CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COMI								cility ID: 00949	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245400 2.STATE VENDOR OR MEDICAID NO. (L2) 854542100).	3. NAME AND ADD (L3) GOLDEN LI ¹ (L4) 660 MAPLE S (L5) WABASSO, M	VINGCENTER - STREET			(L6) 562	293	1. Initi	nination	7(L8) 2. Recertificat 4. CHOW 6. Complaint	iion
5. EFFECTIVE DATE CHANGE OF OWN (L9) 04/01/2006	ERSHIP	7. PROVIDER/SUP		09 ESRD	02 13 PTIP	(L7)	22 CLIA		Site Visit Survey After Cor	9. Other	
6. DATE OF SURVEY 03/08/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE			EAR ENDING 1	DATE:	(L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 44 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	44 (L18) 44 (L17) 19 SNF (L39) S (IF APPLICABLE S	B. Not in Comp Requirements a ICF (L42)	nce With quirements Based On: cceptable POC cliance with Program and/or Applied Waive IID (L43)	SIS:	2. 3. 4.	Technical 24 Hour I 7-Day RN Life Safe A*	I Personnel RN N (Rural SNF) ty Code	_ 6. _ 7. _ 8.	quirements: Scope of Servic Medical Direct Patient Room S Beds/Room (L15)	ces Limit or	
17. SURVEYOR SIGNATURE Christine Bodick-No.	rd, HFE NE	Date :	03/08/2016	(L19)			agency ap Γon, Pro		pecialist	Date: 03/10/20	
	PART II - TO	BE COMPLETEI	D BY HCFA RE		OFFICE (OR SING	GLE STAT	E AGENC	Y		(L20)
DETERMINATION OF ELIGIBILITY	cipate (L21)		PLIANCE WITH CI	VIL	21.	2. Owne		ial Solvency (H Interest Disclos	ICFA-2572) ure Stmt (HCFA	-1513)	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEME BEGINNING I		4. LTC AGREEMEN ENDING DATE (L25)		26. TERMI VOLUNTAR 01-Merger, C 02-Dissatisfa	RY Closure	ACTION: 00 Reimburseme		INVOLUNTA	et Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)		03-Risk of In 04-Other Rea				OTHER	Status Change	
28. TERMINATION DATE:	29	INTERMEDIARY/CA			30. REMAR	RKS					
	22.	00454									
	(L28)	00101		(L31)							

32. DETERMINATION OF APPROVAL DATE

02/19/2016

(L32)

Posted 04/13/2016 Co.

DETERMINATION APPROVAL

(L33)

31. RO RECEIPT OF CMS-1539



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245400 March 11, 2016

Mr. Wayman Fischgrabe, Administrator Golden Livingcenter - Wabasso 660 Maple Street Wabasso, Minnesota 56293

Dear Mr. Fischgrabe:

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 February 23, 2016 the above facility is certified for or recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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.

Golden Livingcenter - Wabasso March 11, 2016 Page 2

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 11, 2016

Mr. Wayman Fischgrabe, Administrator Golden Livingcenter - Wabasso 660 Maple Street Wabasso, Minnesota 56293

RE: Project Number S5400025

Dear Mr. Fischgrabe:

On January 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, effective February 23, 2016 and therefore remedies outlined in our letter to you dated January 29, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Golden Livingcenter - Wabasso March 11, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

ID Prefix

Reg. #

F0323

483.25(h)

Correction

Completed

ID Prefix

Reg. #

F0441

483.65

		POST	-CERT	TIFICATION	N RE	VISIT RE	EPORT			
	R / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION						DATE O	F REVISIT
245400	CATION NUMBER Y1	A. Building B. Wing						Y2	3/8/2010	6 _{Y3}
NAME OF	FACILITY				STREE	T ADDRESS, CIT	Y, STATE, ZIF	CODE		
GOLDEN	I LIVINGCENTER - WAB	ASSO			660 MA	PLE STREET				
					WABAS	SO, MN 56293				
•	number and the identificative y report form).	ation prefix code p	reviously s		2567 (pr	DATE	vn to the left	of each requirement	ent on	DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 02/23/2016	ID Prefix Reg. # LSC	F0248 483.15(f)(1)		Correction Completed 02/23/2016

Correction

Completed

ID Prefix

Reg.#

Correction

Completed



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 11, 2016

Mr. Wayman Fischgrabe, Administrator Golden Livingcenter - Wabasso 660 Maple Street Wabasso, Minnesota 56293

Re: Reinspection Results - Project Number S5400025

Dear Mr. Fischgrabe:

On March 8, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 14, 2016, with orders received by you on November 1, 2001. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building			
00949 _{Y1}	B. Wing	Y2	3/8/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WABA	ASSO	660 MAPLE STREET		
		WABASSO, MN 56293		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEI	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20830		Correction	ID Prefix	21390		Correction	ID Prefix	21435		Correction
Reg. #	MN Rule 4658.05 Subp. 1	520	Completed	Reg. #	MN Rule Subp. 4	e 4658.0800 A-I	Completed	Reg.#	MN Rule 4658.0900 Subp. 1)	Completed
LSC			02/23/2016	LSC			02/23/2016	LSC			02/23/2016
ID Prefix	21990		Correction	ID Prefix	22000		Correction	ID Prefix			Correction
Reg. #	MN St. Statute 62 Subd. 4	26.557	Completed	Reg. #	MN St. Subd. 1	Statute 626.557 4 (a)-(c)	Completed	Reg.#			Completed
LSC			02/23/2016	LSC			02/23/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWE STATE AG		REVIEWED (INITIALS)		DATE 03/11/	2016	SIGNATURE OF SU		955		DATE	08/2016
REVIEWE CMS RO	D BY	REVIEWED (INITIALS)	D BY	DATE		TITLE				DATE	
FOLLOW U	JP TO SURVEY C	OMPLETED (ON	_		ANY UNCORRECTE ED DEFICIENCIES				YES	S NO
						Page 1 of 1			EVENT ID:	CC0812	

Page 1 of 1 EVENT ID: CG8S12

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: CG8S

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I - TO BE COM	PLETED BY THE ST	ALE SURVEY AGENCY	Facility ID: 00949
MEDICARE/MEDICAID PROVIDER NO. (L1) 245400		ORESS OF FACILITY VINGCENTER - WABA	ASSO	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.	(L4) 660 MAPLE S	STREET		1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 854542100	(L5) WABASSO, M	MN	(L6) 56293	5. Validation 4. Crrow 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUP	PLIER CATEGORY	<u>02</u> (L7)	
(L9) 04/01/2006	01 Hospital	05 HHA 09 ES	RD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 01/14/2016 ((L34) 02 SNF/NF/Dual	06 PRTF 10 NF	14 CORF	
8. ACCREDITATION STATUS: (I	L10) 03 SNF/NF/Distinct	07 X-Ray 11 ICI	F/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP 12 RH	IC 16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY	IS CERTIFIED AS:		
From (a):	A. In Complian	ice With	And/Or Approved Waivers Of The	e Following Requirements:
To (b):	Program Rec	quirements	2. Technical Personnel	6. Scope of Services Limit
	Compliance	Based On:	3. 24 Hour RN	7. Medical Director
	1. A	cceptable POC	4. 7-Day RN (Rural SNF)) 8. Patient Room Size
12.Total Facility Beds 44 (I	L18)		5. Life Safety Code	9. Beds/Room
13.Total Certified Beds 44 (I	,	pliance with Program and/or Applied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS	
18 SNF 18/19 SNF 1	19 SNF ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
44	., 5		1001 (0) (1) 01 1001 (1) (1).	
	~ · · · · · · · · · · · · · · · · · · ·	7. IN		
(L37) (L38)	(L39) (L42)	(L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	CABLE SHOW LTC CANCELL	ATION DATE):		
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY AF	PPROVAL Date:
Mardelle Trettel, HFE	E NE II)2/17/2016 (L1	Kate JohnsTon, Pi	rogram Specialist 02/18/2016 (L20)
PART I	II - TO BE COMPLETEI	D BY HCFA REGION	NAL OFFICE OR SINGLE STAT	TE AGENCY
19. DETERMINATION OF ELIGIBILITY		PLIANCE WITH CIVIL	21. 1. Statement of Finance	
1. Facility is Eligible to Participate	RIGH	TTS ACT:	2. Ownership/Control 3. Both of the Above:	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible				
	(L21)			
22. ORIGINAL DATE 23. LTC A	GREEMENT 2	4. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEG	INNING DATE	ENDING DATE	VOLUNTARY 0	<u>INVOLUNTARY</u>
12/01/1986			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41))	(L25)	02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement
	RNATIVE SANCTIONS	(===)	03-Risk of Involuntary Termination	OTHER
	spension of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
A. Su	ispension of Admissions.	(L44)		00-Active
(L27) B Re:	scind Suspension Date:	(LHI)		
		(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/C	ARRIER NO.	30. REMARKS	
	00454			
(L28)		(L3)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION C	OF APPROVAL DATE	Posted 02/19/2016 Co.	
(L32)		(L33	B) DETERMINATION APPRO	OVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 29, 2016

