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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9R07

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245332**

2.STATE VENDOR OR MEDICAID NO.
(L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - EXCELSIOR**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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)

6. DATE OF SURVEY **03/28/2013** (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 **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 04/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/14/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5332

A standard OTC survey was completed at this facility on December 21, 2012. The most serious deficiencies were cited at a S/S level of D. In addition on January 17, 2013, a Federal Monitoring Survey was completed and deficiencies were found, the most serious at a S/S level of F. On January 30, 2013, the CMS RO notified the facility of the following:

- Mandatory DOPNA, effective March 20, 2013
- A loss of NATCEP for a two year period beginning March 20, 2013 if DOPNA were to go into effect

A PCR of the health deficiencies was completed on February 4, 2013. A PCR of the FMS deficiencies was completed on March 28, 2013. All of the deficiencies were found corrected. The facility was found in compliance as of March 20, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA, effective March 20, 2013, be rescinded.

This would also mean that the facility would not be subject to a loss of NATCEP.

See attached CMS-2567 for the results of the February 4, 2013 and March 28, 2013 revisits.

The facility's request for temporary waivers involving the deficiency cited at K20, including the date of completion of October 1, 2013; K25 including the date of completion of May 31, 2013 and K38 including the date of completion of June 1, 2013, has been approved. Documentation supporting the waiver request was forwarded to CMS RO.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5332 April 8, 2013

Ms. Amanda Gentilli, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

Dear Ms. Gentilli:

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 March 20, 2013 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2013

Ms. Kimberly Lyon, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

RE: Project Number S5332022

Dear Ms. Lyon:

On January 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 21, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

In addition, on January 17, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found 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 January 30, 2013, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

Also, the CMS Region V Office notified you in their letter of January 30, 2013, in accordance the Federal Law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), if your facility failed to achieve substantial compliance by March 20, 2013, your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 20, 2013.

On February 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 28, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 21, 2012

and the FMS completed on January 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 21, 2012, and the FMS completed on January 17, 2013, effective March 20, 2013. As a result of the PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter to you dated January 11, 2013, will not be imposed. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013, be rescinded

In the CMS Letter of January 30, 2013, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 20, 2013, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on March 20, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

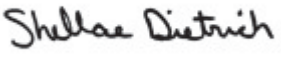
Correction of the Life Safety Code deficiencies cited under K20, K25 and K38 at the time of the January 17, 2013 FMS survey, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver of K20 with a date of completion of October 1, 2013, K25 with a date of completion of May 31, 2013, and K38 with a completion date of June 1, 2013, have been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File 5332r113.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245332	A. Building B. Wing	2/4/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/29/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/29/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **01/29/2013**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **01/29/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/29/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/sd	04/02/13	15507	02/04/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/20/2012			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245332

January 30, 2013
(By Certified Mail and Facsimile)

Ms. Kimberly Lyon, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, MN 55331

Dear Ms. Lyon:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: December 20, 2012

STATE SURVEY RESULTS
On December 20, 2012, a health survey and on December 21, 2012, a Life Safety Code (LSC) survey were completed at Golden Livingcenter - Excelsior by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at Scope and Severity (S/S) level D, cited as follows:

- F279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/Per Care Plan
- F311 -- S/S: D -- 483.25(a)(2) -- Treatment/Services to Improve/Maintain ADLS
- F325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable
- F329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY
In its notice dated January 11, 2013, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by January 29, 2013. However, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on January 17, 2013. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level F, cited as follows:

- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard.

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an informal dispute resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing, to Heather A. Lang, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request

for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is March 20, 2013.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective March 20, 2013 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). We are notifying Palmetto GBA that the denial of payment for all new Medicare admissions is effective on March 20, 2013. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective March 20, 2013.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by June 20, 2013, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 20, 2013, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Golden Livingcenter - Excelsior will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 20, 2013. You will receive further information regarding this from the MDH. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown. Failure to do so could result in our office proceeding with collection of the CMP.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

REQUIRED SPRINKLER STATUS BY AUGUST 13, 2013
On August 13, 2008, CMS published a final rule that requires all long-term care facilities to be equipped with a complete supervised automatic sprinkler system by no later than August 13, 2013. Facilities with no or partial sprinkler systems installed and/or that use waivers or the Fire Safety Evaluation System (FSES) to comply with the current sprinkler requirements have until August 13, 2013 to install or upgrade the sprinkler system. Please review your facility's sprinkler system to ensure it fully complies with the National Fire Protection Association's (NFPA) "Standard for the Installation of Sprinkler Systems" (1999 Edition, NFPA 13). The Federal survey process requires review of the sprinkler system to determine if the system is providing complete coverage or only partial coverage. Complete coverage means that the entire facility, including all closets, storage areas and walk-in coolers and freezers are sprinkler protected. There are specific requirements for overhangs attached to the outside of the building (1999 Edition, NFPA 13, Section 5-13.8), electrical equipment rooms (1999 Edition, NFPA 13,

Section 5-13.11) and Elevator Hoistways and Machine Rooms (1999 Edition, NFPA 13, Section 5-13.6) that are the responsibility of the facility to understand and comply with, that may result in costly upgrades that will require time to complete. **Since there is no waiver and/or FSES provision after August 13, 2013, it is imperative that you ensure that your facility is fully sprinkled in accordance with the regulation on August 13, 2013. Failure to do so is likely to result in enforcement remedies, including but not limited to termination.**

CONTACT INFORMATION

For questions regarding this enforcement case, please contact Tamika J. Brown, Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Certification Specialist, at (312) 353-5169. Information may also be faxed to (443) 380-6614. All correspondence should be directed to Tamika J. Brown in our Chicago office.

Sincerely,

/s/

Heather A. Lang
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services
Palmetto GBA
Office of Ombudsman for Older Minnesotans
Stratis Health
Office of the US Attorney, District of Minnesota

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245332	A. Building B. Wing **01 - MAIN BUILDING 01**	3/28/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **03/01/2013**	ID Prefix	Correction Completed **03/01/2013**
Reg. # **NFPA 101** LSC K0017		Reg. # **NFPA 101** LSC K0022		Reg. # **NFPA 101** LSC K0027	
ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **03/20/2013**
Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054		Reg. # **NFPA 101** LSC K0056	
ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **03/01/2013**	ID Prefix	Correction Completed **03/20/2013**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0072		Reg. # **NFPA 101** LSC K0143	
ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0154		Reg. # **NFPA 101** LSC K0155		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	04/02/13	19251	03/28/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/17/2013

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

FAX to: Number of Pages:

CCN: 245332 DPNA Date: 03/20/2013

Name: Golden Living Center - Excelsior Termination Date: 06/20/2013

City, State: Excelsior, MN

FMS Survey Date: 01/17/2013

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
E	K17	POC 3/20/13
E	K20	**TW 10/1/13**
B	K22	POC 3/1/13
F	K25	**TW 5/31/13**
E	K27	POC 3/1/13
B	K38	**TW 6/1/13**
C	K52	POC 3/20/13
F	K54	POC 3/20/13
E	K56	POC 3/20/13
F	K62	POC 3/20/13
E	K72	POC 3/1/13
E	K143	POC 3/20/13
C	K154	POC 3/20/13
C	K155	POC 3/20/13

Bruce W. Wexelberg

Approved: **YES** By: Bruce W. Wexelberg Date: 03/13/2013

golden living centers®

Enhancing lives through innovative healthcare™

February 7, 2013

Mr. Bruce Wexelberg
Centers for Medicare and Medicaid Service
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

RE: Plan of correction

Dear Mr. Wexelberg:

With this letter we are submitting our plan of correction for the Federal Monitoring Survey that was completed at Golden LivingCenter - Excelsior on January 17, 2013. Please let us know if we need to make any changes to this plan.

