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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BH67

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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

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

6. DATE OF SURVEY **12/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 12/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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 12/22/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245348

December 19, 2014

Ms. Virginia Porter, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Dear Ms. Porter:

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 December 12, 2014 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 19, 2014

Ms. Virginia Porter, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348024

Dear Ms. Porter:

On November 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 5, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 12, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2014, effective December 12, 2014 and therefore remedies outlined in our letter to you dated November 18, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5348r15

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
245348	A. Building B. Wing	12/15/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/12/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/12/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/12/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/12/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/12/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/12/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/12/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/12/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PLH/mm	**Date:** 12/19/2014	**Signature of Surveyor:** 12835	**Date:** 12/15/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/31/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing 01 - MAIN BUILDING 01	12/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 Reg. # **NFPA 101** LSC K0069	Correction Completed **11/17/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **12/01/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	12/19/2014	03005	12/15/2014

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
10/29/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BH67

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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

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

6. DATE OF SURVEY **10/31/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 12/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 18, 2014

Ms. Virginia Porter, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number

Dear Ms. Porter:

On October 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Supervisor
Rochester Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: gary.nederhoff@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 10, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 31, 2015 (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 May 1, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

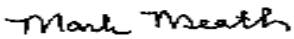
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		12/12/14

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

Electronically Signed | 11/28/2014

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245348	A. BUILDING _____ B. WING _____	10/31/2014

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to submit investigative reports timely to the state agency (SA) for 2 of 3 residents (R17, R44, R23, R53) reviewed for abuse prohibition. Findings include: R17 & R44 had an altercation and although the incident had been investigated and submitted to the state agency, the investigation report had not been submitted to the SA within five working days, per facility policy. Review of the investigation report dated 09/08/14, indicated on 08/29/14; R17 and R44 were involved in an altercation. Both residents were in the dining room when R17 hit R44 on the back of the head with a plastic coffee cup. The incident report was submitted to the SA on 8/29/14. However, the investigative report was not submitted to the SA until 09/08/14; six working days after the incident report was submitted. R23 & 53 were involved in an altercation and although the incident had been investigated and	F 225	11/19/14 an in service was completed informing staff of proper procedures for reporting incidents and abuse. 12/12/14 all nursing staff completed education via self paced learning through Golden University USS-1000 Abuse and Neglect and USS-19300 Elder Justice Act. Staff is trained that the the Executive director or Designee will be immediately informed of incidents of potential maltreatment, abuse/neglect, and resident to resident altercations. Audits will be completed on all incident reports within 24 hours of a reported incident, any required follow up or re-education will be completed at that time. Audit results will then be presented at QAPI for review and QAPI action plan as needed. DNS will be responsible to bring	

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F 225	Continued From page 2 submitted to the state agency, the investigation report had not been submitted to the SA within five business days, per facility policy. Review of the investigation report dated 10/17/14, indicated on 10/09/14 R23 and R53 were involved in an altercation. Both residents were in their shared bedroom when R23 reached out and punched R53 in the stomach. The incident report was submitted to the SA on 10/09/14. However, the investigative report was not submitted to the SA until 10/17/14; six working days after the incident report was submitted. During interview on 10/30/14, at 12:46 p.m. the assistant director of nursing (ADON) confirmed she/he completed the investigative reports and stated both reports were submitted late by one day to the SA, then stated the facility is short by one person. During interview on 10/30/14, at 1:24 p.m. the administrator stated the investigative reports are expected to be submitted to the SA within five working days. The facility's abuse policy dated October 2011, directed staff to submit the investigative report to the SA within five working days of the incident.	F 225	information and audits to QAPI meetings.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		12/12/14

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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their abuse policy for submitting investigative reports timely to the state agency (SA) for 2 of 3 residents (R17, R44, R23, R53) reviewed for abuse prohibition. Findings include: The facility's abuse policy dated October 2011, directed staff to submit the investigative report to the SA within five working days of the incident. R17 was involved in an incident with R44. Although the incident had been investigated and submitted to the state agency, the investigation report had not been submitted to the SA within five working days, per facility policy. Review of the investigation report dated 09/08/14, indicated on 08/29/14 R17 and R44 were involved in an altercation. Both residents were in the dining room when R17 hit R44 on the back of the head with a plastic coffee cup. The incident report was submitted to the SA on 8/29/14. However, the investigative report was not submitted to the SA until 09/08/14; six working days after the incident report was submitted. R23 was involved in an incident with R53. Although the incident had been investigated and submitted to the state agency, the investigation report had not been submitted to the SA within five business days, per facility policy. Review of the investigation report dated 10/17/14, indicated on 10/09/14 R23 and R53 were involved in an altercation. Both residents were in their	F 226	Education, completed by DNS, provided to all nursing staff on the process of submitting an incident report per state and facility policy. Will be reviewed with new hires and annually. DNS will be responsible to make sure all staff are compliant. All staff is educated to inform the Executive Director or designee immediately of incidents of potential maltreatment, abuse/neglect and resident to resident altercations. Audits will be completed on all incident reports within 24 hours of reported incident. Any required follow up or education will be completed at this time. Audit results will be presented at QAPI for review and action planned as needed. Licensed Nursing staff educated regarding the requirement to initiate an accident/incident report per state and facility policy. Completed 12/12/2014. The DNS or designee is responsible party for overseeing, educating, and bringing audits to QAPI.	