Mr. Wayman Fischgrabe, Administrator Golden Livingcenter - Wabasso 660 Maple Street Wabasso, Minnesota 56293

RE: Project Number S5400025

Dear Mr. Fischgrabe:

On January 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Golden Livingcenter - Wabasso January 29, 2016 Page 2

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343

Fax: (320)223-7348

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 February 23, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 23, 2016 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;

Golden Livingcenter - Wabasso January 29, 2016

Page 3

- 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.

Golden Livingcenter - Wabasso January 29, 2016 Page 4

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 April 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900 Golden Livingcenter - Wabasso January 29, 2016 Page 5

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF F						
NAME OF F		245400	B. WING _		01/	14/2016
	PROVIDER OR SUPPLIER LIVINGCENTER - WA	ABASSO		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 00	00		
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
F 225 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	PORT	F 22	25		2/23/16
	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have abusing, neglecting, or abusing, neglecting, or abuse, neglecting, or have abuse, neglect, mistreatment appropriation of their property; viedge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies.				
	involving mistreatmincluding injuries of misappropriation of immediately to the ato other officials in a through established State survey and ce	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the ertification agency). ER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

02/02/2016

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245400	B. WING		01/14/2016
	PROVIDER OR SUPPLIER	ABASSO		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 225	violations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclucertification agency incident, and if the	eve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225	5	
	by: Based on interview facility failed to ensimmediately reporte state agency, then for 1 of 1 residents been abused during. Findings include: R45's quarterly min 11/19/15, indicated was independent w During an interview stated registered number, and grabbed Finding at her. R45 fill out a grievance of the incident to the fill out a prievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident to the fill out a grievance of the incident of the fill out a grievance of the incident of the inc	imum data set (MDS) dated she was cognitively intact and ith all activities of daily living. on 1/14/15, at 11:53 a.m. R45 arse (RN)-D had "assaulted" 45's forearm and spoke stated she was "too scared to form," but added she reported acility administrator. Further, dent occurred during the		Preparation, submission and implementation of this Plan of corre does not constitute an admission of agreement with the facts and concluset forth on the survey report. Our Correction is prepared and execute means to continuously improve the of care and to comply with all applicate and federal regulatory required GLC-Wabasso realizes the importation immediate reporting of allegations of abuse to the administrator and State agency. The performing a comprehenvestigation. The policy and procedure for immediate reporting of abuse allegations has be reviewed for resident #45. All residents have the potential to be	or usions Plan d as a quality able ments. nce of of e nensive diate peen

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	facility administrator incident between F 9/9/15, but was not of abuse until 9/21, administrator state brought the concerdoesn't document, when someone tell administrator state State agency, "I do state agency." During an interview stated R45 approarbecause RN-D grathought she was postated she did not potential abuse to agency though. R45's progress not RN-D had grabbed when she asked R The note did not id State agency was abuse. R45's Verification of 9/21/15, consisted made by staff. RN abuse by R45 on 9 not been initiated undocuments. The pto include a, "Detail event/allegation," verification," verification,	age 2 on 1/14/15, at 2:07 p.m. the or stated he thought the 145 and RN-D occurred on a made aware of the allegation 1/15 (12 days later). The dhe was unaware who on to his attention, adding he "Who told me something, [or] is me something." Further, the dhe did not report it to the not believe I reported it to the not believe I reported it to the bed a hold of her arm and possibly angry with her. RN-A report the allegation of the administrator or State the administrator or State the staff and reported that ther arm "the other day" and N-D to let go, RN-D said "no." entify if the administrator or notified of the allegation of the which staff identified as, the Isic some time last week the Isic some time Isic some time Isic some Isic some time Isic some Isic so	F 2	225	affected by the deficit practice. To further incident to other residents reeducation will be provided to staff timely reporting of abuse allegation administrator and state agency the performing a comprehensive investigation. To monitor its performance and to resure solutions are sustained, rando bimonthly audits until June 1 2016 arandomly there after as needed on following: immediate reporting of at allegations and comprehensive investigations and if reported to the will be performed by the E.D./Desig with audit results reviewed in QAPI quarterly and as needed.	f on s to the n make om and the ouse	

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F 225	provided spacing to interview summary, "[RN-D] grabbed m week." The forms so "immediate residen left blank. The colle identify any intervier abuse concerns, or reported concerns. A facility Policies ar Investigation and R of Federal or State or Injuries of Unknows 3/2012, identified at or mistreatment were immediately to the [administrator] of the Minnesota Department and to the Common Director." Further, "Investigate each so thoroughly and repositive tight and Common State and Federal Edel 18 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negle	right arm." Further, the form of describe a, "Resident "which staff identified, y arm [right] sometime last spacing to identify what, trotection," was initiated was ected notes and form did not ws of other staff to rule out follow up to R45 on her and Procedures Regarding eporting of Alleged Violations Laws Involving Maltreatment, was Source policy dated all allegations of abuse, neglect re to be, "reported executive Director e facility [and] to the nent of health [State agency] in Entry Point by the Executive the policy directed staff to, such alleged violation out the results of all e Minnesota Department of the Entry Point as required by aw." P/IMPLMENT, ETC POLICIES	F 22			2/23/16
	This REQUIREMEN	NT is not met as evidenced				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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F 226	by: Based on intervier facility failed to improcedures to ensimmediately report state agency, and for 1 of 1 residents been abused during Findings include: A facility Policies a Investigation and For Federal or State or Injuries of Unkn 3/2012, identified a or mistreatment with immediately to the [administrator] of the Minnesota Department and to the Common Director." Further, "Investigate each state thoroughly and reprinvestigations to the Health and Common State and Federal R45's quarterly minustry and the stated registered in the stated registered in the stated registered in the stated registered in the incident to the stated incident to the stated registered in the incident the in	w and document review, the olement policies and sure allegations of abuse were ted to the administrator and comprehensively investigated is (R45) who reported she had ing the survey. Ind Procedures Regarding Reporting of Alleged Violations is Laws Involving Maltreatment, own Source policy dated all allegations of abuse, neglect ere to be, "reported Executive Director the facility [and] to the ment of health [State agency] on Entry Point by the Executive in the policy directed staff to, such alleged violation port the results of all the Minnesota Department of on Entry Point as required by	F 2	GLC-Wabasso realizes the immediate reporting of alleabuse to the administrator agency. The performing a investigation. The policy and procedure for reporting of abuse allegation reviewed for resident #45. All residents have the pote affected by the deficit practifurther incident to other respective reeducation will be provided timely reporting of abuse a administrator and state agree performing a comprehensitive stigation. To monitor its performance sure solutions are sustained bimonthly audits until June randomly there after as new following: immediate report allegations and compreher investigations and if reportive will be performed by the E. with audit results reviewed quarterly and as needed.	gations of and State comprehensive for immediate ons has been tital to be tice. To prevent sidents d to staff on llegations to the ency then we and to make ed, random 1 2016 and eded on the ting of abuse nsive ed to the MDH D./Designee	