Sincerely,

Kim Lyon, NHA
Interim Administrator
Golden LivingCenter - Excelsior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 1/17/13 following a Minnesota Department of Health Survey on 12/21/12. At this Comparative Federal Monitoring Survey, Golden Living Center - Excelsior 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 related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Golden Living Center - Excelsior is a one story building with a partial basement of Type II (111) construction that was built in 1961. The building is fully sprinklered, except where noted under tag K56. There is supervised smoke detection located in the corridors and spaces open to the corridors. The facility has 56 certified beds. All 56 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 46. The requirement at 42 CFR, subpart 483.70(a) is NOT MET as evidenced by:	K 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations,	K 017	K017 • Supervised smoke detector will be installed in the Administrator's office. • Responsible Party: Director of Maintenance • Date of correction: March 20, 2013	

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

Interim Executive Director 2/7/13

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 017	Continued From page 1 waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor wall separations in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.1, 19.3.6.2 and 19.3.6.5. This deficient practice could affect approximately 20 of the 46 residents. Findings include: On 1/17/13 at 12:45pm, observation revealed that there was a sliding glass window in the corridor wall between the Facility Administrator's office and the entry vestibule. When open the window created a 17" by 33" opening in the corridor wall. The Facility Administrators office did not meet one of the exceptions for a space allowed to be open to the corridor. This deficient practice was confirmed by the Facility Administrator and the Director of Maintenance at the time of discovery.	K 017		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation	K 020		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 020	Continued From page 2 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1, 19.3.1.1, 8.2.3, 8.2.3.2.3, 8.2.3.2.4 and 8.2.5, as well as NFPA 90A - 1999 section 3-4.7 . This deficient practice could affect approximately 20 of the 46 residents. Finding include: On 1/17/13 at 12:51pm, observation revealed that there were three 24" by 24" ducts that penetrated the fire rated floor and there were no fire dampers where they penetrated the floor or where they exited the shaft enclosure. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 020	K020 • Facility requests temporary waiver for completion of this correction in order to have architectual consult, obtain contractor bids, and complete work. • Proposed date of correction: October 1, 2013 Amended on 3/7/13 to include: K020: Shall be corrected by installing fire dampers at the floor penetration for all ducts penetrating the basement and first floor rated assembly. The ducts coming out of the shaft shall be protected by combination fire/smoke dampers.	3/7/13
K 022 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022	K022 • The sign that reads "This is not an exit" was removed during survey. • Staff will be educated on signage of exit doors • Audits will be completed weekly to ensure exit doors are kept free of conflicting signage.	Revised 3/11/13

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K 022	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate marking of means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.2.10.1, 7.10, 7.10.1.4 and 7.10.8.1. This deficient practice could affect approximately 20 of the 46 residents. Findings include: On 1/17/13 at 10:02am, observation revealed that the north exterior door was identified as an exit by an exit sign above the door. Adjacent to the door was a sign that read "Emergency Fire Exit." However, there was a sign taped onto the center of the door that read "This is not an exit." The conflicting signage on the door could be confusing to people who need to exit the building in an emergency. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 022	• Responsible Party: Director of Maintenance • Date of correction: March 1, 2013	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025	K025 • Facility requests temporary waiver for completion of this correction in order to have architectual consult, obtain contractor bids, and complete work • Proposed date of correction: May 31, 2013	revised 3/11/13

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K 025	Continued From page 4 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect all 46 residents. Findings include: 1. On 1/17/13 at 12:58pm, observation revealed that above the ceiling at the smoke barrier by room 157 the smoke barrier did not extend to the roof deck above. 2. On 1/17/13 at 1:01pm, observation revealed that above the ceiling at the smoke barrier by room 114 the smoke barrier did not extend to the roof deck above. 3. On 1/17/13 at 1:02pm, observation revealed that above the ceiling at the smoke barrier by room 113 the smoke barrier did not extend to the roof deck above. These deficient practices were confirmed by the Director of Maintenance at the time of discovery.	K 025	Amended on 3/11/13 to include: K025: Ducts penetrating the smoke barrier shall be provided with smoke dampers in accordance with Minnesota Mechanical Code and the return air from corridor 136 will be ducted back to the air handling unit. The wall by rooms 113, 114, & 157 shall be extended to the roof deck and designed to smoke barrier wall requirements. Work to be completed by May 31, 2013	3/9/13 Revised 3/11/13
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated	K 027	K027 • Door has been fixed to ensure it closes appropriately.	

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K 027	Continued From page 5 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 observation and interview, the facility failed to provide doors in smoke barrier walls that met the requirements of NFPA 101 - 2000 edition, sections 19.3.7.5, 19.3.7.6 and 8.3.4. This deficient practice could affect approximately 20 of the 46 residents. Findings include: On 1/17/13 at 12:58pm, observation revealed that the coordinator on the cross-corridor smoke barrier doors by room 114 did not function properly when tested and the smoke barrier doors did not close three out of three times when tested. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 027	• All other fire doors have been checked to ensure they function properly • Fire doors will be checked monthly. • Responsible Party: Director of Maintenance • Date of correction: March 1, 2013	
K 038 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K038 • Facility will eliminate grade change utilizing elevation plate or by replacing concrete slab to match grade at exit door. • Other exit doors have been checked to ensure grade change does not exist	

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K 038	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 19.2.2, 7.1.6, 7.1.6.2 and 7.2.1.3. This deficient practice could affect approximately 30 the 46 residents. Findings include: On 1/17/13 at 1:37pm, observation revealed that there was a 1-1/4" grade change at the main dining room exterior exit door. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 038	• Facility requests a temporary waiver for this as weather does not permit cement work at this time. • Proposed date of correction: June 1, 2013	
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to test and to properly document the test of	K 052	K052 • GB Technologies to perform fire alarm system test and inspection to include itemized list of all initiating devices tested. • Report form will be revised to include this information annually during inspection. • Responsible Party: Director of Maintenance • Date of correction: March 20, 2013	

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K 052	Continued From page 7 the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3.1, 7-3.2 and 7.5.2.2. This deficient practice could affect all 46 residents. Findings include: On 1/17/13 at 11:08am, review of the document titled "C B Technologies, Inspection and Testing Form" dated 2/2/12 revealed that the fire alarm system test and inspection report did not include all of the required information. There was no itemized list of all of the initiating devices that were tested. This deficient practice was confirmed by the Facility Administrator and the Director of Maintenance at the time of discovery.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to sensitivity test all of the fire alarm system smoke detectors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Section 7-3.2.1. This deficient practice could affect all 46 residents. Findings include:	K 054	K054 • GB Technologies to perform fire alarm system test and inspection to include a list of each smoke detector, the range they are designed to function within, and actual sensitivity of each smoke detector that was tested. • Report form will be revised to include this information annually during inspection. • Responsible Party: Director of Maintenance • Date of correction: March 20, 2013	

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K 054	Continued From page 8 On 1/17/13 at 11:08am, review of the document titled "C B Technologies, Inspection and Testing Form" dated 2/2/12 revealed that the smoke detector sensitivity testing section of the report did not include all the required information. There was no list of each smoke detector that was tested. There was no information on the range those smoke detectors were designed to function within. There was no information on the actual sensitivity reading of the test and the report did not indicate if the smoke detectors passed or failed the test. This deficient practice was confirmed by the Facility Administrator and the Director of Maintenance at the time of discovery.	K 054		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 056	K056 • Summit Fire, contracted sprinkler company, will correct this by ensuring that the pipe is supported by structure, not by duct work. • Director of Maintenance and sprinkler contractor will audit building to ensure that sprinkler pipes are supported by structure only. • Responsible Party: Director of Maintenance • Date of Correction: March 20, 2013	

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K 056	Continued From page 9 failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Section 6.2.1.3. This deficient practice could affect approximately 20 of the 46 residents. Findings include: On 1/17/13 at 1:03pm, observation revealed that above the ceiling by the nurses station a sprinkler pipe was supported from an air supply duct and not directly from the structure. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 056		
K 062 SS=F	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 observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2.2.1.1 and 2-4.1.4. This deficient practice could affect all 46 residents. Findings include: On 1/17/13 at 1:49pm, observation revealed that there were not two sprinklers in the spare sprinkler box of each type of sprinkler that was	K 062	K062 • Director of Maintenance will obtain 2 additional sprinkler heads for each type used in facility and ensure these are kept in stock. • Responsible Party: Director of Maintenance • Date of Correction: March 20, 2013	

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K 062	Continued From page 10 used in the facility. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 062		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress free of obstructions in accordance with NFPA 101 - 2000 edition, sections 19.2.1, 7.1.10, 7.1.10.1 and 7.1.10.2. This could affect approximately 30 of the 46 residents. Findings include: On 1/17/13 at 1:36pm, observation revealed that the exterior exit door from the main dining room was obstructed by a service cart that was stored in front of the door. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 072	K072 • Cart removed from exit door during survey. • Education provided to all staff to ensure exit doors are not obstructed. • Audits will be completed weekly to ensure exit doors are kept free of obstructions. • Responsible party: Director of Maintenance • Date of Correction: March 1, 2013	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility	K 143	K143 • Liquid Oxygen transfer room will be mechanically ventilated and sprinklered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