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F 226	Continued From page 4 shared bedroom when R23 reached out and punched R53 in the stomach. The incident report was submitted to the SA on 10/09/14. However, the investigative report was not submitted to the SA until 10/17/14; six working days after the incident report was submitted. During interview on 10/30/14, at 12:46 p.m. the assistant director of nursing (ADON) confirmed she/he completed the investigative reports and stated both reports were submitted late by one day to the SA, then stated the facility is short by one person. During interview on 10/30/14, at 1:24 p.m. the administrator stated the investigative reports are expected to be submitted to the SA within five working days.	F 226		
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	F 279		12/1/14

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F 279	Continued From page 5 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed to address frequent bruising for 1 of 3 residents (R4) reviewed for non-pressure related skin conditions and to address behavioral interventions for 1 of 5 residents (R4) receiving an antipsychotic who was reviewed for unnecessary drug use. Findings include: R4's care plan lacked interventions for frequent bruising: R4's physician progress notes, dated 8/6/14, revealed R4 had a history of multiple bruises and skin tears to the arms and hands. R4's care plan, dated 10/30/14 lacked any identified concerns with bruising or interventions related to skin injuries or prevention. During observation on 10/29/14, at 9:33 a.m. R4 was noted to have a large bruise on the left wrist that was dark purple in color, and was raised in two areas. During observation on 10/30/2014, at 7:07 a.m. R4 was observed lying in bed. The bruising on R4's arms appeared to be spreading out and fading in color. During interview on 10/30/2014, at 2:25 p.m. nursing assistant (NA)-A stated R4 frequently had bruises on his arms, and she had reported them to the nurse. NA-A could not recall any specific interventions staff used to prevent bruising. On 10/30/14, at 2:30 p.m. registered nurse (RN)-B measured R4's arm bruising and	F 279	The care team developed a collaborative care team to review care plans, behavioral plans, psychotropic medication and change of conditions. This team will meet every other Monday starting on 12/01/2014 and will be ongoing. The team consists of the DNS, MDS coordinator, ACU Coordinator, Social Worker, and a nursing assistant. Dietary, activities and therapy will join meeting on an as needed basis. The goal of the collaborative care team is to ensure that care plans are accurate and up to date and to ensure that communication is accurate between all members of the care team. R4 has had care plan updated to include psychotropic medication plan, behavioral interventions and interventions for bruising. The DNS and MDS coordinator are responsible for compliance of the collaborative care meetings.	

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F 279	Continued From page 6 identified 12 separate areas of bruising, one on the inside left upper arm 2 centimeters (cm) x 1 cm, an area on the proximal lower arm measuring 2 cm x 1.5 cm, area on the distal lower arm 2.5 cm x 1.5 cm, top of the left hand 12 cm x 10 cm and on top of the left ring finger measuring 1.5 m x 1.5 cm. The right arm had an area on the elbow measuring 14 cm x 7.5 cm, the outer left arm had an area 1 cm x 1 cm, left forearm 2.5 cm x 0.5 cm, top of right hand 9 cm x 8 cm and the right lower arm had three areas measuring 2 cm x 0.5 cm, 3.5 cm x 2 cm and 1 cm x 1.5 cm respectively. During interview on 10/30/14, at 8:58 a.m., the assistant director of nursing (ADON) staff should fill out a Minnesota incident report for bruises, and monitor bruises until they are healed. On 10/31/14, at 1:30 p.m., a policy for care plans was requested and none was provided. R4's care plan was not developed to address behavioral concerns and interventions: R4 was admitted to the facility on 11/20/13. R4's current diagnoses according to the physician's order sheets, dated 10/30/14, revealed dementia with behavioral disturbances, depressive disorder and hallucinations. R4 ' s most recent quarterly Minimum Data Set (MDS), dated 8/13/14, revealed R4 exhibited hallucinations and wandering one to three days in the last week. R4's Brief Interview for Mental Status (BIMS) score was three (severe cognitive impairment). R4's Care Area Assessment (CAA) from R4's admission MDS, dated 12/03/13, indicated R4 received scheduled antidepressants and antipsychotics on a daily basis and was followed by psychology. R4's care plan, dated 10/30/14 did not identify	F 279		