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F 226	facility administrator incident between F 9/9/15, but was not of abuse until 9/21/ administrator state brought the concerdoesn't document, when someone tell administrator state State agency, "I do state agency." During an interview stated R45 approach because RN-D grathought she was postated she did not agency though. R45's progress not R45 had approach RN-D had grabbed when she asked R The note did not id State agency was abuse. R45's Verification of 9/21/15, consisted made by staff. RN abuse by R45 on 9 not been initiated udocuments. The pto include a, "Detail		F 2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED	
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F 248 SS=D	RN-D grabbed her provided spacing to interview summary. "[RN-D] grabbed m week." The forms: "immediate residen left blank. The colleidentify any intervie abuse concerns, or reported concerns. 483.15(f)(1) ACTIV INTERESTS/NEED. The facility must proof activities designed the comprehensive	tha [sic] some time last week, right arm." Further, the form of describe a, "Resident" which staff identified, y arm [right] sometime last spacing to identify what, t protection," was initiated was ected notes and form did not ws of other staff to rule out follow up to R45 on her	F 2			2/23/16	
	by: Based on observatoreview the facility fainterest were offere (R15, R5 and R21) facility activity programmings include: R15's significant ch (MDS), 1/6/16, identinact was independently in the activity programming. The activity programming in the programming in the programming in the involved with a general series of the involved wi	ion, interview and document alled to ensure activities of d/provided for 3 of 3 residents who had concerns about the ram. ange Minimum Data Set attified she was cognitively dent with activities of daily preference identified it was also to have reading material, group of people, go outside for involved in her favorite		GLC-Wabasso realizes the imporproviding ongoing programs of addesigned to meet the interest and physical, mental and psychsocial well-being of its residents. The activities assessment for results, 15 and 21 have been reviewed reassessed, with identified approactivities put in place. All residents have the potential to affected by deficit activity assess and not completing of scheduled activities. To prevent further incide	idents d and oriate be ments		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ABASSO		66	TREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE STREET /ABASSO, MN 56293		
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F 248	activity. The MDS express ideas and others. R15's Activities Ass prior to admission Itelevision, reading, games. Even though R15 did these activity at the time. During interview on stated that she enjoy Council and has madifferent activities system that has spowii video game wa Calendar but she his since she arrived at know how to set up use it. Bingo is play Wednesday, and the available. During follow up vis R15 again expressionsted on the activity provided. Review of the Resignon June 2015 to and on 10/12/15 the bowling tournamen wanted to move the	also indicated R15 was able to wants and could understand ressment of 10/27/15 identified R15 spent time watching puzzles and computer video gh the assessment identified ities before admission, the mes were "present: not now." suggestions for activity staff 1/11/16 at 07:21 p.m. R15 regretating in Resident ade several suggestions of uch as Wii video game (gamin orts and other games). The slisted on the Activity as not seen since this game to this facility. The staff do not of the game so residents can red every day except for the game so residents can red every day except for the game sure this activity was set on 01/14/16 at 8:46 a.m. and concerns that activities ities calendar were not dent Council Meeting Minutes January 2016 were reviewed as council wanted to have a Wii t, and on 06/08/15 residents and have a bean bag	F 2	448	other residents all resident assess have been reviewed to ensure accuand have been updated as needed staff involved with activities have be reeducated on appropriate assess activities and the completion of schactivities. To monitor its performance and to resure solutions are sustained randor bimonthly audits will be completed June 1st 2016 and randomly there as needed of activity assessments performing scheduled activities will performed by the ED/designee with results reviewed in QAPI quarterly aneeded.	racy further een ment of eduled make m until after and be audit	

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F 248	activities director (A from June 2015 to The Wii video game her Sunday evening staff work Monday the evening bingo a volunteer and other the activity staff are state they have a Whas tennis, bowling Wheel of Fortune, I gaming system was television but "no owas unsure when the played, but thought first started her post The AD stated resiductivities either indi Resident Council. Swanted to play the was unable to find fall. Even though swanted to play this June 2015 Resider added it to the activities would add the February calendar, game system gets During interview on assistant (NA)-D stinstructions to assist weekends. If the rewe will get those. Tactivity calendar, but oset this system up to set the system up to set this system up to set	1/13/16 at 8:29 a.m. with AD) the facility activity calendar January 2016 were reviewed. The sees were routinely scheduled as. The AD stated that activity through Friday 8:00-3:30 p.m., activity was led by a resident recommunity volunteers, since a not working. AD continued to vii video gaming system that and other sports along with Deal and No Deal games. The see hooked to the main lobby the knows how to run it". She will be a shooked to the main lobby the Wii video game was last it was June 2015 when she	F 24	48		

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F 248	video game system sue but she was un game, nor has anyo Although R15 had the use the Wii video govideo/computer gar system was not availed even though this was calendar since Junealso suggested bear change the Wii video evenings, these recompleted that reflect it rights of the resident residents, including R5's significant character and R5 was indepelliving. The MDS further preferences that we included having boom agazines to read; doing things with grin favorite activities fresh air in good were supported to the same support of the same su	7 a.m. NA-A stated the Wii is available for residents to sure how to operate the one asked her to do this. Old facility staff she wanted to aming system, and had used mes at home. The Wii gaming allable to be used by residents as on the monthly activity a 2015. The resident council an bag tournament, and to go game to Wednesday quests were never acted upon. Twices Guide: Calendar Policy as that that each activities will be the schedules, choices, and next at hours convenient to the afternoons and weekends. Inge Minimum Data Set (MDS) tified R5 had intact cognition and with activities of daily other identified activity ere "very important" to R5 oks, newspapers and listening to preferred music; oups of people; participating and going outside to get eather. The MDS also bole to express ideas and	F 2	248			
	R5's quarterly Recr	eation Services Assessment,					

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F 248	dated 10/2/15, iden preferences include independently, with small group, in-root the community. The R5 occupied her tincrafts or games wit good participation in R5's leisure prefere games, puzzles, wo games, walking, tel gardening, arts and R5's care plan, date would like to continue to expendent of the can still do activities crafts, bingo, outing simple pleasure: Owill continue to expendent of the can still do activities supplies I need. In Invite me to my favorafts orn [sic] othe that I might be interested to the facility on the activities. Further, to provide our own In a subsequent into p.m. R5 stated they activities that were because there was activity. R5 also steepected to do the	tified R5's program ed activities done friends/family, large group, m, out of room, outside, or in e assessment also indicated ne with independent activities, h other residents, and showed n group activities. In addition, ences included bingo, table ord searches, computer evision, music, reading, I crafts, shopping, and movies. ed 12/16/15, indicated, "I ue participating in the es I currently enjoy such as; gs, watching tv, reading. Life's trafts." The goal for R5 was, "I ress my enjoyment and e activities." Staff were ck in with me to make sure I independently and have any vite me to go on outings. orite activities such as; bingo r games and to try new things	F 2	48		

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F 248	occasions, "but not stated she wished shoard and erase all scheduled but did referenced to staff" at the facility of limitation.	e activity program on several hing gets better." R5 also she could go to the activity I the events that were not happen, and if she had, much left on the activity board. on 1/13/16, at 7:11 a.m. R5 bed. There were colored markers and a pedside table. 1/13/16, at 8:45 a.m. nursing ated R5 was very active and IA-A further stated R5 often puzzles, and played games and IA-A also stated, "[R5] has pout not having enough to do." on 1/13/16 at 1:28 p.m. R5 able in the dayroom playing to other unidentified residents. on 1/14/16, at 8:26 a.m. the on 1/14/16, at 8:26 a.m. the on the dayroom playing to other unidentified residents. on 1/14/16, at 8:26 a.m. the on the AD further stated at several residents were activity program and it was the to figure out how to meet of the residents. The AD that there was "no activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity on the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity of the weekends as a factor of the activity o	F 2	248			
	NA-D stated R5 like	on 1/14/16, at 8:58 a.m. ed to play bingo, Farkle, and o stated there were days that					