(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 11 wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store liquid oxygen in a room that was in accordance with the requirements of NFPA 99 - 1999 edition, Section 8-6.2.5.2. This deficient practice could affect approximately 10 of the 46 residents. Findings include: On 1/17/13 at 1:43pm, observation revealed that the liquid oxygen transferring room was not mechanically ventilated and was not sprinklered. This deficient practice was confirmed by the Director of Maintenance at the time of discovery.	K 143	• Responsible Party: Director of Maintenance • Date of Correction: March 20, 2013	
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is	K 154	K154 • Facility Fire Watch Policy will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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K 154	Continued From page 12 out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a policy that addressed when the sprinkler system was out of service for more than four hours in a 24 hour period as required by NFPA 101 - 2000 edition Section 9.7.6.1. This deficient practice could affect all 46 residents. Findings include: On 1/17/13 at 10:42am, review of the undated document titled Excelsior Health Care Center Fire Protection/Fire Alarm System Impairment" revealed that the policy the facility had when the sprinkler system was out of service did not indicate that the person conducting the fire watch had no other responsibilities while conducting the fire watch. This deficient practice was confirmed by the Facility Administrator and the Director of Maintenance at the time of discovery.	K 154	be revised to indicate that the person doing the fire watch has no other responsibilities. • Education of this policy will be provided to all staff . • Responsible Party: Executive Director • Date of Correction: March 1, 2013	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155	K155 • Facility Fire Watch Policy will be revised to indicate that the person doing the fire watch has no other responsibilities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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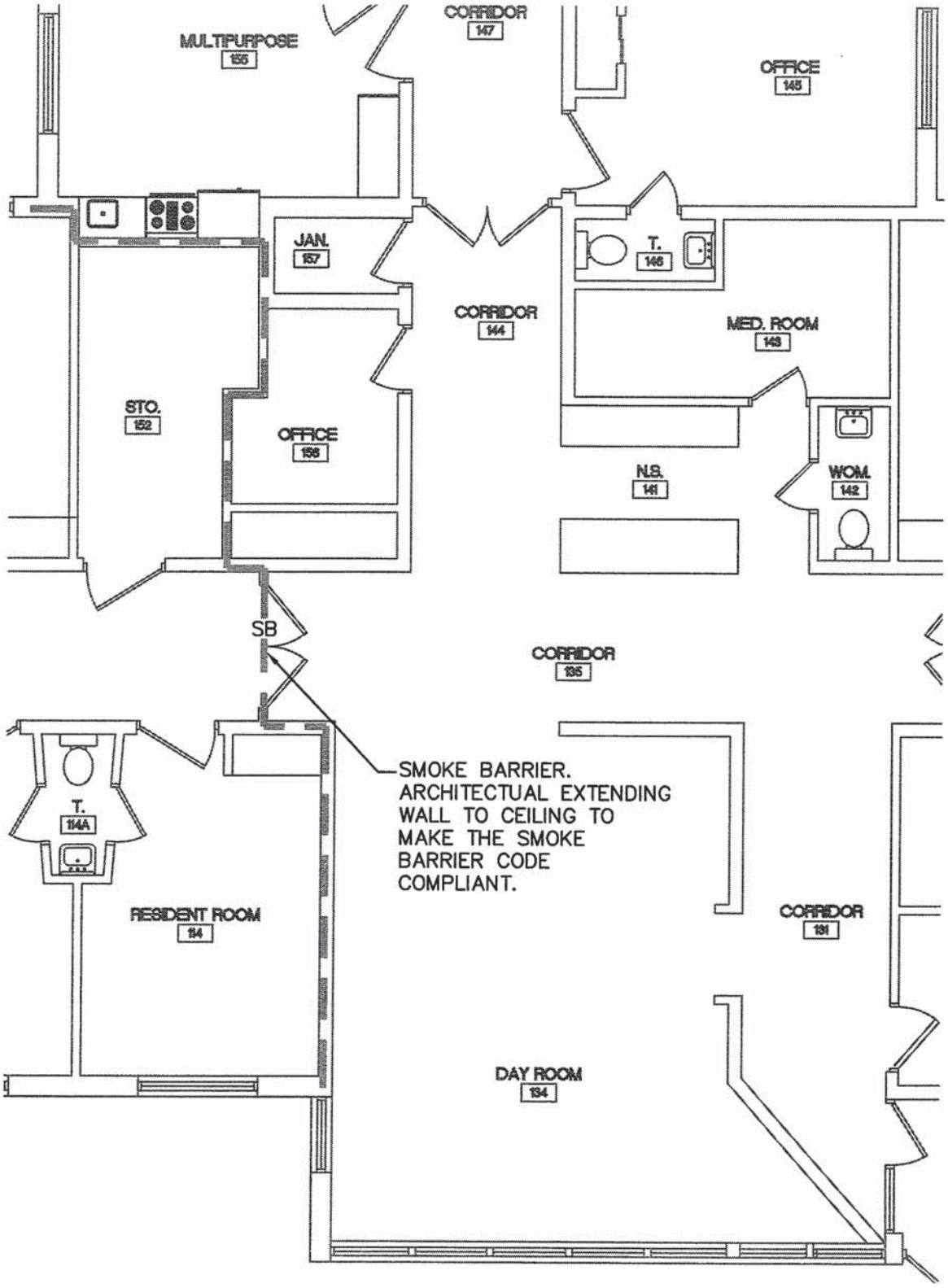
K 155	Continued From page 13 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a policy that addressed when the fire alarm system was out of service for more than four hours in a 24 hour period as required by NFPA 101 - 2000 edition Section 9.6.1.8. This deficient practice could affect all 46 residents. Findings include: On 1/17/13 at 10:42am, review of the undated document titled Excelsior Health Care Center Fire Protection/Fire Alarm System Impairment" revealed that the policy the facility had when the fire alarm system was out of service did not indicate that the person conducting the fire watch had no other responsibilities while conducting the fire watch. This deficient practice was confirmed by the Facility Administrator and the Director of Maintenance at the time of discovery.	K 155	• Education of this policy will be provided to all staff . • Responsible Party: Executive Director • Date of Correction: March 1, 2013	


MULTIPURPOSE
155
CORRIDOR
147
OFFICE
145
JAN.
157
T.
146
CORRIDOR
144
MED. ROOM
143
STO.
152
OFFICE
156
N.S.
141
WOM.
142
SB
CORRIDOR
135
SMOKE BARRIER.
ARCHITECTUAL EXTENDING
WALL TO CEILING TO
MAKE THE SMOKE
BARRIER CODE
COMPLIANT.
T.
114A
RESIDENT ROOM
114
CORRIDOR
131
DAY ROOM
134

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9R07

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245332**
2.STATE VENDOR OR MEDICAID NO.
(L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - EXCELSIOR**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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)

6. DATE OF SURVEY **12/20/2012** (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 IMR**	**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 **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Candace Bolduc, HFE NE II 01/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/14/2013 (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 2/14/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5332

At the time of the standard survey completed December 21, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 6474

January 11, 2013

Ms. Mary Harrel, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

RE: Project Number S5332022 and H5332022

Dear Ms. Harrel:

On December 21, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 21, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5332022. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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 December 21, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5332022 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794

Fax: (651) 201-3790

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 January 29, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 March 20, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 20, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5332s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

(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. Complaint #H5332022 was investigated at the time of the survey and was found to be unsubstantiated.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 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	F 279	F 279 -Resident 38 has a comprehensive care plan in place that addresses Deep tissue injury. -Care plans for all other residents with deep tissue injuries will be reviewed for accuracy.	1/29/13

POC accepted as effective 1/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim Administrator	1/17/13

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
	245332	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

(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 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R38) in the sample who had a deep tissue injury. Findings include: The facility failed to develop a comprehensive care plan for R38 for a deep tissue injury. On 12/19/12, at 9:41 a.m. during observation of cares for R38 staff were observed to remove R38's soft slippers. A quarter size (approximately) purplish blue intact area was observed on outer side of resident's left heel. R38 was admitted to the facility in 9/12 with diagnoses including dementia, peripheral vascular disease, peripheral neuropathy, obesity, and diabetes. A progress note dated 12/16/12, identified the presence of a left inner aspect of heel that appeared dark purple in color in the center and reddened skin surrounding that measured approximately two centimeter (cm) in circumference. When interviewed on 12/18/12, at 9:15 a.m. the director of nursing (DON) stated R38 had a suspected deep tissue injury (purple mark) on side of left heel which recently developed. R38's quarterly Minimum Data Set (MDS) assessment dated 12/15/12, did not reflect the	F 279	-Licensed staff will receive education on timely updating of care plan to indicate discovery of deep tissue injuries and initiation of appropriate nursing interventions. -Audits will be completed weekly on care plans of residents with deep tissue injuries to ensure deep tissue injuries have been identified and appropriate nursing interventions have been implemented. -Results of audits will be reviewed in QAPI -Responsible party is DNS the facility will ensure care plans for all residents will be updated at the time of their next MDS assessment. gf per admin. 1/24/13 RECEIVED JAN 18 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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	245332	A. BUILDING _____ B. WING _____	12/20/2012