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F 279	Continued From page 7 R4's behavioral symptoms, or any pharmacological or non-pharmacological approaches. During observation on 10/29/14, at 9:33 a.m., R4 was observed in his room and exhibited no behaviors. During observation on 10/30/14, at 7:07 a.m., R4 was observed lying in bed with his walker at bedside. R4 exhibited no behaviors at this time and had a flat facial affect. During observation on 10/30/14, at 8:30 a.m., R4 was observed in the dining room, smiling and eating, conversing with tablemates. During observation on 10/30/2014, at 12:24 p.m., R4 was observed ambulating in the hallway. R4 was smiling with a pleasant facial expression. R4's physician progress notes, dated 9/5/14, revealed R4 exhibited delusions not distressing to him but worrisome, and that R4 was not a threat to himself or others. R4's psychology visit notes, dated 8/26/14, included recommendations such as encouraging R4 to play the harmonica, monitor for hallucinations, encourage R4 to ignore visual hallucinations and focus on concrete, real items in his room. During interview on 10/29/14, at 4:00 p.m., licensed practical nurse (LPN)-A reported R4 saw animals and tried to pet them, and occasionally saw people. The visualizations were not distressing to R4. During interview on 10/30/2014, at 1:43 p.m. registered nurse (RN)-B stated R4 had sometimes been physically aggressive towards others. RN-B indicated non-pharmacological approaches for behaviors that sometimes worked for R4 included reality orientation and snacks as well as having him visit staff at the nursing station.	F 279		

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F 279	Continued From page 8 During interview on 10/30/14, at 2:09 p.m. RN-C stated R4's care plan definitely should have addressed his behaviors and interventions because R4 had "Outrageous behaviors and psychoactive drug use." The facility policy entitled Behavior Management Committee, last revised 2013, and indicated the focus of the Behavior Management Committee is to conduct an interdisciplinary review, analysis and if warranted revision or creations of a behavior management plan both behavioral and pharmacological. The policy further directed an interdisciplinary behavior committee was in place to review all patients/residents with behaviors or on antipsychotics.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/1/14

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F 280	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan related to activities of daily living (ADL's) for 1 of 3 residents (R3) who was reviewed for rehabilitation services. Findings include: R3's current care plan dated 4/25/14 indicated R3 had physical functioning deficits related to self-care impairment, mobility impairment, and range of motion limitations. The care plan did not show any intervention listed on the care plan in regards to R3's ADL's to be utilized by staff. R3's current nursing assistant care sheets undated indicated R3 used a Hoyer lift (mechanical lift) with assist of one for transfers. The quarterly Minimum Data Set (MDS) assessment dated 7/18/14, identified R3 required extensive assist and two people to physically assist with transfers. During observation on 10/30/14 at 7:47 a. m. R3 had just finished getting dressing changes to his buttocks, when nursing assistant (NA)-F and NA-G started assisting R3 by rolling him side to side to pull up his pants that were down by his ankles, they continued to roll him side to side while placing a lift sling under his buttocks area and upper torso. At 7:50 a.m. NA-F got the mechanical lift and with NA-G assistance they began to hook R3 to the mechanical lift, R3 was then lifted to a sitting position off the bed. NA-F began to maneuver the mechanical lift while NA-G assisted by holding R3's legs until he was positioned over the wheelchair. Once R3 was positioned over the wheelchair NA-G went on the back side of R3's wheelchair and guided him in	F 280	The care team has developed a collaborative care meeting to review care plans, behavioral plans, psychotropic medication and change of conditions. This team will meet every other Monday starting on 12/01/2014 and will be ongoing. The team consists of the DNS, MDS coordinator, ACU Coordinator, Social Worker, and a nursing assistant. Dietary, activities and therapy will join meeting on an as needed basis. The goal of this meeting is to ensure that care plans are accurate and up to date and to ensure that communication is accurate between all members of the care team. R3 had care sheets were updated immediately. R3 has since discharged. The DNS and MDS coordinator are will be responsible for compliance of the collaborative care meetings.	

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F 280	Continued From page 10 the wheel chair while NA-F lowered the lift. At 7:51 R3 is sitting in his electric wheel chair and properly positioned. During interview on 10/30/14 at 2:20 p.m. registered nurse (RN)-B confirmed R3 uses a mechanical lift with assist of two staff for all transfers and has not changed since he was admitted to the facility. During interview on 10/30/14 at 3:05 p.m. physical therapist (PT) verified that R3 use the mechanical lift with assist of two staff for all transfer. PT confirmed they tried to use a standing lift and a sit to stand transfer in the past but it did not go well and went back to a mechanical lift due to his tremors. During interview on 10/31/14 at 8:09 a.m. RN-C confirmed the care plan is developed after the 14 day MDS is done and verified the care plan was not filled out for R3's ADL's. RN-C reviewed nursing assistant care sheets and confirmed the care sheets had R3 using a Hoyer lift with assist of one for transfers. During interview on 10/31/14 at 8:16 assistant director of nursing (ADON) confirmed that the care plan was not filled out for R3's ADL's and stated, "It got missed." ADON verified that the NAs use the nursing care sheets and confirmed the nursing care sheets had R3 using a Hoyer lift with assist of one for transfers and then stated, "It should say assist of 2 instead of 1." A care plan policy related to revision was requested and none provided.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		12/1/14