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F 248	scheduled activities not provided becau available. In addition residents have told our activity program. When interviewed of director of nursing of Farkle, Lucky Dissummer, enjoyed groing to the thrift stand crafts. The Dofor example, if only activity may get car at least three reside order for an activity. R21's quarterly MD R21 was cognitively indicated R21 was on the unit. R21's care plan, dapreferred independ with my family and things in groups and times a week with find was to continue paractivities or things were instructed to inactivity programs the enjoy, monitor R21' activities and supplication assist R21 in partical and encourage R2-appointments rather	s on the activity calendar were se there were no staff on, NA-D stated, "Several me they are not happy with n." on 1/14/16, at 9:15 a.m. the (DON) stated R5 played a lot ce, loved to garden in the oing out in the community, ore, and she loved to do arts DN added, with our activities, three residents sign up, the neeled. The DON also stated ents must be signed up in	F 2	48			

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F 248	11/30/15, indicated junk dealer and he The assessment further speech, was alert, others. The assess have any present le participated in. Professindependent and out of the room and further indicated R2 skills groups but off had no real interest than popcorn on Fr Wednesdays. R21 as to other activities offered. When interviewed a stated that the faciliare interesting to his life he worked with does not offer anythexplained he did no could longer read the R21 was observed in his wheelchair by	R21's past occupation was a worked with iron and steel. In ther indicated R21's vision ing was intact, had clear cooperative and interacts with ment indicated R21 did not eisure preferences that he gram preferences listed R21 did preferred large groups, being doutside. The assessment 21 had attended some life ten refused. In addition, R21 tin other group activities other idays and oven cooking on had not given any suggestions is that he would like to see on 11/11/16, at 7:01 p.m. R21 ity does not offer activities that im. R21 further stated that all with his hands and the facility hing like that here. R21 of enjoy bingo because he	F 24	8			
	p.m. R21 stated he activities at the faci asked him to attend a big deal because interested him. R21	had not participated in any lity all week, and no one had deither. R21 stated, it was not there were no activities that I could not recall if any staff pested alternate activities that					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Continued From page 14 During interview on 1/14/16, at 2:40 p.m. NA-D stated R21 did not participate in any activities and		F 248			
F 323 SS=D	that the only activitic popcorn on Fridays groups on site performance on stated she had offer that there were large for use. The AD furrorganized schedule The AD stated that and that R21 was do R21 had not given to what he would like activity program do R21.	es R21 participates in is and when there are music orming. 1/14/16, at 3:59 p.m. the AD red R21 building blocks and e print bingo cards available ther stated there were no d activities specific to men. R21 refuses group activities ifficult to please. In addition the facility any suggestions on to do. The AD also stated the les not provide 1:1 time with	F 323			2/23/16
	environment remain as is possible; and	sure that the resident as as free of accident hazards each resident receives and assistance devices to				
	by: Based on observat review, the facility fa adequate supervision accidents when nav doorway to the outo	ion, interview, and document ailed to ensure residents had on/assistance to prevent rigating the facility exit loor smoking area for 1 of 5 served who used the outdoor		GLC-Wabasso realizes the import providing an environment that is free accidents and hazards and providing adequate supervision and assistive devices to prevent accidents.	ee of ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245400	B. WING			01/	14/2016
	PROVIDER OR SUPPLIER	ABASSO		66	TREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE STREET VABASSO, MN 56293	, ,	,, = 0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	smoking area. Findings include: R55's undated face admitted to the faci impairment, abnormand cerebral vascu undated care plan i with wheelchair (w/assistance of one state of the doorway threshold. Scooting motion, gedoorway threshold, open to get inside. On 1/12/16, at 9:50 wheelchair outside When R55 finished open, and started to the doorway, but was threshold, and his well and the doorway exit door open to al building. On 1/13/16, at 8:10 the exit doorway gestanding up, with the	sheet identified he was newly lity with diagnoses of cognitive nalities of gait and mobility, lar infarction (stroke). R55's dentified he was dependent c) mobility and received taff for transfers and toileting. on 01/11/16, at approximately ne facility smoking in his R55 finished smoking, he ass door open, and was brward, while scooting in the ing around the glass door and into the floor to propel himself He continued in this jerking, etting his wheelchair over the while holding the facility door a.m. R55 was observed in his in the facility smoking area. Is smoking, he pulled the door of maneuver his w/c through as unable to get over the w/c was caught in the doorway. It is sistent (PTA)-B whom saw of a saisted him by holding the low R55 to get into the a.m. R55 was observed in his ing outside to smoke. He was e wheelchair directly behind on the door handle, while	F3	23	Resident #55 has been reassesses safety and maneuvering of the use smoking door. All residents have the potential to be affected by the deficit practice. All smokers have been reassessed for Staff have been reeducated on appropriately assessing residents a maneuver the smoking door thresh prevent further incident the threshot the smoking door has been replaced. To monitor its performance and to sure solutions are sustained, rando bimonthly audits will be completed. June 1st 2016 and then randomly needed of resident safety of mane the smoking door threshold will be performed by the ED/designee with results reviewed in QAPI quarterly needed.	of the respective per safety ability to hold. To hold	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245400	B. WING _		01	/14/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - W.	ABASSO		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH	OULD BE	(X5) COMPLETION DATE
F 323	trying to walk outsice R55 legs were shake walk through the dobehind him. Registed walking down the hands yelled to R55 proceed down the hroom, and did not a (AD) who was in the smoking area exit or room, and held the back in his wheelch himself over the through the wheels of his character outside smoking area. When interviewed on the whole outside smoking area out the door, and going to get caught stated that resident do this independent. Review of R55 phys. 1/09/16, identified from the wastransfer. R55's Smoking Saf 1/11/16 identified from the wastransfer. R55's primary listed as wheelchain himself. There was	de over the doorway threshold. Ry and unstable while trying to borway pulling his wheelchair ered nurse, (RN)-A was allway, with medications in her 5, "Be careful." RN-A, nallway into another residents assist R55. The activity director e activity room, adjacent to the door came hurriedly out of the door open for R55. R55 sat hair and proceeded to wheel eshold but became stuck with hair. AD assisted R55 over the ding the exit door to the ea. on 1/13/16, at 8:14 a.m. the AD R55 around the door a few use he was standing trying to ad it looked like his foot was on his foot pedal. She further s who smoke must be able to	F 32	23		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245400	B. WING		0	1/14/2016
	PROVIDER OR SUPPLIER	ABASSO		STREET ADDRESS, CITY, STATE, ZIP COD 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE
F 323	"Nursing reported [with safety with get Observe [R55] with [sic] out of facility a open to come back Spoke to DON abo as at this time he is unsupervised." During interview or occupational therape R55 had problems his stroke history. Ophone call from phy (PTA)-B this morning and out of smoking was that residents	illy Treatment Note identified, R55] had increased difficulty ting in and out smoking door. It this and did struggle to set and leaning. Unable to get door in facility without assistance, ut increased difficulty with this, is unsafe to be smoking a 1/12/16, at 3:38 p.m. certified by assistant (COTA)-A stated propelling his w/c, because of COTA-A stated she received a sysical therapy assistant and about R55's ability to go in exit door. The facility's policy	F3	23		
	registered nurse (Rshe was aware (Rswheelchair" when a smoke. She sent a wheelchair position to see if he could swhich was passed no indication the fa R55 through the exinterventions to hel for R55. On 01/13/2016 at a overnight staff have attempted to self-tr	on 01/13/16, at 12:13 p.m. RN)-A stated that on 1/11/16 is) "nearly tipping out of attempted to go outside to request to evaluate (R55's) for ing. We were to watch R55's afely get in and out of building, on during report. There was cility had alerted staff to assist it doorway, or identified other preduce the risk of accident at 12:15 p.m. (NA)-A stated the exported that R55 had ansfer and they were or for this. She had not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING _		01/	/14/2016
	PROVIDER OR SUPPLIER	ABASSO		STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	received any directing going in and out of not told us anything. The above observed director of nursing (p.m. The DON state concerns that R55 of the facility to smooth assessments are of determine if they are designated smoking reassessing (R55) at the smoking door s. The Golden Living Procedure, last reviresident who desires of the facilities ID determined that the resident. All resident ability to safely smooth policy does not ider to manipulate the dismoking area, to propose the facility must estable to help prevent the of disease and infection Control Presafe, sanitary and of the prevent the of disease and infection Control	on to assist, or monitor R55 the smoking area. They have tions were discussed with DON) on 01/13/2016 at 12:40 ted she was unaware of any had difficulty getting in and out oke. The facility smoking completed with each resident to e able to get in and out of the g area safely. They would be ability to maneuver through o he would remained safe. Wabasso Smoking Policy And ised on 4/13 identified, "Every es to smoke is permitted to so a practice would be safe for the outs shall be assessed for their oke independently" The other independently" The other independent are assessed oorway to the resident event any potential accident of CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control	F 32			2/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING		 	01/1	14/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WABASSO				STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		1 0 1/1 1/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what p should be applied t (3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dihand washing is indeprofessional practic (c) Linens Personnel must ha	ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective afections. Read of Infection cion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F4	41			
	by: Based on interview facility failed to imp program which incl trending, and analy potential transmiss	NT is not met as evidenced and document review, the lement an infection control uded consistent monitoring, sis of infections to reduce the ion to other residents in the e potential to affect all 32 in the facility.			GLC-Wabasso realizes the import maintaining an infection control prodesigned to provide safe, sanitary comfortable environment to prever development and transmission of cand infection. All residents have the potential to be affected by the deficit practice, to provide the safe of	ogram at the disease	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING			01/1	14/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WABASSO				66	FREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE STREET FABASSO, MN 56293		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	41	further incident staff have been reeducated on the consistent documentation of infection control surveillance flow sheets and line list as well as analysis to determine cau possible transmission risk or preventage of the consistent of the consist	nake m S then he will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245400	B. WING		01	/14/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WABASSO				STREET ADDRESS, CITY, STATE, ZIP CO 660 MAPLE STREET WABASSO, MN 56293			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	41			