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F 279	Continued From page 2 presence of venous or arterial ulcers during the assessment period, and no foot problems or interventions were identified. R38's care plan dated 9/17/12, identified the resident as at risk for pressure ulcer due to the skin being desensitized, diagnoses of peripheral vascular disease, Braden score (for measuring pressure ulcer risk)of 15, obesity, presence of edema (excess fluid in the tissues) and bowel incontinence. The goal stated "Skin will remain intact." The care plan failed to identify the suspected deep tissue injury to the left heel and relevant interventions. When interviewed on 12/20/12, at 3:30 p.m. the DON confirmed the care plan was not updated. No further information was provided. The Skin Integrity Guideline dated 1/11, indicated "The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified."	F 279		
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 assistance for 1 of 3 residents (R68) who was unable to	F 282	F 282 - Resident 68 is provided assistance for oral cares per care plan -All residents that are unable to complete oral cares independently would have the potential to be effected. -Nursing staff will be educated to complete oral cares per care plan. -Minimally, weekly audits to be completed to ensure that residents requiring assistance with oral cares receive per care plan.	1/29/13

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F 282	Continued From page 3 independently complete oral cares. Findings include: R68 was not provided assistance with oral care according to her care plan dated 10/17/12. The plan noted the resident had a self-care impairment, and staff was directed to provide assistance of one to perform oral cares. At 9:26 a.m. on 12/18/12, R68 was observed with a heavy build up of white matter and accumulated food along the bottom gum line of her natural lower teeth; no upper teeth were present. The resident demonstrated confusion and difficulty answering questions. The following two days the resident's condition of her teeth remained the same with a thick white matter and accumulated food along the bottom gum line and no upper teeth at 9:30 a.m. on 12/19/12 and at 8:30 a.m. on 12/20/12. At 9:35 a.m. on 12/20/12, the nursing assistant (NA)-A was interviewed, and stated, R68 required limited assistance from staff for activities of daily living including oral care. At 9:38 a.m. on 12/2012, the ADON was interviewed, and stated, R68 needed limited assistance from staff and reminders to ask for help for activities of daily living including oral care. At 9:40 a.m. on 12/20/12, the ADON was asked to assess the current condition of R68's teeth. The ADON stated, "It looks like she needs to have her teeth brushed." The ADON described R68's gum line as having a build up of food and plaque along her bottom gum line. The ADON verified R68 required daily assistance of staff for oral care management.	F 282	-Results of audits will be reviewed in QAPI -Responsible party is DNS	

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F 282	Continued From page 4 The facility Oral Hygiene policy dated 2006, read that the basic responsibility of the licensed nurse, nursing assistant and other staff was to cleanse the mouth, teeth and dentures of residents, to prevent infection and irritation, to moisten mucous membranes and to promote personal hygiene. The policy directed staff to assist residents with positioning, setting up supplies and assist residents as needed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance for 1 of 3 residents (R68) who was unable to independently complete oral cares. Findings include: R68 was not provided assistance with oral care. R68 was admitted to the facility on 10/5/12, with diagnoses including advanced dementia with behavioral complications. At 9:26 a.m. on 12/18/12, R68 was observed with a heavy build up of white matter and accumulated food along the bottom gum line of her natural lower teeth; no upper teeth were present. The resident demonstrated confusion and difficulty	F 311	F 311 - Resident 68 is provided assistance for oral cares per care plan -All residents that are unable to complete oral cares independently would have the potential to be effected. -Nursing staff will be educated to complete oral cares per care plan. -Minimally, weekly audits to be completed to ensure that residents requiring assistance with oral cares receive per care plan. -Results of audits will be reviewed in QAPI -Responsible party is DNS	1/29/13

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F 311	Continued From page 5 answering questions. The following two days the resident's condition of her teeth remained the same with a thick white matter and accumulated food along the bottom gum line and no upper teeth at 9:30 a.m. on 12/19/12 and at 8:30 a.m. on 12/20/12. At 9:35 a.m. on 12/20/12, the nursing assistant (NA)-A was interviewed, and stated, R68 required limited assistance from staff for activities of daily living including oral care. At 9:38 a.m. on 12/2012, the ADON was interviewed, and stated, R68 needed limited assistance from staff and reminders to ask for help for activities of daily living including oral care. At 9:40 a.m. on 12/20/12, the ADON was asked to assess the current condition of R68's teeth. The ADON stated, "It looks like she needs to have her teeth brushed." The ADON described R68's gum line as having a build up of food and plaque along her bottom gum line. The ADON verified R68 required daily assistance of staff for oral care management. R68's Minimum Data Set initial (MDS) dated 10/12/12 indicated the resident resisted care 1-3 days during the assessment period and had memory problems. She required extensive assistance of one person with activities of daily living, although was capable of increased independence. Broken or loose fitting full or partial dentures was identified. R68's dental care plan dated 10/17/12, noted R68 had a physical functioning deficit related to self-care impairment, and, mobility impairment.	F 311		

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F 311	Continued From page 6 Staff was to provide assistance of one staff for oral cares, and dental exams as necessary to maintain current level of physical functioning. The facility Oral Hygiene policy dated 2006, read that the basic responsibility of the licensed nurse, nursing assistant and other staff was to cleanse the mouth, teeth and dentures of residents, to prevent infection and irritation, to moisten mucous membranes and to promote personal hygiene. The policy directed staff to assist residents with positioning, setting up supplies and assist residents as needed.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess nutritional needs and determine immediate interventions after 1 of 1 resident (R32) experienced a choking episode and subsequent weight loss. Findings include:	F 325	F 325 -Resident 32 has been assessed for nutritional needs and appropriate interventions have been care planned. - Residents determined to be at nutritional risk have a potential to be effected. - Nursing and dietary will be educated on implementation and provision of appropriate nutritional needs per care plan. -Weekly audit of nutritional needs to be conducted to ensure compliance with care plan. -Results of audits will be reviewed in QAPI -Responsible party is DNS/DSM	1/29/13

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F 325	Continued From page 7 R32 was not provided with adequate interventions following a choking episode. The resident expressed fear of choking and discomfort with eating, and experienced weight loss after the choking incident. The facility failed to ensure interventions were in place to reduce the risk of the resident aspirating and choking following a previous choking incident involving the Heimlich maneuver. R32 was admitted to the facility on 2/20/12 with diagnoses including metabolic encephalopathy, depressive disorder, and cognitive impairment. Nursing notes revealed the resident experienced a choking episode resulting in the need for the Heimlich maneuver to dislodge the food on 12/14/12. An incident report dated 12/14/12, identified R32 choked on food and required the Heimlich maneuver to be performed. During the incident R32 coughed up a chunk of food which consisted of ham and yams. R32 was being treated for pneumonia and receiving speech therapy services at the time of the incident. R32's diet was changed from a regular texture to a mechanical soft texture on 12/14/12. R32 was observed during lunch at 1:00 p.m. on 12/18/12. The resident was provided a plate with seafood quiche, spinach and Texas toast. R32 stated, "I do not like quiche." The resident was provided an alternative plate with large pieces of baked ham, sliced buttered potato and beans. The resident demonstrated difficulty with feeding herself. The director of nursing (DON) sat next to	F 325		

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F 325	Continued From page 8 the resident during the lunch meal. R32 stated, "I shake too much--I cannot pick up my food." The DON recommended the resident use a fork instead of a spoon. R32 was observed to chew one piece of ham. R32 attempted to swallow the ham and stated, "I can't get this down. If I choke on it, I will let you [the DON] do the Heimlich, but I do not want to do the Heimlich." At 1:10 p.m. the DON requested dietary staff provide smaller pieces of ham. R32 was provided a bowl with smaller, cubed pieces of ham. R32 was observed grabbing her neck stating, "It hurts. I am not going to eat anymore." R32 declined to eat any more food. At 1:25 p.m. the DON verified R32 was supposed to be on a mechanical soft diet due to a recent choking episode. R32 was observed during breakfast at 8:45 a.m. on 12/19/12. The resident was provided a plate with eggs, a biscuit, and hot cereal. The resident demonstrated difficulty opening a sugar packet, as well as in feeding herself, due to shaking of her right upper extremity. At 8:50 a.m. the speech/language pathologist (SLP) sat down beside the resident. R32 informed the SLP as she pointed to her throat, "I am trying to get this down. I don't want my eggs and biscuit. They don't go down. If I wasn't so shaky I would do all right." At 8:55 a.m. the resident swallowed some hot cereal and began coughing and then ate some eggs and asked the SLP, "Is it going down okay?" The SLP responded, "Chew those eggs up good." The resident held her throat multiple times during the observation, and was instructed by the SLP to drink fluid. At 8:57 a.m. R32 pointed to the biscuit and stated, "I am never going to eat that--that won't work." The SLP responded that the eggs went down "okay," however, R32 displayed facial	F 325		

