintain the sprinkler system in a reliable operation condition due to: 1) There was a 4'x4' hole in the ceiling in the 2nd floor Med Room. This deficient condition was verified by the Maintenance Supervisor.	K 062		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for the proper arrangement of room intended for the transferring of liquid oxygen from one container to another per NFPA 99 8-6.2.5.2.	K 143	K 143, S/S= D A new and operable exhaust/ ventilation unit in the first floor Oxygen Transfer/ Storage room was installed 03/28/16 by Altemp Mechanical, Inc. The vent was check and is in operable condition. All penetrations were sealed. The old, inoperable exhaust fan was disconnected and replaced by a glass panel. Executive Director will report findings to the QAPI committee. Executive Director and Maintenance Director will conduct fire safety audits on a quarterly basis to assure fire safety systems are operable and in working condition.	04/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING 01 - MAIN BUILDING 51 B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LINDEN	105 WEST LINDEN 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 143	Continued From page 4 Findings include: On facility tour between 10930 AM to 12:30 PM on 03/15/2016,observation revealed that the exhaust fan in the 2nd floor oxygen transfilling room was not operating. This deficient condition was verified by the Maintenance Supervisor.	K 143		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code: 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. Findings include: On facility tour between 10930 AM to 12:30 PM on 03/15/2016, observation and staff interview revealed an extension cord was plugged into 2 refridgerators in the 2nd floor Med Room. This deficient practice was verified by the Maintenance Supervisor	K 147	K 147, S/S = D The extension cord connecting the two refrigerators in the second floor Medication Room has been removed. The refrigerators have been kept in the Medication room and have been plugged into a standard wall outlet. No other extension cords were identified to be in use.	04/08/16