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400	B. WING _		01	/14/2016
	PROVIDER OR SUPPLIER	ABASSO		STREET ADDRESS, CITY, STATE, ZIP COE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	determine possible to reduce the risk or residents, action plas same infections in twas needed for star. The facility January Infections had not be infections when required During interview on of nursing (DON), where the facility infection connurses fill out an infection, and turns placed the informat Resident Infections cultures, and antibility added up the number reported the informat facility's quality assistated she knew the infection because stated she does not infection form, and be used to accurate the infection form, and the used to accurate the infection form and the used to accurate the u	lysis of the collected data to causes of the infections, ways f transmission to other ans to address preventing the the facility, and if education ff and/ or residents. 2016, Line Listing of Resident been started to track resident quested on 1/14/16. 1/14/16, at 1:28 p.m. director who was in charge of the strol program, stated the floor fection control surveillance at which differs per type of it into her. DON stated she ion onto the Line Listing of form to track the infection, otic use. The DON stated she her of infections by type, and ation quarterly during the urance committee. The DON e culture information of each he looked it up, however, she t track it on the Resident stated that information should ely analyze the data collected.	F 44	11		

Printed: 01/25/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 COMPLETED AND PLAN OF CORRECTION 245400 B. WING 01/13/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GOLDEN LIVINGCENTER - WABASSO** 660 MAPLE STREET **WABASSO, MN 56293** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 13, 2016. At the time of this survey, Golden LivingCenter Wabasso was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies... Golden LivingCenter Wabasso was constructed as follows: The original building was constructed in 1964, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1994 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 32 at time of the survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted January 29, 2016

Mr. Wayman Fischgrabe, Administrator Golden Livingcenter - Wabasso 660 Maple Street Wabasso, Minnesota 56293

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5400025

Dear Mr. Fischgrabe:

The above facility was surveyed on January 11, 2016 through January 14, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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.

Golden Livingcenter - Wabasso January 29, 2016 Page 2

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 Jessica Sellner, Unit Supervisor at (320) 223-7343.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

00949		B. WING	01/14/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOLDEN	N LIVINGCENTER - WA	ARASSO	LE STREET O, MN 5629	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and many of lack of compliance. re-inspection with a result in the assess	nether a violation has been			
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

02/02/16

(X6) DATE

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
	00949		B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET O, MN 5629:	2		
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, th corrected prior to e Minnesota Departm On January 11-14, Department's staff, the following correction that you and identify the dat	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	the State Licensing federal software. Ta	Correction Orders using ag numbers have been sota state statutes/rules for				
	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

6899

Minnesota Department of Health STATE FORM

If continuation sheet 2 of 27 CG8S11

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00949	B. WING		01/14/2016		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	01/1	4/2010	
GOLDEN	I LIVINGCENTER - WA	660 MAPI	E STREET	,			
GOLDLIN		WABASSO	O, MN 56293				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 000	Continued From page 2		2 000				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			2/23/16	
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.						
	by: Based on observati review, the facility fa adequate supervision accidents when navi doorway to the outo	on, interview, and document ailed to ensure residents had on/assistance to prevent vigating the facility exit door smoking area for 1 of 5 served who used the outdoor		corrected			
	Findings include:						
	admitted to the facilimpairment, abnorn	sheet identified he was newly lity with diagnoses of cognitive nalities of gait and mobility, lar infarction (stroke). R55's					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.25.110.1			
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET O, MN 5629:	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	with wheelchair (w/cassistance of one s	dentified he was dependent c) mobility and received staff for transfers and toileting.				
	3:00 p.m. outside the wheelchair. When I pulled the facility glathrusting his body for wheelchair (w/c) godigging his left heel over the threshold. scooting motion, ge	on 01/11/16, at approximately ne facility smoking in his R55 finished smoking, he ass door open, and was orward, while scooting in the ing around the glass door and into the floor to propel himself He continued in this jerking, etting his wheelchair over the while holding the facility door				
	On 1/12/16, at 9:50 a.m. R55 was observed in his wheelchair outside in the facility smoking area. When R55 finished smoking, he pulled the door open, and started to maneuver his w/c through the doorway, but was unable to get over the threshold, and his w/c was caught in the doorway. Physical therapy assistant (PTA)-B whom saw R55 in the doorway, assisted him by holding the exit door open to allow R55 to get into the building.					
	the exit doorway go standing up, with the him with one hand of trying to walk outside R55 legs were shake walk through the do behind him. Registe walking down the hands yelled to R55 proceed down the hands and did not a	a.m. R55 was observed in sing outside to smoke. He was be wheelchair directly behind on the door handle, while de over the doorway threshold. By and unstable while trying to porway pulling his wheelchair ered nurse, (RN)-A was allway, with medications in her 5, "Be careful." RN-A, nallway into another residents assist R55. The activity directors activity room, adjacent to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET 50, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	smoking area exit of room, and held the back in his wheelch himself over the thrithe wheels of his chithreshold while hold outside smoking area. When interviewed of stated, she helped in minutes ago, becauted get out the door, and going to get caught stated that residents do this independent. Review of R55 phys 1/09/16, identified Framechanics and was transfer. R55's Smoking Safi 1/11/16 identified framewe without assist area. R55's primary listed as wheelchair himself. There was difficulty maneuverismoking area. The 1/12/16 PT Dai "Nursing reported [I with safety with gett Observe [R55] with [sic] out of facility are open to come back Spoke to DON about the safety with gett open to come back Spoke	door came hurriedly out of the door open for R55. R55 sat tair and proceeded to wheel eshold but became stuck with nair. AD assisted R55 over the ding the exit door to the ea. On 1/13/16, at 8:14 a.m. the AD R55 around the door a few use he was standing trying to aid it looked like his foot was on his foot pedal. She further is who smoke must be able to				