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F 325	Continued From page 9 grimacing and continued to hold her throat. R32 began coughing on hot cereal and the SLP asked, "Was it sticking? You can swallow twice to get it down." R32 responded, "I'll never get it down." The SLP informed the resident she did not have to eat it, however, the resident continued eating and coughing on the hot cereal. At 9:00 a.m. R32 stated, "I have to go." The SLP instructed her to drink some liquids. R32 responded, "I am trying to eat but it hurts." The SLP told her, "You will heal up--it will get better. Just chew it up really nice--just chew it up good." The resident continued grimacing and coughing and stated, "I can't. I think I better go. I need a Tylenol--this is such a bother. I just can't get my breath--this hurts." The SLP informed the resident, "You are getting better." At 9:11 a.m. the resident wheeled herself away from the dining room. She had consumed 100 percent (%) of the hot cereal, none of the biscuit, and approximately 10% of the eggs. At 12:50 p.m. on 12/20/12, R32 was again observed during mealtime. She was served Polish sausage, cubed potatoes, and squash. No staff were seated next to her during the meal. R32 moaned and groaned with each bite of food she consumed, as well as between bites of food. She also grabbed at her neck stating, "Ouch...ouch...." R32 consumed less than 25% of the meal. The Meal Log record for R32 during the week of 12/12/12-12/19/12, was reviewed. The log indicated R32 consumed 75-100 percent of her breakfast 6 of the 7 days, 50-100 percent of her lunch 4 of the 7 days and 50-100 percent of her dinner 5 of the 7 days. The director of nursing	F 325		

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F 325	Continued From page 10 (DON) verified the meal consumption monitoring was inaccurate stating, "I don't think what is in the computer is accurate. I am not going to lie to you." She confirmed the nursing assistants (NAs) were responsible for monitoring resident intake. The DON stated she and the ADON were also involved in monitoring and tracking resident weights. R32 had been receiving a supplement, which the DON explained had been discontinued on 9/9/12. At 9:15 a.m. on 12/19/12, the SLP was interviewed, and stated speech therapy was initiated for R32 because she was having difficulty swallowing pills and was refusing pills because of this. The SLP further stated R32 had progressed in therapy, and she was getting ready to discharge the resident from therapy last Wednesday. The SLP reported the resident had a current diagnosis of pneumonia, was very congested, and then on Friday she had a choking episode. The SLP stated up until Friday, the resident received a regular diet and had been consuming 100% of her food. "Currently, she is scared to eat now," because of the episode. The SLP reported the resident stayed away from things like eggs and "tends to go for more creamier food." She verified the resident's throat must be irritated, as she did complain it hurt... "plus she has the cough, so her appetite was not as good." The SLP stated R32 had consumed 25% of her meal. She confirmed the resident now received a mechanical soft diet with thin liquids, and medication was being administered whole in applesauce. The SLP stated she talked to R32 that day about having her medication crushed. The SLP stated she expected the meat for a mechanical soft diet would be ground. She stated	F 325		

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F 325	Continued From page 11 she sometimes recommended extra gravy be added. She did not typically recommend bacon be served. She stated she utilized communication sheets to communicate with staff, but confirmed, "I don't have one for [R32]." She stated if diet orders where changed, she usually wrote a "clarification order." The SLP stated, "I am very surprised R32 was provided ham during lunch," and verified the resident was at risk for choking and aspiration. At 9:30 a.m. on 12/19/12, the dietary services director was interviewed. She stated she was aware R32 did not want quiche for the lunch meal on the previous day and staff mistakenly provided her with regular ham as an alternative. The dietary services director further stated staff identified the mistake and provided R32 with smaller pieces of ham. The dietary services director verified R32 was on a mechanical soft diet and stated R32 should have received "ground up ham." At 9:45 a.m. on 12/19/12, the director of nursing (DON) was interviewed and explained R32 needed more assistance than she had in the past, and had experienced a change in the last week after the choking incident. The resident was described as being "fearful of eating" and the facility obtained a psychological referral, as well as a palliative care social worker who came to see her. The DON verified in the previous two days R32 had consumed less than 10 percent of her meals. R32's daughter was interviewed on 12/19/12, at 10:15 a.m. She stated the ADON called her and reported "my mom choked on some ham and he	F 325		

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F 325	Continued From page 12 did the Heimlich maneuver." The daughter reported R32 was receiving speech therapy now, but she was having a hard time eating and had a cold and pneumonia. The daughter stated, "I am surprised that she would eat ham again because she was upset about choking on the ham, and refused to eat initially and now staff have to encourage her and provide support. I also have not been following the rules completely and have been bringing cut up grapes because my big thing now is that she gets food, and I know she likes the grapes. I know they take good care of her and she can be a handful. I would rather her eat something." The daughter stated staff had not explained the risks and benefits of not following the orders for a mechanical soft diet. At 11:00 a.m. on 12/19/12, the DON and the dietitian were interviewed. They reported the physician was "on his way to assess her" current nutritional status. The DON stated a staff meeting had been held to ensure documentation accuracy of meal consumption, and some staff were given verbal warnings "so that we can continue to go forward.". She further stated the resident continued to receive the mechanical soft diet and the SLP increased sessions to five times weekly, as R32 was having some fear regarding her eating, and 1:1 reassurance was being provided. R32's mechanical soft diet was reflected on the meal card. In addition, R32 was taking an antibiotic for pneumonia that may have been upsetting her stomach. The DON said the pneumonia diagnosis was made prior to the choking incident. The dietitian confirmed textured crisp bacon was allowed on the mechanical soft diet unless there was a specific order for "no bacon." The resident was served ham because	F 325		

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F 325	Continued From page 13 she declined the quiche. The registered dietician stated, "I am not sure if she got the ham or not, and another staff member was actually the one that went and got the other meal. I honestly--I can't tell you. I did not see any choking or swallowing." At 2:10 p.m. on 12/20/12, the DON was asked to provided information on how R32 was assessed following the choking incident to determine fear and anxiety versus a trauma to her throat. The DON stated, "We do not have an actual assessment. In talking [R32], said she was fearful. I think I have some documentation--part of it. I talked to her in great length on Monday, and that is the biggest fault of my own that I did not document my conversation." The DON verified she was aware of R32 grabbing at ther throat during meals and complaining of pain. At 2:30 p.m. on 12/20/12, the DON stated she thought R32 had an order for Tylenol. "I know [R32] has had cough medicine today at 10:30 a.m. for complaints of a sore throat and cough. Maybe I am wrong and she did not get any Tylenol." The DON further stated, "I don't even have an order for Tylenol. Right now she just has the order that was started today for cough medicine." The DON verified the resident had not received Tylenol the previous day as she requested. The DON verified R32 had not received any pain medications since the choking incident on 12/14/12 despite verbalized and demonstrated irritation/pain with swallowing meals. The DON further stated, "I am really hopeful that this irritation will go away, and the plan is to follow up in a week with the doctor, and then it will be up to him to see how she is doing	F 325		

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	245332	A. BUILDING _____ B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	516 DIVISION STREET EXCELSIOR, MN 55331

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F 325	Continued From page 14 next week." The DON verified that the physician observed the resident as she ate the mechanical soft diet versus a regular diet. She confirmed the resident's diet had been changed to an as tolerated order on 12/19/12 after the physcian met with R32 and her daughter. The DON stated she thought the resident's daughter had the biggest influence on his decision to order a regular diet for the resident. A licensed practical nurse (LPN)-A was interviewed on 12/20/12, at 2:45 p.m. and reported, "She [R32] has been coughing a little bit more in the past few days and requested to have some cough medicine." The LPN stated the night nurse had also mentioned in report that [R32] had been coughing intermittently during the night. The LPN placed an order for cough medicine on 12/20/12, six days following the choking incident, but no order for Tylenol had been obtained. R32's record revealed a Hospital Discharge Summary dated 2/19/12 that listed diagnoses of malnutrition and dementia. A physician's order dated 11/8/12, was for "speech therapy [ST] to evaluate and treat for dysphasia" (swallowing disorder). A clarification the following day indicated speech therapy should evaluate and treat the resident three times weekly for thirty days, addressing swallowing in individual and group settings. The Speech Therapy Plan of Care dated 11/9/12, identified R32 was referred to ST for dysphasia due to nursing cocerns of R32 experiencing increased difficulty at meals and increased difficulty swallowing pills. Without therapy, R32 was identified as "at risk for aspiration/choking."	F 325		