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F 309	Continued From page 11 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruising was assessed and monitored for 2 of 3 residents (R4 & R21) reviewed for non-pressure related skin conditions. In addition, the facility failed to ensure 1 of 1 resident (R27) reviewed for fluid restrictions was being provided appropriate fluids at mealtime. Findings include: R4 was admitted to the facility on 11/20/13. R4's current diagnoses according to the physician's order sheets, dated 10/30/14, revealed dementia with behavioral disturbances, depressive disorder and hallucinations. R4's most recent quarterly Minimum Data Set (MDS), dated 8/13/14, revealed R4 had a Brief Interview for Mental Status (BIMS) score of three (severe cognitive impairment). R4's physician progress notes, dated 8/6/14, revealed R4 had a history of multiple bruises and skin tears to the arms and hands. R4's care plan, dated 10/30/14 lacked any identified concerns with bruising or interventions related to skin injuries. R4's nursing progress notes for the last three months and treatment sheets lacked any documentation regarding bruising injuries or monitoring of any areas for resolution. During observation on 10/29/14, at 9:33 a.m. R4 was noted to have a large bruise on the left wrist that was dark purple in color, and had two raised	F 309	The care team has developed a collaborative care meeting to review care plans, behavioral plans, psychotropic medication and change of conditions. This team will meet every other Monday starting on 12/01/2014 and will be ongoing. The team consists of the DNS, MDS coordinator, ACU Coordinator, Social Worker, and a nursing assistant. Dietary, activities and therapy will join meeting on an as needed basis. The goal of this meeting is to ensure that care plans are accurate and up to date and to ensure that communication is accurate between all members of the care team. All nursing staff educated on wound policies and weekly charting by DNS and required to complete self paced study University P9537 Identification, Documentation and Prevention of Wounds. R4 care plan updated to reflect bruising interventions and wound nurse to follow patient weekly. R4 group sheets updated to reflect need to monitor and report bruising immediately to charge nurse. R4 will have skin monitored weekly on wound	

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F 309	Continued From page 12 areas. During observation on 10/30/2014, at 7:07 a.m. R4 was observed lying in bed. The bruising on R4's arms appeared to be spreading out and fading in color. During interview on 10/30/14, at 9:09 a.m. licensed practical nurse (LPN)-A stated R4's arms were always bruised and that was normal for him. When residents experienced bruising, she typically recorded this on a report sheet to pass along for the next shift and did not do anything further with the information. LPN-A stated she should probably make a nursing note about bruises and chart on their progress towards healing. LPN-A was not aware of any new bruising on R4's arms and did not recall seeing anything on the shift to shift report sheets. During interview on 10/30/2014, at 2:25 p.m. nursing assistant (NA)-A stated R4 frequently had bruises on his arms, and she had reported them to the nurse. NA-A was unsure what happened to the information after that. On 10/30/14, at approximately 2:30 p.m. registered nurse (RN)-B measured R4's arm bruising and identified 12 separate areas of bruising, one on the inside left upper arm 2 centimeters (cm) x 1 cm, an area on the proximal lower arm measuring 2 cm x 1.5 cm, area on the distal lower arm 2.5 cm x 1.5 cm, top of the left hand 12 cm x 10 cm and on top of the left ring finger measuring 1.5 m x 1.5 cm. The right arm had an area on the elbow measuring 14 cm x 7.5 cm, the outer left arm had an area 1 cm x 1 cm, left forearm 2.5 cm x 0.5 cm, top of right hand 9 cm x 8 cm and the right lower arm had three areas measuring 2 cm x 0.5 cm, 3.5 cm x 2 cm and 1 cm x 1.5 cm respectively. During interview on 10/30/14, at 8:58 a.m., the assistant director of nursing (ADON) staff should	F 309	rounds. R21 has had care plan updated to reflect bruising risk and skin monitoring. R27 has had care plan updated to reflect fluid restriction and noncompliance. Care plan has documentation to has shift to identify noncompliance of fluid restriction and amount of mLs of intake for resident every shift. All residents with fluid restrictions will be monitored Weekly audits will be conducted once a week times 4 weeks, then once a month for 3 months, and as needed thereafter to monitor compliance. Audit results will be reviewed during QAPI to provide redirection or change when necessary and dictate continuation or completion of this monitor based on compliance. All residents have weekly skin checks performed by nursing staff Weekly audits will be performed to insure skin checks are being completed; this will be completed by daily clinical team. Weekly audits will be completed to identify dietary changes and required care planning and monitoring. This will be completed by daily clinical team. DNS and MDS Coordinator are	

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F 309	Continued From page 13 fill out a Minnesota incident report for bruises, and monitor bruises until they are healed. Review of the policy entitled Wound Evaluation Flow Sheet, undated, indicated staff was to complete a wound evaluation flow sheet for each pressure or non-pressure wound, and review and update the flow sheet weekly. R21 lacked an assessment and monitoring of a bruise on right hand. R21 was admitted on 10/12/2010. R21's current diagnoses according to the physician order sheets, dated 10/1/14 indicated R21 had diagnoses of chronic pulmonary heart disease, chronic airway obstruction, and congestive heart failure. R21's annual Minimum Data Set (MDS), dated 7/30/2014 revealed R21 had severe cognitive impairment and required extensive assist of one for bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. Review of R21's current care plan, dated 9/17/10 indicated to inspect skin with care. Report reddened areas, rashes, bruising, and open areas to charge nurse. However the care plan did not identify any concerns with bruising or interventions related to skin injuries. During observation on 10/29/14 at 1:15 p.m. R21 has a bruise on his right hand by his thumb area dark purple in color and approximately 2.5 centimeters round. During observation on 10/30/14 at 8:20 a.m. R21 continued to have bruise on his right hand by his thumb area that is dark purple in color with no change.	F 309	responsible for compliance.	