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CG8S11 If continuation sheet 5 of 27

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00949	B. WING		01/1	14/2016
	PROVIDER OR SUPPLIER	ARASSO 660 MAPI	DRESS, CITY, S LE STREET O, MN 56293	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	During interview on occupational therap R55 had problems his stroke history. Ophone call from phy (PTA)-B this morning and out of smoking was that residents independently go in smoke.	1/12/16, at 3:38 p.m. certified by assistant (COTA)-A stated propelling his w/c, because of COTA-A stated she received a visical therapy assistanting about R55's ability to go in exit door. The facility's policy needed to able to and out of the building to	2 830			
	During an interview on 01/13/16, at 12:13 p.m. registered nurse (RN)-A stated that on 1/11/16 she was aware (R55) "nearly tipping out of wheelchair" when attempted to go outside to smoke. She sent a request to evaluate (R55's) for wheelchair positioning. We were to watch R55's to see if he could safely get in and out of building, which was passed on during report. There was no indication the facility had alerted staff to assist R55 through the exit doorway, or identified other interventions to help reduce the risk of accident for R55.					
	overnight staff have attempted to self-tra supposed to monito received any directi	at 12:15 p.m. (NA)-A stated the e reported that R55 had ansfer and they were or for this. She had not on to assist, or monitor R55 the smoking area. They have				
	director of nursing (p.m. The DON state concerns that R55 of the facility to small assessments are constants.	tions were discussed with (DON) on 01/13/2016 at 12:40 ted she was unaware of any had difficulty getting in and out oke. The facility smoking completed with each resident to e able to get in and out of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00040	B. WING		01/1	4/0016
		00949			01/1	4/2016
	PROVIDER OR SUPPLIER	660 MAPI	JRESS, CITY, S .E STREET	STATE, ZIP CODE		
GOLDEN LIVINGCENTER - WABASSO WABASS			D, MN 56293	3		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From page 6		2 830			
	reassessing (R55)	g area safely. They would be ability to maneuver through o he would remained safe.				
	Procedure, last reviresident who desire so if the facilities ID determined that the resident. All resider ability to safely smoopolicy does not ider to manipulate the d	Wabasso Smoking Policy And sed on 4/13 identified, "Every is to smoke is permitted to so T [interdisciplinary] team has a practice would be safe for the its shall be assessed for their ske independently" The patify, if resident are assessed oorway to the resident event any potential accident				
	SUGGESTED METHOD OF CORRECTION: The administrator could monitor and educate all staff to ensure they were aware of potential accident hazards, and use equipment per manufacture recommendations and implement fall intervention. The administrator or designee could monitor to ensure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			2/23/16
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for	and procedures. The infection ast include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and as of infectious diseases;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00949	B. WING		01/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - WA	ARASSO	E STREET D, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21390	C. isolation and reduce risk of trans D. in-service ed prevention and content in E. a resident he immunization progradefined in part 465 procedures of resid the prevention and F. the development in E. a system for H. a system for products which affer disinfectants, antise incontinence product. I. methods for reduction in E. the development in E. the development in E. a system for E. a system for products which affer disinfectants, antise incontinence products.	If precautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of dicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and	21390			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program which included consistent monitoring, trending, and analysis of infections to reduce the potential transmission to other residents in the facility. This had the potential to affect all 32 residents residing in the facility. Findings include: The facility form used to track resident infections titled Line Listing of Resident Infections dated July 2015, to December 2015, were reviewed and identified the following to be tracked for resident infections: - Room			corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00949	B. WING		01/	14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOLDE	N LIVINGCENTER - WA	ARASSO	LE STREET SO, MN 56293	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21390	- Unit - Name - Admission date - Type of infection - If UTI (urinary trace) (yes or no) - Symptoms/ Date - Cultures: Date/Site - Treatment - Other actions (if new procession of the infection of the infection, ways transmission to other	et infection), catheter present? e/ Results eeded) ection criteria ssociated infection) stion control flowsheet's dated December 2015, typically ent name, type of infection, it met infection criteria, and en was HAI or CAI. However, ensistent documentation of ther a catheter was present for eptoms, actual symptoms, organism, and the date the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00949		B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
GOLDEN	I LIVINGCENTER - WA	ABASSO	E STREET O, MN 56293	2		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 9	21390			
	or residents.	ation was needed for staff and/				
	the month of Nover residents had UTI's respiratory infection unspecified MRSA staphylococcus aur not identify any resiconsistent docume of symptoms, and/o to determine the or catheter was prese Further, the listing of the collected data to of the infections, was transmission to oth address preventing	ting of Resident Infections for mber 2015, identified two so, one resident had a so, and one resident had a (methicillin- resistant reus) infection. The listing did dent room numbers, notation of onset and resolving or applicable cultures obtained ganism, and identify if a not with the UTI infections. The did not identify any analysis of the determine possible causes and the same infections in the ation was needed for staff and/				
	The facility Line Listing of Resident Infections for the month of December 2015, identified three residents had UTI's, one resident had a respiratory infection, and one resident had a unspecified skin infection. The listing did not identify any resident room numbers, consistent documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine the organism. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents.					
		2016, Line Listing of Resident been started to track resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00949		B. WING		01/1	01/14/2016	
	PROVIDER OR SUPPLIER	ABASSO	660 MAPL	DRESS, CITY, S LE STREET O, MN 56293	STATE, ZIP CODE	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21390	Continued From parinfections when required infections when required During interview on of nursing (DON), with the facility infection connurses fill out an infection, and turns placed the informat Resident Infections cultures, and antibidadded up the number reported the informat facility's quality assistated she knew the infection because is stated she does not infection form, and be used to accurate A policy on the facil was requested but SUGGESTED MET director of nursing of infection control proprocedures are estanalysis of collected regarding policy and ensure compliance. TIME PERIOD FOR (21) days.	uested on 1/14/16 1/14/16, at 1:28 p who was in charge trol program, state ection control survi, which differs per it into her. DON s ion onto the Line L form to track the io bic use. The DON er of infections by ation quarterly dur urance committee e culture informatic he looked it up, ho t track it on the Re stated that informatic ly analyze the dat ity's infection continot provided. THOD OF CORRE or designee could orgram to ensure po- ablished to include d data, inservice s d procedure, and a	o.m. director of the ed the floor veillance type of tated she listing of infection, I stated she type, and ing the listing of each owever, she esident at collected. Tolon: The review their olicies and the taff audit to	21390				
21435	MN Rule 4658.0900 Recreation Program Subpart 1. General home must provide	n; General al requirements. A	nursing	21435			2/23/16	
	nome must provide	an organized dell	vity and					