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F 325	Continued From page 15 In the Initial Assessment, R32 was independent at mealtime with feeding herself, but required assistance to cut food into small pieces. The resident consumed up to 100% of meals, but did require encouragement to increase fluid intake. The Speech Therapy Progress and Updated Plan of Care dated 12/9/12, identified R32 was being treated for dysphasia. R32 was noted to be tolerating the current diet of regular textures with thin liquids without much difficulty and tolerating pill pass, however it was noted in the past week the resident had experienced increased difficulty with swallowing. The report revealed R32 was complaining pills felt like they were "getting stuck" in her throat. The report identified R32's oral intake also decreased from 100 percent to between 25-50 percent. R32 was identified to be at risk for aspiration and choking. The Comprehensive Assessment dated 11/29/12, identified R32 was on a regular diet with a history of anorexia and malnutrition. R32's weight was noted to be 113 and stable. R32 was identified to require limited to extensive assist with all areas of activities of daily living (ADL'S). R32's care plan dated 2/22/12, identified the resident as at nutritional risk due to below ideal body weight and difficulty eating independently. Goals were for her laboratory values to return to normal and remain within normal limits, and to consume 50% of meals to meet energy requirements, having no weight loss in 90 days. Interventions directed staff to provide diet as ordered, fortified foods with meals, invite to food related activities, monitor meal consumption daily, monthly weights, obtain food/beverage	F 325		

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F 325	Continued From page 16 preferences, provide substitutes, snacks between meals, and adaptive equipment. At 3:00 p.m. on 12/19/12, the DON stated the physician met with R32 and her daughter. A house supplement was being initiated, and her diet was changed from mechanical soft to "whatever [R32] will eat." According to the resident's daughter, she did not care what she ate, as long as she ate. The physician also ordered some laboratory work. The plan was to weigh her in the coming week and update the physician. The resident was weighed and R32 was down six pounds in 16 days.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 - Resident 6 has had pharmacy recommendations reviewed by PMD. - All residents with pharmacy recommendations have a potential to be effected. - Licensed staff will be educated to follow up with MD on all pharmacy recommendations in a timely manner. - Monthly Audits will be completed on all pharmacy recommendations to ensure timely follow up. -Results of audits will be reviewed in QAPI -Responsible party is DNS the facility will ensure all residents will be reviewed for unnecessary drugs by their next MDS assessment. gsr- per administrator 1/24/13	1/29/13

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F 329	Continued From page 17	F 329		

This REQUIREMENT is not met as evidenced by:
Based on document review, and interview, the facility failed to follow up with pharmacy recommendations with the attending physician for 1 of 10 residents in the sample (R6) who were reviewed for unnecessary medications.

Findings include:

R6 had physician orders dated 11/29/12, included Remeron (mirtazepine)15 milligrams (mg) at bedtime daily depression since 11/3/10, as well as vitamin D (encourages the absorption and metabolism of calcium and phophorus) 2000 unit capsule daily for vitamin D deficiency since 8/31/11, and then changed on 9/3/11 for calcium with vitamin D (bone supplement) 600-200 mg-unit two times a day after a fracture.

Pharmacy recommendations for R6 dated 10/25/12, indicated "[R6] is on Remeron 15 mg since November 2011. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose." Pharmacy recommendations for R6 dated 1/3/12, indicated, "This resident has been on Vitamin D 2,000 units since 8/10, and Ca+ Vit 200 units bid (a total of 2400 units daily). Would you please consider, if it would be appropriate to check Vit D level?" A review of the physician visits and labwork following the recommendations by the pharmacist

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F 329	Continued From page 18 revealed the vitamin D level and laboratory testing were not completed. A physician visit dated 11/29/12, did not address any of the pharmacy recommendations and the "Nursing Communication: Reason for Visit" was left blank. The Medication Monitoring Medication Regimen Review and Reporting policy and procedure dated 10/07, indicated "The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. Those with authority and responsibility include the administrator and the director of nursing, and may also include the attending physician and the medical director, where appropriate." On 12/20/12, at 1:52 p.m. the assistant director of nursing (ADON) reviewed the unaddressed pharmacy recommendations for R6. The ADON stated the expectation was that the nurses send the physician the recommendations via a fax, and then check back in a few days to see if a response was received. If not, a fax was to be re-sent. Since R6 went out to see the physician, the ADON stated would expect the nurse to write the unaddressed recommendation on the reason for visit part of the physician visit form. If the physician still did not address the concern, it would be expected the nurse contact the physician by phone. The ADON confirmed the pharmacy recommendations for a gradual dose reduction (GDR) for the Remeron and lab to check vitamin D level had not been addressed for R6.	F 329		

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	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/21/2012**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 21, 2012. At the time of this survey, Golden Livingcenter Excelsior was found in 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. This 1-story building was determined to be of Type II(222) construction. It has a partial 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 corridor that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 48 beds at the time of the survey.	K 000		

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 6474

January 11, 2013

Ms. Mary Harrel, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, Minnesota 55331

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5332022 and H5332022

Dear Ms. Harrel:

The above facility was surveyed on December 17, 2012 through December 20, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5332022 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

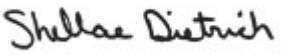
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your 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,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5332s13lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00988	A. BUILDING _____ B. WING _____	12/20/2012

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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: On December 17, 18, 19, and 20, 2012 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	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.	

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2 000	Continued From page 1 Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	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 which 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.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557,	2 560		

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2 560	Continued From page 2 subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R38) in the sample who had a deep tissue injury. Findings include: The facility failed to develop a comprehensive care plan for R38 for a deep tissue injury. On 12/19/12, at 9:41 a.m. during observation of cares for R38 staff were observed to remove R38's soft slippers. A quarter size (approximately) purplish blue intact area was observed on outer side of resident's left heel. R38 was admitted to the facility in 9/12 with diagnoses including dementia, peripheral vascular disease, peripheral neuropathy, obesity, and diabetes. A progress note dated 12/16/12, identified the presence of a left inner aspect of heel that appeared dark purple in color in the center and reddened skin surrounding that measured approximately two centimeter (cm) in circumference. When interviewed on 12/18/12, at 9:15 a.m. the director of nursing (DON) stated R38 had a suspected deep tissue injury (purple mark) on side of left heel which recently developed. R38's quarterly Minimum Data Set (MDS) assessment dated 12/15/12, did not reflect the presence of venous or arterial ulcers during the assessment period, and no foot problems or interventions were identified.	2 560		

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2 560	Continued From page 3 R38's care plan dated 9/17/12, identified the resident as at risk for pressure ulcer due to the skin being desensitized, diagnoses of peripheral vascular disease, Braden score (for measuring pressure ulcer risk)of 15, obesity, presence of edema (excess fluid in the tissues) and bowel incontinence. The goal stated "Skin will remain intact." The care plan failed to identify the suspected deep tissue injury to the left heel and relevant interventions. When interviewed on 12/20/12, at 3:30 p.m. the DON confirmed the care plan was not updated. No further information was provided. The Skin Integrity Guideline dated 1/11, indicated "The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
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.	2 565		

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2 565	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance for 1 of 3 residents (R68) who was unable to independently complete oral cares. Findings include: R68 was not provided assistance with oral care according to her care plan dated 10/17/12. The plan noted the resident had a self-care impairment, and staff was directed to provide assistance of one to perform oral cares. At 9:26 a.m. on 12/18/12, R68 was observed with a heavy build up of white matter and accumulated food along the bottom gum line of her natural lower teeth; no upper teeth were present. The resident demonstrated confusion and difficulty answering questions. The following two days the resident's condition of her teeth remained the same with a thick white matter and accumulated food along the bottom gum line and no upper teeth at 9:30 a.m. on 12/19/12 and at 8:30 a.m. on 12/20/12. At 9:35 a.m. on 12/20/12, the nursing assistant (NA)-A was interviewed, and stated, R68 required limited assistance from staff for activities of daily living including oral care. At 9:38 a.m. on 12/2012, the ADON was interviewed, and stated, R68 needed limited assistance from staff and reminders to ask for help for activities of daily living including oral care. At 9:40 a.m. on 12/20/12, the ADON was asked to assess the current condition of R68's teeth. The ADON	2 565		

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2 565	Continued From page 5 stated, "It looks like she needs to have her teeth brushed." The ADON described R68's gum line as having a build up of food and plaque along her bottom gum line. The ADON verified R68 required daily assistance of staff for oral care management. The facility Oral Hygiene policy dated 2006, read that the basic responsibility of the licensed nurse, nursing assistant and other staff was to cleanse the mouth, teeth and dentures of residents, to prevent infection and irritation, to moisten mucous membranes and to promote personal hygiene. The policy directed staff to assist residents with positioning, setting up supplies and assist residents as needed. SUGGESTED METHOD OF CORRECTION: The administrator 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		
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;	2 915		