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F 309	Continued From page 14 Review of R21's nursing notes and treatment administration record back to 10/1/14 and physician progress notes back to 8/25/14 showed no indication that R21 had a bruise on his right hand by his thumb area or that staff were monitoring this area for a bruise. Review of R21's medication administration record indicated staff was to do a weekly skin assessment on R21 every Wednesday. The last skin assessment was done on 10/29/14 with a check mark in the appropriate square indicating R21's skin was checked with no areas of concern. During interview on 10/30/14 at 8:20 a.m. R21 was unable to say where and how he got the bruise on his right hand. During interview on 10/30/14 at 8:23 a.m. nursing assistant (NA)-F confirmed the bruise on R21's right hand and verified that she had reported to licensed practical nurse (LPN)-A on either 10/26/14 or 10/27/14. During interview on 10/30/14 at 8:25 a.m. LPN-A verified that R21 did have a bruise on his right hand and confirmed that NA-F did report it to her earlier in the week. LPN-A confirmed she did look at the bruise but did not fill out an incident report because R21 bumps his hands all the time and stated, " I did not think it was big enough to do an incident report." LPN-A verified that it is the facilities policy to fill out an incident report when it is unwitnessed and we are currently not monitoring the bruise. During interview on 10/30/14 at 8:58 a.m. assistant director of nursing (ADON) confirmed	F 309		

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F 309	Continued From page 15 that staff did not to fill out a Minnesota incident report in regards to R21's bruise to his right hand. ADON verified that staff is to fill out an incident report for bruise, they are to track the bruise in the DQI tracking system and they normally do monitor the bruises until they are healed. During interview on 10/31/14 at 1:25 p.m. registered nurse (RN)-A brought measurements of R21's bruise on his right hand by his thumb and it measured 2.2 centimeters x 1.3 centimeters. Review of policy titled, Wound Evaluation Flow Sheet, undated, indicated staff were to complete a wound evaluation flow sheet for each pressure or non-pressure wound, this will assist in identifying risks and appropriately establish a plan of care or update the current skin integrity care plan. Staff is to update the flow sheet weekly, review status and changes in the wound from previous week, and update the medical doctor and family with changes. R27 lacked implementation and monitoring of physician ordered fluid restrictions. According to the physician orders dated 10/30/14 R27 had diagnoses that included chronic systolic heart failure, neurogenic bladder, depressive disorder, diabetes and R27 was readmitted to the facility on 10/27/14. R27 was observed on 10/29/14 at 1:30 p.m. while eating lunch in his room. On the food tray R27 had fluids that included a glass of water, a glass of milk, a small glass of juice, and a cup of coffee or approximately 780 cc of fluid. In addition R27 was observed to have four unopened cans of mountain dew and one open can of mountain dew at bedside, and a pitcher of water. R27	F 309		

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F 309	Continued From page 16 stated he did not know if he was on any fluid restrictions and stated that he had just been released from the hospital where he had had fluid removed from his lungs. R27 was observed on 10/30/14 at 7:15 a.m. sleeping in bed. R27 had 5 unopened cans and 1 opened can of pop sitting on the table beside the bed. Two pitchers of water were also on the bedside stand. At 8:05 a.m. R27 was served breakfast which included a carton of milk, glass of juice, glass of water, and cup of coffee or 780 cc of fluid. R27 was observed to drink the fluid on his breakfast tray. On 10/30/14 at 12:00 noon, R27 was observed to be sitting on his bed having lunch. The tray had a 240 cc glass of milk on the tray and nursing assistant (NA)-A was observed to enter the room with a 120 cc glass of juice and a 240 cc glass of water. NA-A stated she was aware of the fluid restriction and had reminded R27 of the restriction. The physician orders dated 10/27/14 indicated a fluid restrictions of 1500 cc (cubic centimeters) fluid daily. The order noted dietary was to provide 240 cc every meal (720 cc/day) leaving 780 cc for nursing and resident pleasure. The order also directed staff to record how many cc ' s consumed every shift including dietary. The order was changed by the dietician on 10/30/14 to include 1500 ccs daily. Dietary to provide 240 cc every meal (720 cc/day) and 120 cc from supplement leaving 660 cc for nursing and residents pleasure. Record how many cc ' s consumer every shift including dietary.	F 309		