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00949	1		01/1	4/2016
	PROVIDER OR SUPPLIER	660 MAPI	DRESS, CITY, 9 .E STREET	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - WA	ABASSO	O, MN 5629	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	recreation program based on each indivistrengths, and need meet the physical, right well-being of each recomprehensive rescomprehensive plat 4658.0400 and 468 provided opportunities planning and develor recreation program. This MN Requirement by: Based on observative review the facility fainterest were offere (R15, R5 and R21) facility activity program. Findings include: R15's significant che (MDS), 1/6/16, identificated was independent interest was independent interest with a gresh aid and to be activity. The MDS are express ideas and others. R15's Activities Assignificant reading, games. Even though games. E	. The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and . ent is not met as evidenced ion, interview and document ailed to ensure activities of ed/provided for 3 of 3 residents who had concerns about the	21435	corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00949	B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	ARASSO 660 MAP	DDRESS, CITY, S LE STREET SO, MN 56293			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21435	R15 had no activity at this time. During interview on stated that she enjoy Council and has madifferent activities in system that has spower was calendar but she has since she arrived at know how to set up use it. Bingo is play Wednesday, and the available. During follow up vis R15 again expressed posted on the activity provided. Review of the Reside from June 2015 to and on 10/12/15 the bowling tournament wanted to move the non-bingo nights, at tournament. During interview on activities director (A from June 2015 to and June 2015 to an activities director (A from June 2015 to an activities director	suggestions for activity staff 1/11/16 at 07:21 p.m. R15 byed participating in Resident ade several suggestions of uch as Wii video game (gamin orts and other games). The s listed on the Activity as not seen since this game t this facility. The staff do not the game so residents can red every day except for rey make sure this activity was sit on 01/14/16 at 8:46 a.m. red concerns that activities ties calendar were not dent Council Meeting Minutes January 2016 were reviewed re council wanted to have a Wii t, and on 06/08/15 residents wii games to 7:00 p.m. on and have a bean bag 1/13/16 at 8:29 a.m. with AD) the facility activity calendar January 2016 were reviewed.				
	her Sunday evening staff work Monday if the evening bingo a volunteer and other the activity staff are state they have a W	es were routinely scheduled gs. The AD stated that activity through Friday 8:00-3:30 p.m., activity was led by a resident community volunteers, since not working. AD continued to /ii video gaming system that , and other sports along with				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00949	B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	ABASSO 660 MAP	DRESS, CITY, S LE STREET O, MN 56293	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Wheel of Fortune, I gaming system was television but "no or was unsure when the played, but thought first started her post activities either indiverse activities either activities activ	Deal and No Deal games. The shooked to the main lobby he knows how to run it". She he Wii video game was last it was June 2015 when she				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ABASSO	.E STREET D, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 14	21435			
	change the Wii vide evenings, these red R5's significant char dated 12/4/15, iden and R5 was indepeliving. The MDS fur preferences that we included having boom agazines to read; doing things with grin favorite activities fresh air in good we	an bag tournament, and to go game to Wednesday quests were never acted upon. Inge Minimum Data Set (MDS) tified R5 had intact cognition ndent with activities of daily rether identified activity gre "very important" to R5 oks, newspapers and listening to preferred music; roups of people; participating grand going outside to get eather. The MDS also ble to express ideas and derstand others.				
	dated 10/2/15, iden preferences include independently, with small group, in-room the community. The R5 occupied her tincrafts or games wit good participation in R5's leisure prefere games, puzzles, wo games, walking, tel gardening, arts and R5's care plan, date would like to continue recreational activities crafts, bingo, outing simple pleasure: Owill continue to expessitisfaction with the instructed to, "Checker of the control of the continue to expessitisfaction with the instructed to, "Checker of the control					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COntinued From page 15 supplies I need. Invite me to go on outings. Invite me to my favorite activities such as; bingo crafts orn [sic] other games and to try new things that I might be interested in." When interviewed on 1/12/16, at 9:11 a.m. R5 stated she did not think they had any activity staff at the facility on the weekends to provide activities. Further, R5 stated, "We are expected to provide our own activities on the weekends." In a subsequent interview on 1/13/16, at 12:09 p.m. R5 stated they did not do a lot of the activities that were identified on the activity board because there was no staff available to run the activity. R5 also stated "the residents are expected to do the activity ourselves." In addition, R5 stated, "I have expressed my concerns" about the activity program on several	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED	
GOLDEN LIVINGCENTER - WABASSO GEO MAPLE STREET WABASSO, MN 56293 (X4) ID PREFIX TAG SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21435 Continued From page 15 supplies I need. Invite me to go on outings. Invite me to my favorite activities such as; bingo crafts orn [sic] other games and to try new things that I might be interested in." When interviewed on 1/12/16, at 9:11 a.m. R5 stated she did not think they had any activity staff at the facility on the weekends to provide activities. Further, R5 stated, "We are expected to provide our own activities on the weekends." In a subsequent interview on 1/13/16, at 12:09 p.m. R5 stated they did not do a lot of the activities that were identified on the activity board because there was no staff available to run the activity. R5 also stated, "I have expressed my concerns" about the activity program on several			00949		B. WING		01/	14/2016
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21435 Continued From page 15 supplies I need. Invite me to go on outings. Invite me to my favorite activities such as; bingo crafts orn [sic] other games and to try new things that I might be interested in." When interviewed on 1/12/16, at 9:11 a.m. R5 stated she did not think they had any activity staff at the facility on the weekends to provide activities. Further, R5 stated, "We are expected to provide our own activities on the weekends." In a subsequent interview on 1/13/16, at 12:09 p.m. R5 stated they did not do a lot of the activities that were identified on the activity board because there was no staff available to run the activity. R5 also stated "the residents are expected to do the activity ourselves." In addition, R5 stated, "I have expressed my concerns" about the activity program on several			ABASSO 660	MAPL	E STREET	,		
supplies I need. Invite me to go on outings. Invite me to my favorite activities such as; bingo crafts orn [sic] other games and to try new things that I might be interested in." When interviewed on 1/12/16, at 9:11 a.m. R5 stated she did not think they had any activity staff at the facility on the weekends to provide activities. Further, R5 stated, "We are expected to provide our own activities on the weekends." In a subsequent interview on 1/13/16, at 12:09 p.m. R5 stated they did not do a lot of the activities that were identified on the activity board because there was no staff available to run the activity. R5 also stated "the residents are expected to do the activity ourselves." In addition, R5 stated, "I have expressed my concerns" about the activity program on several	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLETE
occasions, "but nothing gets better." R5 also stated she wished she could go to the activity board and erase all the events that were scheduled but did not happen, and if she had, there would not be much left on the activity board. During observation on 1/13/16, at 7:11 a.m. R5 was sleeping in her bed. There were approximately 100 colored markers and a newspaper on her bedside table. During interview on 1/13/16, at 8:45 a.m. nursing assistant (NA)-A stated R5 was very active and "loves activities." NA-A further stated R5 often colored, worked on puzzles, and played games with other residents. NA-A also stated, "[R5] has voiced concerns about not having enough to do." During observation on 1/13/16 at 1:28 p.m. R5 was sitting at the table in the dayroom playing Yahtzee with seven other unidentified residents.	21435	supplies I need. In Invite me to my favorafts orn [sic] othe that I might be inter When interviewed of stated she did not that the facility on the activities. Further, to provide our own In a subsequent interport. R5 stated they activities that were because there was activity. R5 also stated she wished a stated she wished a she wished a she wished shourd and erase all scheduled but did not the would not be During observation was sleeping in her approximately 100 newspaper on her to buring interview on assistant (NA)-A stated she worked on with other residents voiced concerns about the colored, worked on with other residents voiced concerns about the colored of the colore	vite me to go on outings. orite activities such as; bir games and to try new the ested in." on 1/12/16, at 9:11 a.m. Fhink they had any activity weekends to provide R5 stated, "We are experienced activities on the weekend erview on 1/13/16, at 12:17 did not do a lot of the identified on the activity on staff available to run the activity ourselves." In a "I have expressed my exactivity program on sevential have expressed my exactivity for a large expression of the activity for a large expression of 1/13/16, at 7:11 a.m. or bed. There were colored markers and a product of the expression of 1/13/16, at 8:45 a.m. numbered R5 was very active at IA-A further stated R5 ofto puzzles, and played gams. NA-A also stated, "[R5] bout not having enough to on 1/13/16 at 1:28 p.m. Find the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the dayroom playing the product of the puzzles in the product of the puzzles and the product of the provide the product of the product of the product of the product of	nings R5 r staff cted ds." 09 coard the eral o ty d, coard. R5 rsing and en nes] has o do." R5	21435			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00949	B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	ARASSO 660 MAPL	DRESS, CITY, S LE STREET O, MN 56293	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	When interviewed of activity director (AD participated in activity dice game), school games, and entertal she was aware that "unhappy" with the taking her some time the activity needs of further referenced to staff" at the facility of limitation. During an interviewed NA-D stated R5 like Yahtzee. NA-D also scheduled activities not provided becaut available. In addition residents have told our activity program. When interviewed of director of nursing (of Farkle, Lucky Dice summer, enjoyed growing to the thrift stand crafts. The DC for example, if only activity may get car at least three reside order for an activity. R21's quarterly MD R21 was cognitively indicated R21 was on the unit.	on 1/14/16, at 8:26 a.m. the o) stated R5 frequently ities such as bingo, Farkle (a visits, Lucky Dice, table inment. The AD further stated is several residents were activity program and it was ne to figure out how to meet if the residents. The AD hat there was "no activity in the weekends as a factor of on 1/14/16, at 8:58 a.m. and to stated there were days that is on the activity calendar were see there were no staff on, NA-D stated, "Several me they are not happy with in." on 1/14/16, at 9:15 a.m. the EDON) stated R5 played a lot be, loved to garden in the oing out in the community, ore, and she loved to do arts on also stated ents must be signed up in	21435			