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2 915	Continued From page 6 (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance for 1 of 3 residents (R68) who was unable to independently complete oral cares. Findings include: R68 was not provided assistance with oral care. R68 was admitted to the facility on 10/5/12, with diagnoses including advanced dementia with behavioral complications. At 9:26 a.m. on 12/18/12, R68 was observed with a heavy build up of white matter and accumulated food along the bottom gum line of her natural lower teeth; no upper teeth were present. The resident demonstrated confusion and difficulty answering questions. The following two days the resident's condition of her teeth remained the same with a thick white matter and accumulated food along the bottom gum line and no upper teeth at 9:30 a.m. on 12/19/12 and at 8:30 a.m. on 12/20/12. At 9:35 a.m. on 12/20/12, the nursing assistant (NA)-A was interviewed, and stated, R68 required limited assistance from staff for activities of daily living including oral care.	2 915		

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2 915	Continued From page 7 At 9:38 a.m. on 12/2012, the ADON was interviewed, and stated, R68 needed limited assistance from staff and reminders to ask for help for activities of daily living including oral care. At 9:40 a.m. on 12/20/12, the ADON was asked to assess the current condition of R68's teeth. The ADON stated, "It looks like she needs to have her teeth brushed." The ADON described R68's gum line as having a build up of food and plaque along her bottom gum line. The ADON verified R68 required daily assistance of staff for oral care management. R68's Minimum Data Set initial (MDS) dated 10/12/12 indicated the resident resisted care 1-3 days during the assessment period and had memory problems. She required extensive assistance of one person with activities of daily living, although was capable of increased independence. Broken or loose fitting full or partial dentures was identified. R68's dental care plan dated 10/17/12, noted R68 had a physical functioning deficit related to self-care impairment, and, mobility impairment. Staff was to provide assistance of one staff for oral cares, and dental exams as necessary to maintain current level of physical functioning. The facility Oral Hygiene policy dated 2006, read that the basic responsibility of the licensed nurse, nursing assistant and other staff was to cleanse the mouth, teeth and dentures of residents, to prevent infection and irritation, to moisten mucous membranes and to promote personal hygiene. The policy directed staff to assist residents with positioning, setting up supplies and assist residents as needed.	2 915		

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2 915	Continued From page 8 SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with oral care. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 915		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess nutritional needs and determine immediate interventions after 1 of 1 resident (R32) experienced a choking episode and subsequent weight loss. Findings include: R32 was not provided with adequate interventions following a choking episode. The resident	2 965		

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2 965	Continued From page 9 expressed fear of choking and discomfort with eating, and experienced weight loss after the choking incident. The facility failed to ensure interventions were in place to reduce the risk of the resident aspirating and choking following a previous choking incident involving the Heimlich maneuver. R32 was admitted to the facility on 2/20/12 with diagnoses including metabolic encephalopathy, depressive disorder, and cognitive impairment. Nursing notes revealed the resident experienced a choking episode resulting in the need for the Heimlich maneuver to dislodge the food on 12/14/12. An incident report dated 12/14/12, identified R32 choked on food and required the Heimlich maneuver to be performed. During the incident R32 coughed up a chunk of food which consisted of ham and yams. R32 was being treated for pneumonia and receiving speech therapy services at the time of the incident. R32's diet was changed from a regular texture to a mechanical soft texture on 12/14/12. R32 was observed during lunch at 1:00 p.m. on 12/18/12. The resident was provided a plate with seafood quiche, spinach and Texas toast. R32 stated, "I do not like quiche." The resident was provided an alternative plate with large pieces of baked ham, sliced buttered potato and beans. The resident demonstrated difficulty with feeding herself. The director of nursing (DON) sat next to the resident during the lunch meal. R32 stated, "I shake too much--I cannot pick up my food." The DON recommended the resident use a fork instead of a spoon. R32 was observed to chew one piece of ham. R32 attempted to swallow the	2 965		

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2 965	Continued From page 10 ham and stated, "I can't get this down. If I choke on it, I will let you [the DON] do the Heimlich, but I do not want to do the Heimlich." At 1:10 p.m. the DON requested dietary staff provide smaller pieces of ham. R32 was provided a bowl with smaller, cubed pieces of ham. R32 was observed grabbing her neck stating, "It hurts. I am not going to eat anymore." R32 declined to eat any more food. At 1:25 p.m. the DON verified R32 was supposed to be on a mechanical soft diet due to a recent choking episode. R32 was observed during breakfast at 8:45 a.m. on 12/19/12. The resident was provided a plate with eggs, a biscuit, and hot cereal. The resident demonstrated difficulty opening a sugar packet, as well as in feeding herself, due to shaking of her right upper extremity. At 8:50 a.m. the speech/language pathologist (SLP) sat down beside the resident. R32 informed the SLP as she pointed to her throat, "I am trying to get this down. I don't want my eggs and biscuit. They don't go down. If I wasn't so shaky I would do all right." At 8:55 a.m. the resident swallowed some hot cereal and began coughing and then ate some eggs and asked the SLP, "Is it going down okay?" The SLP responded, "Chew those eggs up good." The resident held her throat multiple times during the observation, and was instructed by the SLP to drink fluid. At 8:57 a.m. R32 pointed to the biscuit and stated, "I am never going to eat that--that won't work." The SLP responded that the eggs went down "okay," however, R32 displayed facial grimacing and continued to hold her throat. R32 began coughing on hot cereal and the SLP asked, "Was it sticking? You can swallow twice to get it down." R32 responded, "I'll never get it down." The SLP informed the resident she did not have to eat it, however, the resident continued eating and coughing on the hot cereal. At 9:00	2 965		

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2 965	Continued From page 11 a.m. R32 stated, "I have to go." The SLP instructed her to drink some liquids. R32 responded, "I am trying to eat but it hurts." The SLP told her, "You will heal up--it will get better. Just chew it up really nice--just chew it up good." The resident continued grimacing and coughing and stated, "I can't. I think I better go. I need a Tylenol--this is such a bother. I just can't get my breath--this hurts." The SLP informed the resident, "You are getting better." At 9:11 a.m. the resident wheeled herself away from the dining room. She had consumed 100 percent (%) of the hot cereal, none of the biscuit, and approximately 10% of the eggs. At 12:50 p.m. on 12/20/12, R32 was again observed during mealtime. She was served Polish sausage, cubed potatoes, and squash. No staff were seated next to her during the meal. R32 moaned and groaned with each bite of food she consumed, as well as between bites of food. She also grabbed at her neck stating, "Ouch...ouch...." R32 consumed less than 25% of the meal. The Meal Log record for R32 during the week of 12/12/12-12/19/12, was reviewed. The log indicated R32 consumed 75-100 percent of her breakfast 6 of the 7 days, 50-100 percent of her lunch 4 of the 7 days and 50-100 percent of her dinner 5 of the 7 days. The director of nursing (DON) verified the meal consumption monitoring was inaccurate stating, "I don't think what is in the computer is accurate. I am not going to lie to you." She confirmed the nursing assistants (NAs) were responsible for monitoring resident intake. The DON stated she and the ADON were also involved in monitoring and tracking resident weights. R32 had been receiving a supplement, which the DON explained had been discontinued	2 965		

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2 965	Continued From page 12 on 9/9/12. At 9:15 a.m. on 12/19/12, the SLP was interviewed, and stated speech therapy was initiated for R32 because she was having difficulty swallowing pills and was refusing pills because of this. The SLP further stated R32 had progressed in therapy, and she was getting ready to discharge the resident from therapy last Wednesday. The SLP reported the resident had a current diagnosis of pneumonia, was very congested, and then on Friday she had a choking episode. The SLP stated up until Friday, the resident received a regular diet and had been consuming 100% of her food. "Currently, she is scared to eat now," because of the episode. The SLP reported the resident stayed away from things like eggs and "tends to go for more creamier food." She verified the resident's throat must be irritated, as she did complain it hurt... "plus she has the cough, so her appetite was not as good." The SLP stated R32 had consumed 25% of her meal. She confirmed the resident now received a mechanical soft diet with thin liquids, and medication was being administered whole in applesauce. The SLP stated she talked to R32 that day about having her medication crushed. The SLP stated she expected the meat for a mechanical soft diet would be ground. She stated she sometimes recommended extra gravy be added. She did not typically recommend bacon be served. She stated she utilized communication sheets to communicate with staff, but confirmed, "I don't have one for [R32]." She stated if diet orders where changed, she usually wrote a "clarification order." The SLP stated, "I am very surprised R32 was provided ham during lunch," and verified the resident was at risk for choking and aspiration.	2 965		