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F 309	Continued From page 17 The quarterly interdisciplinary resident review (QIRR) dated 10/21/14 was reviewed. QIRR indicated R27 had no long or short memory impairment, usually understood conversations, displayed verbal abusive behaviors but did not indicate resistance to care, identified indicators of impaired respiratory functions (cough, continuous oxygen, thick tenacious secretion, difficulty breathing/shortness of breath, and labored breathing.) The nutritional assessment dated 10/27/14 completed by the registered dietician (RD) indicated R27 was to receive 240 cc of fluid each meal. The dietician also noted the resident was diuresed in the hospital and the weight was down 7%. The dietician did not indicate she had discussed risk vs benefits of non-compliance with a fluid restriction. The assistant director of nursing (ADON) was interviewed on 10/30/14 at 12:50 p.m. ADON stated R27 was readmitted so the care plan was not correct and that the dietician would make the changes to the orders and the care plan. On 10/30/14 at 11:30 a.m. the dietician (RD) stated R27 was to receive only one cup of fluid at meals. RD stated she was unaware of what had been provided on the trays for fluid. RD stated she thought that R27 may want more fluid, but that she had not documented anything related to the fluid restrictions. On 10/30/14 at 12:50 p.m. RD stated she had made the changes to the orders because no one had done it since the certified dietary manager was off. RD stated she had also adjusted the care plan today to include the fluid restrictions.	F 309		

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F 309	Continued From page 18 The ADON was interviewed on 10/31/14 at 1:30 p.m. She indicated the facility had not completed any fluid intake monitoring until 10/30/14. ADON stated she or the nurse practitioner had probably discussed the fluid restriction requirement and compliance, but not documented such a conversation. ADON stated she was not sure when the conversation had happened or what had been discussed.	F 309		
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		12/1/14

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R4) reviewed for unnecessary drugs who received Haloperidol (an antipsychotic medication) had an appropriate indication for use and parameters for use. Findings include: R4 was admitted to the facility on 11/20/13. R4's current diagnoses according to the physician's order sheets, dated 10/30/14, revealed dementia with behavioral disturbances, depressive disorder and hallucinations. R4's most recent quarterly Minimum Data Set (MDS), dated 8/13/14, revealed R4 exhibited hallucinations and wandering one to three days in the last week. R4's Brief Interview for Mental Status (BIMS) score was three which indicated severe cognitive impairment. R4's most current Care Area Assessment (CAA) for psychoactive drug use, dated 12/03/13, indicated R4 received scheduled antidepressants and antipsychotics on a daily basis and was followed by psychology. R4's physician order sheets, dated 10/30/14, listed an active order for Haloperidol 5 milligrams every two hours as needed for agitation and/or hallucinations. The initial start date of the order was 9/6/14. R4's medication sheets for the months of 9/14 and 10/14 revealed R4 received the Haloperidol on six occasions, with the most recent dose administered on 10/24/14. R4's care plan, dated 10/30/14 and did not identify R4's behavioral symptoms, or any pharmacological or non-pharmacological approaches for behaviors. During observation on 10/29/14, at 9:33 a.m., R4 was observed in his room and exhibited no	F 329	All residents taking psychotropic medication have the potential to be affected by the deficient practice. The care team has developed a collaborative care meeting to review care plans, behavioral plans, psychotropic medication and change of conditions. This team will meet every other Monday starting on 12/01/2014 and will be ongoing. The team consists of the DNS, MDS coordinator, ACU Coordinator, Social Worker, and a nursing assistant. Dietary, activities and therapy will join meeting on an as needed basis. The goal of this meeting is to ensure that care plans are accurate and up to date and to ensure that communication is accurate between all members of the care team. Audits will be completed quarterly by DNS and MDS Coordinator on residents with psychotropic medication R4's haloperidol dosage and indications for use have been changed to not exceed 20 mg daily and to be used for hallucinations and delusions that cause resident distress and/or cause resident to be a danger to himself and/or others. Care plan has been updated to reflect psychotropic medication use. DNS and MDS coordinator are the responsible for compliance.	

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F 329	Continued From page 20 behaviors at this time. During observation on 10/30/14, at 7:07 a.m., R4 was observed lying in bed with his walker at bedside. R4 exhibited no behaviors at this time and had a flat facial affect. During observation on 10/30/14, at 8:30 a.m., R4 was observed in the dining room, smiling and conversing with tablemates. During observation on 10/30/2014, at 12:24 p.m., R4 was observed ambulating in the hallway and had a pleasant facial expression. R4's physician progress notes, dated 9/5/14, revealed R4 exhibited delusions that were not distressing to him, and that R4 was not a threat to himself or others. R4's psychology visit notes, dated 8/26/14, included recommendations such as encouraging R4 to play the harmonica, monitor him for hallucinations and encourage him to ignore visual hallucinations. During interview on 10/29/14, at 4:00 p.m., licensed practical nurse (LPN)-A stated R4 had more behaviors in the evening and received the Haloperidol as needed, although she had never had to give R4 any. LPN-A reported R4 saw animals and tried to pet them, and occasionally saw people who were not there. These visualizations were not distressing to R4. During interview on 10/30/2014, at 1:43 p.m. registered nurse (RN)-B stated she had given R4 the Haloperidol and used it for physical aggression towards others. RN-B indicated non-pharmacological approaches that sometimes worked for R4 included reality orientation and snacks as well as having him visit staff at the nursing station. During interview on 10/30/2014, at 2:02 p.m., the pharmacy consultant (CP) stated the Haloperidol order lacked appropriate parameters and should	F 329		

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F 329	Continued From page 21 be "Discontinued immediately." The CP stated the current order could potentially allow for a total of 60 mg of Haloperidol in a 24 hour period and this was concerning. The CP also stated that agitation was not a good indication for use of Haloperidol, the indications for the use should be more specific. During interview on 10/30/14, at 2:25 p.m., nursing assistant (NA)-A stated R4 generally did not have a lot of behaviors, but wandered at night. The facility policy entitled Behavior Management Committee, last revised 2013, indicated the focus of the Behavior Management Committee is to conduct an interdisciplinary review, analysis, and if warranted revision or creations of a behavior management plan both behavioral and pharmacological. The policy further directed an interdisciplinary behavior committee was in place to review all patients/residents with behaviors or on antipsychotics.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		10/31/14

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F 356	Continued From page 22 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the daily nurse staff posting included actual hours worked and number of licensed and unlicensed direct care staff on duty. This had the potential to affect all 40 residents in the facility. Findings include: During the initial tour on 10/28/2014, at 4:40 p.m. the nurse staff posting included the census at 40, the correct date,total registered nurse (RN) hours per shift, licensed practical nurse (LPN) hours per shift, and nursing assistant (NA) hours per shift. The posting lacked the number of staff in each discipline and the actual hours worked by licensed and unlicensed direct care staff. Throughout the survey, the nurse staff posting format has remained the same with the same information each day. On 10/31/14, at	F 356	Total staffing hours summary was added to the daily nurse staff posting. Staff educated on proper system for posting nurse staffing information and a spreadsheet was created to ensure compliance. Staffing hours are updated thoroughout the day on the nurse staff posting to ensure compliance. Will be continuously monitored by ED and DNS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 356	Continued From page 23 approximately 12:50 p.m. nursing assistant (NA)-B stated she posts the nurse staff posting near the west wing each day. The nurse staff posting lacked the actual hours worked by licensed and unlicensed direct care nursing staff each day. During an interview on 10/31/14, at 2:52 p.m. the assistant director of nursing and NA-B verified the nursing staff posting did not include actual hours worked and the number of nursing staff on duty each day. The facility policy and procedure for the nursing staff hours revised on 3/1/13, directed the following information shall be posted on a daily basis at the beginning of each shift: Center/location name Current date Total number and actual hours worked by licensed and unlicensed staff responsible for resident care, including RNs, LPNs, and NAs. Resident census.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		12/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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F 428	Continued From page 24 by: Based on observation, interview and document review, the facility pharmacy consultant failed to identify irregularities and refer them to the physician for 1 of 5 residents (R4) reviewed for unnecessary drugs who received Haloperidol (an antipsychotic medication) and lacked appropriate indications and parameters for use. Findings include: R4 was admitted to the facility on 11/20/13. R4 ' s current diagnoses according to the physician ' s order sheets, dated 10/30/14, revealed dementia with behavioral disturbances, depressive disorder and hallucinations. R4's most recent quarterly Minimum Data Set (MDS), dated 8/13/14, revealed R4 exhibited hallucinations and wandering one to three days in the last week. R4's Brief Interview for Mental Status (BIMS) score was three (severe cognitive impairment). R4's most current Care Area Assessment (CAA) for psychoactive drug use, dated 12/03/13, indicated R4 received scheduled antidepressants and antipsychotics on a daily basis and was followed by psychology. R4 ' s physician order sheets, dated 10/30/14, listed an active order for Haloperidol 5 milligrams (mg) every two hours as needed for agitation and/or hallucinations. The initial start date of the order was 9/6/14. R4 ' s medication sheets for the months of 9/14 and 10/14 revealed R4 received the Haloperidol on six occasions, with the most recent dose administered on 10/24/14. R4's care plan, dated 10/30/14 did not identify R4 ' s behavioral symptoms, nor any pharmacological or non-pharmacological approaches. R4's physician progress notes, dated 9/5/14, revealed R4 exhibited delusions that were not	F 428	The care team has developed a collaborative care team to meet and review care plans, behavioral plans, psychotropic medication and change of conditions. This team will meet every other Monday starting on 12/1/14 and will be ongoing. The team consists of the DNS, MDS Coordinator, ACU Director, Social Worker, and nursing assistant. Dietary, activities, and therapy will join on an as needed basis. The goal of this meeting is to ensure that care plans are accurate and p to date and to ensure that communication is accurate between all members of the care team. The DNS has implemented a system that is easy to review for staff, MD, CNP, and pharmacist to easily review the psychotropic medications. DNS and pharmacist will meet monthly to review psychotropic concerns/inconsistencies. Concerns will also be discussed at QAPI meetings monthly. R4's care plan has been updated to reflect need for psychotropic concerns/inconsistencies. Dosage and indications for use have been updated to include a maximum daily dosage and indications for use. Collaborative Care team will be in charge of following and reporting to QAPI Meeting members monthly. Consultant	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 428	Continued From page 25 distressing to him and that R4 was not a threat to himself or others. R4's medication regimen reviews completed by the consultant pharmacist (CP) revealed no irregularities were reported on 10/9/14. The 9/15/14 review indicated R4 was receiving PRN (as needed) Haldol and to monitor. During interview on 10/29/14, at 4:00 p.m., licensed practical nurse (LPN)-A stated R4 exhibited more behaviors in the evening and received the Haloperidol as needed, although she had never had to give R4 any. LPN-A reported R4 saw animals and tried to pet them, and occasionally saw people. The visualizations were not distressing to R4. During interview on 10/30/2014, at 1:43 p.m. registered nurse (RN)-B stated she had given R4 the Haloperidol and used it for physical aggression towards others. RN-B indicated non-pharmacological approaches that sometimes worked for R4 included reality orientation and snacks as well as having him visit staff at the nursing station. During interview on 10/30/2014, at 2:02 p.m., the CP stated the Haloperidol order lacked the proper parameters for use and should be " Discontinued immediately. " The CP stated the current order could potentially allow for a total of 60 mg of Haloperidol in a 24 hour period and this was concerning, she would not recommend more than three milligrams up to three times per day. The CP also stated that agitation was not a good indication for use of Haloperidol, the indications for the use should be more specific than currently listed. The facility policy entitled Behavior Management Committee, last revised 2013, indicated the focus of the Behavior Management Committee is to conduct an interdisciplinary review, analysis and if	F 428	pharmacist and DNS will be responsible parties to insure compliance.	