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2 965	Continued From page 13 At 9:30 a.m. on 12/19/12, the dietary services director was interviewed. She stated she was aware R32 did not want quiche for the lunch meal on the previous day and staff mistakenly provided her with regular ham as an alternative. The dietary services director further stated staff identified the mistake and provided R32 with smaller pieces of ham. The dietary services director verified R32 was on a mechanical soft diet and stated R32 should have received "ground up ham." At 9:45 a.m. on 12/19/12, the director of nursing (DON) was interviewed and explained R32 needed more assistance than she had in the past, and had experienced a change in the last week after the choking incident. The resident was described as being "fearful of eating" and the facility obtained a psychological referral, as well as a palliative care social worker who came to see her. The DON verified in the previous two days R32 had consumed less than 10 percent of her meals. R32's daughter was interviewed on 12/19/12, at 10:15 a.m. She stated the ADON called her and reported "my mom choked on some ham and he did the Heimlich maneuver." The daughter reported R32 was receiving speech therapy now, but she was having a hard time eating and had a cold and pneumonia. The daughter stated, "I am surprised that she would eat ham again because she was upset about choking on the ham, and refused to eat initially and now staff have to encourage her and provide support. I also have not been following the rules completely and have been bringing cut up grapes because my big thing now is that she gets food, and I know she likes the grapes. I know they take good care of her and she can be a handful. I would rather her	2 965		

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2 965	Continued From page 14 eat something." The daughter stated staff had not explained the risks and benefits of not following the orders for a mechanical soft diet. At 11:00 a.m. on 12/19/12, the DON and the dietitian were interviewed. They reported the physician was "on his way to assess her" current nutritional status. The DON stated a staff meeting had been held to ensure documentation accuracy of meal consumption, and some staff were given verbal warnings "so that we can continue to go forward." She further stated the resident continued to receive the mechanical soft diet and the SLP increased sessions to five times weekly, as R32 was having some fear regarding her eating, and 1:1 reassurance was being provided. R32's mechanical soft diet was reflected on the meal card. In addition, R32 was taking an antibiotic for pneumonia that may have been upsetting her stomach. The DON said the pneumonia diagnosis was made prior to the choking incident. The dietitian confirmed textured crisp bacon was allowed on the mechanical soft diet unless there was a specific order for "no bacon." The resident was served ham because she declined the quiche. The registered dietician stated, "I am not sure if she got the ham or not, and another staff member was actually the one that went and got the other meal. I honestly--I can't tell you. I did not see any choking or swallowing." At 2:10 p.m. on 12/20/12, the DON was asked to provided information on how R32 was assessed following the choking incident to determine fear and anxiety versus a trauma to her throat. The DON stated, "We do not have an actual assessment. In talking [R32], said she was fearful. I think I have some documentation--part of it. I talked to her in great length on Monday,	2 965		

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2 965	Continued From page 15 and that is the biggest fault of my own that I did not document my conversation." The DON verified she was aware of R32 grabbing at ther throat during meals and complaining of pain. At 2:30 p.m. on 12/20/12, the DON stated she thought R32 had an order for Tylenol. "I know [R32] has had cough medicine today at 10:30 a.m. for complaints of a sore throat and cough. Maybe I am wrong and she did not get any Tylenol." The DON further stated, "I don't even have an order for Tylenol. Right now she just has the order that was started today for cough medicine." The DON verified the resident had not received Tylenol the previous day as she requested. The DON verified R32 had not received any pain medications since the choking incident on 12/14/12 despite verbalized and demonstrated irritation/pain with swallowing meals. The DON further stated, "I am really hopeful that this irritation will go away, and the plan is to follow up in a week with the doctor, and then it will be up to him to see how she is doing next week." The DON verified that the physician observed the resident as she ate the mechanical soft diet versus a regular diet. She confirmed the resident's diet had been changed to an as tolerated order on 12/19/12 after the physcian met with R32 and her daughter. The DON stated she thought the resident's daughter had the biggest influence on his decision to order a regular diet for the resident. A licensed practical nurse (LPN)-A was interviewed on 12/20/12, at 2:45 p.m. and reported, "She [R32] has been coughing a little bit more in the past few days and requested to have some cough medicine." The LPN stated the night nurse had also mentioned in report that [R32] had been coughing intermittently during the night. The	2 965		

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2 965	Continued From page 16 LPN placed an order for cough medicine on 12/20/12, six days following the choking incident, but no order for Tylenol had been obtained. R32's record revealed a Hospital Discharge Summary dated 2/19/12 that listed diagnoses of malnutrition and dementia. A physician's order dated 11/8/12, was for "speech therapy [ST] to evaluate and treat for dysphasia" (swallowing disorder). A clarification the following day indicated speech therapy should evaluate and treat the resident three times weekly for thirty days, addressing swallowing in individual and group settings. The Speech Therapy Plan of Care dated 11/9/12, identified R32 was referred to ST for dysphasia due to nursing cocerns of R32 experiencing increased difficulty at meals and increased difficulty swallowing pills. Without therapy, R32 was identified as "at risk for aspiration/choking." In the Initial Assessment, R32 was independent at mealtime with feeding herself, but required assistance to cut food into small pieces. The resident consumed up to 100% of meals, but did require encouragement to increase fluid intake. The Speech Therapy Progress and Updated Plan of Care dated 12/9/12, identified R32 was being treated for dysphasia. R32 was noted to be tolerating the current diet of regular textures with thin liquids without much difficulty and tolerating pill pass, however it was noted in the past week the resident had experienced increased difficulty with swallowing. The report revealed R32 was complaining pills felt like they were "getting stuck" in her throat. The report identified R32's oral intake also decreased from 100 percent to between 25-50 percent. R32 was identified to be at risk for aspiration and choking.	2 965		

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(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
2 965	Continued From page 17 The Comprehensive Assessment dated 11/29/12, identified R32 was on a regular diet with a history of anorexia and malnutrition. R32's weight was noted to be 113 and stable. R32 was identified to require limited to extensive assist with all areas of activities of daily living (ADL'S). R32's care plan dated 2/22/12, identified the resident as at nutritional risk due to below ideal body weight and difficulty eating independently. Goals were for her laboratory values to return to normal and remain within normal limits, and to consume 50% of meals to meet energy requirements, having no weight loss in 90 days. Interventions directed staff to provide diet as ordered, fortified foods with meals, invite to food related activities, monitor meal consumption daily, monthly weights, obtain food/beverage preferences, provide substitutes, snacks between meals, and adaptive equipment. At 3:00 p.m. on 12/19/12, the DON stated the physician met with R32 and her daughter. A house supplement was being initiated, and her diet was changed from mechanical soft to "whatever [R32] will eat." According to the resident's daughter, she did not care what she ate, as long as she ate. The physician also ordered some laboratory work. The plan was to weigh her in the coming week and update the physician. The resident was weighed and R32 was down six pounds in 16 days. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at risk for choking received appropriate interventions to maintain nutrition and ensure safety as determined necessary by their	2 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00988	A. BUILDING _____ B. WING _____	12/20/2012

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2 965	Continued From page 18 individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review, and interview, the	21535		

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21535	Continued From page 19 facility failed to follow up with pharmacy recommendations with the attending physician for 1 of 10 residents in the sample (R6) who were reviewed for unnecessary medications. Findings include: R6 had physician orders dated 11/29/12, included Remeron (mirtazepine)15 milligrams (mg) at bedtime daily depression since 11/3/10, as well as vitamin D (encourages the absorption and metabolism of calcium and phophorus) 2000 unit capsule daily for vitamin D deficiency since 8/31/11, and then changed on 9/3/11 for calcium with vitamin D (bone supplement) 600-200 mg-unit two times a day after a fracture. Pharmacy recommendations for R6 dated 10/25/12, indicated "[R6] is on Remeron 15 mg since November 2011. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose." Pharmacy recommendations for R6 dated 1/3/12, indicated, "This resident has been on Vitamin D 2,000 units since 8/10, and Ca+ Vit 200 units bid (a total of 2400 units daily). Would you please consider, if it would be appropriate to check Vit D level?" A review of the physician visits and labwork following the recommendations by the pharmacist revealed the vitamin D level and laboratory testing were not completed. A physician visit dated 11/29/12, did not address any of the pharmacy recommendations and the "Nursing Communication: Reason for Visit" was left blank. The Medication Monitoring Medication Regimen Review and Reporting policy and procedure dated 10/07, indicated "The consultant pharmacist reviews the medication regimen of	21535		

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21535	Continued From page 20 each resident at least monthly. Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. Those with authority and responsibility include the administrator and the director of nursing, and may also include the attending physician and the medical director, where appropriate." On 12/20/12, at 1:52 p.m. the assistant director of nursing (ADON) reviewed the unaddressed pharmacy recommendations for R6. The ADON stated the expectation was that the nurses send the physician the recommendations via a fax, and then check back in a few days to see if a response was received. If not, a fax was to be re-sent. Since R6 went out to see the physician, the ADON stated would expect the nurse to write the unaddressed recommendation on the reason for visit part of the physician visit form. If the physician still did not address the concern, it would be expected the nurse contact the physician by phone. The ADON confirmed the pharmacy recommendations for a gradual dose reduction (GDR) for the Remeron and lab to check vitamin D level had not been addressed for R6. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		