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	245348	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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F 428	Continued From page 26 warranted revision or creations of a behavior management plan both behavioral and pharmacological. The policy further directed an interdisciplinary behavior committee was in place to review all patients/residents with behaviors or on antipsychotics.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Golden Living Center-Rush City was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 or By E-Mail to: Marian Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/28/2014

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
	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Living Center-Rush City is a 1-story building with a partial basement. The building was constructed in 1967. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on review of available documentation the kitchen hood extinguishment system is not	K 069	The kitchen hood extinguishment system was inspected on 11/17/14 by a	11/17/14

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

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K 069	Continued From page 2 properly being maintained in accordance with MSFC(07) section 904.5.1 & NFPA 96. This deficient practice could effect all building occupants in the event of a fire under the hood. Findings include: At the conclusion of the facility tour on 10-29 -14 at approximately 9:30AM, based on a review of available documentation, the last inspection. testing and maintenance of the kitchen hood extinguishment system was completed 12-13. This procedure is required every 6 months. This deficient practice was confirmed by the Director of Maintenance (JW) at the time of exit.	K 069	contracted agency, Nardini. Nardini verified that that the system is in complance with all applicable standards as of 11/17/14. The inspectoins have been set up on a schedule for Nardini to automatically come out every 6 months for required inspections. Maintenance Director will be responsible for monitoring to prevent a reoccurrence of deficiency.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency generator is being properly inspected and tested weekly and monthly as required by NFPA 110. This deficient practices could affect all residents staff and visitors.	K 144	Generator was surveyed on 11/21/14 by Interstate for load ability. It was determined that the label rating is based for gasoline or L.P. fules. The generator is running on Natual Gas and would affect the rating. Interstate states that "the	12/1/14

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 144	Continued From page 3 Findings include: At the conclusion of the facility tour on 10-29-14 at 9:30 AM, based on interview, and review of the documentation, with the Facility Maintenance Director, it could not be determined, if the emergency generator is being inspected weekly and or monthly in accordance with the requirements as outline in NFPA 110. It could not be determined if all the parameters of required inspection are being met. This would include the monthly 30% load testing. The generator is a 45, natural gas fueled, and cooled by pass through city water Forms were provided to the facility at the time of exit. This deficient practice was confirmed by the Facility Maintenance staff(JW) and (KN) Administrator at the time of exit.	K 144	customer is meeting the 30% requirement, even at a 35 KW Rating. 30% of 35 KW is 32 amps. It appears the average load is about 35 amps." On 11/24/14 a load bank was initially started by Interstate and was held at an 78% load. On 12/1/14 a load bank will be completed on the generatorn to verify compliance. A load bank will be completed again in 2015 to verify and maintain compliance. Maintenance Director will verify infomatoin getting put into a compliance spreadsheet to insure generator is being properly tested weekly and monthly. Executive Director will review for compliance on a monthly basis.	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
November 18, 2014

Ms. Virginia Porter, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, MN 55069

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5348024

Dear Ms. Porter:

The above facility was surveyed on October 28, 2014 through October 31, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731, or email: gary.nederhoff@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5348s15license

00994 S5348024 BH6711
GOLDEN LIVINGCENTER RUSH CITY
650 BREMER AVENUE SOUTH
RUSH CITY, MN 55069
320-358-4765

Scanning Sheet

Fill in one:
Event #_____ Exit Date_____

Resident Name _____Resident #_____
or

Name of Facility Task_____

Surveyor Name PLN Federal Number 12835

Certification Survey X PCR survey_____ Other_____

If specific information from a complaint, make sub folder - Complaint H_____.

For Supervisors:

Circle appropriate scanning place:

Admin-- sub folder H/H signed hic

Scan Docs-- sub folder

Send Papers to:

12/17/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00994	A. BUILDING: _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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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 October 28, 29, 30, and 31, 2014 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000		