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	.E STREET O, MN 5629:	.		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D, WIN 3029	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21435	Continued From pa	ge 17	21435			
21400	with my family and things in groups an times a week with f was to continue paractivities or things were instructed to in activity programs the enjoy, monitor R21' activities and supply assist R21 in partical and encourage R21 appointments rathed R21's Recreation S11/30/15, indicated junk dealer and he The assessment fur was impaired, hear speech, was alert, others. The assess have any present lesparticipated in. Progras independent and out of the room and further indicated R2 skills groups but off had no real interest than popcorn on Fr Wednesdays. R21 as to other activities offered. When interviewed of stated that the faciliare interesting to his life he worked we does not offer anyth	friends rather than doing d left the facility one to two riends. The care plan goal articipating in independent with friends and family. Staff nvite R21 to sit in during nat they may think R21 would be participation level, offer ites for activities in R21's room, ipating in his favorite activities in to attend scheduled for than going out with friends. Hervices Assessment dated R21's past occupation was a worked with iron and steel. Ther indicated R21's vision ing was intact, had clear cooperative and interacts with ment indicated R21 did not eisure preferences that he gram preferences that he gram preferences listed R21 did preferred large groups, being did outside. The assessment en refused. In addition, R21 in other group activities other idays and oven cooking on had not given any suggestions is that he would like to see	21400			

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00949		B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ΔΚΔ99()		E STREET), MN 56293	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21435	Continued From pa	ige 18		21435			
	in his wheelchair by	on 1/14/16, at 2:22 p.m. the front door of the fact was being played in the control of the fact was being played in the control of the fact that the control of the fact that the fact	cility,				
	p.m. R21 stated he activities at the faci asked him to attend a big deal because interested him. R21	erview on 11/14/16, at 2 had not participated in a lity all week, and no one deither. R21 stated, it was there were no activities could not recall if any spested alternate activities	any had as not that taff				
	During interview on 1/14/16, at 2:40 p.m. NA-D stated R21 did not participate in any activities and that the only activities R21 participates in is popcorn on Fridays and when there are music groups on site performing.		es and				
	stated she had offer that there were large for use. The AD fur organized schedule. The AD stated that and that R21 was on R21 had not given what he would like.	1/14/16, at 3:59 p.m. the red R21 building blocks are print bingo cards avail ther stated there were not activities specific to mR21 refuses group activities lifficult to please. In addition the facility any suggestion to do. The AD also state as not provide 1:1 time versions.	and lable o nen. rities tion ons on				
	dated 2009 indicate start at the schedul offered that reflect rights of the resider	rvices Guide: Calendar Fes that that each activity ed time, and activities we the schedules, choices, at hours convenient to afternoons and weeken	should ill be and to the				
	SUGGESTED MET	HOD OF CORRECTION	NI-				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY
		00949	B. WING		01/1	14/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - WA	ARASSO	60, MN 5629	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 19	21435			
	each resident's ass	could train all staff to ensure essed activity preferences are audit to ensure this is				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21990	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 4 Reporting - nerable Adults	21990			2/23/16
	immediately make a entry point. Use of for the deaf or other considered an oral point may not require extent possible, the content to identify the caregiver, the nature maltreatment, any emaltreatment, the noreporter, the time, coincident, and any ot reporter believes me the suspected maltreporter may disclosin section 13.02, and section 144.335, to comply with this subsection.	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the e and extent of the suspected evidence of previous ame and address of the date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined a medical records under the extent necessary to odivision.				
	by: Based on interview facility failed to ensi immediately reporte state agency, then of	and document review, the ure allegations of abuse were ed to the administrator and comprehensively investigated (R45) who reported she had		corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET 60, MN 5629	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	age 20	21990			
	11/19/15, indicated was independent w During an interview stated registered number, and grabbed Rharshly at her. R45	nimum data set (MDS) dated she was cognitively intact and with all activities of daily living. on 1/14/15, at 11:53 a.m. R45 urse (RN)-D had "assaulted" R45's forearm and spoke stated she was "too scared to				
	the incident to the f	form," but added she reported acility administrator. Further, dent occurred during the er 2015.				
	facility administrato incident between R 9/9/15, but was not of abuse until 9/21/administrator stated brought the concert doesn't document, when someone tells administrator stated	on 1/14/15, at 2:07 p.m. the or stated he thought the 45 and RN-D occurred on made aware of the allegation (15 (12 days later). The d he was unaware who n to his attention, adding he "Who told me something, [or] is me something." Further, the d he did not report it to the not believe I reported it to the				
	stated R45 approace because RN-D grade thought she was postated she did not re	on 1/14/15, at 3:51 p.m. RN-A ched her and was, "Disturbed" bbed a hold of her arm and pssibly angry with her. RN-A report the allegation of the administrator or State				
	R45 had approache	es dated 9/19/15, identified ed staff and reported that her arm "the other day" and				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.22.1.10.1			
		00949	B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - W	ARASSO	PLE STREET SO, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	nge 21	21990			
	The note did not ide	N-D to let go, RN-D said "no." entify if the administrator or notified of the allegation of				
	9/21/15, consisted made by staff. RN-abuse by R45 on 9 not been initiated u documents. The properties to include a, "Detail event/allegation," w "Resident reported RN-D grabbed her provided spacing to interview summary "[RN-D] grabbed m week." The forms "immediate resident left blank. The collidentify any interview interview summary "mediate resident left blank. The collidentify any interview interview summary "mediate resident left blank. The collidentify any interview interview summary "mediate resident left blank. The collidentify any interview summary "mediate resident left blank. The collident left blank. The collident left blank interview summary "mediate resident left	of Investigation report dated of several hand written notes -A was told of the potential /9/15, however the report had ntil 9/21/15 according to the rovided form identified a space led description of the which staff identified as, tha [sic] some time last week, right arm." Further, the form o describe a, "Resident," which staff identified, y arm [right] sometime last spacing to identify what, at protection," was initiated was ected notes and form did not less of other staff to rule out r follow up to R45 on her				
	Investigation and R of Federal or State or Injuries of Unknows 3/2012, identified a or mistreatment we immediately to the [administrator] of the Minnesota Department of the Common Director." Further, "Investigate each set thoroughly and reprinted the common of the com	Executive Director ne facility [and] to the nent of health [State agency] n Entry Point by the Executive the policy directed staff to, uch alleged violation	t			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00949	B. WING	·····	01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET O, MN 5629:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	State and Federal land A SUGGESTED ME The director of nurs review, revise, development of the director of nurs review, revise, development of the director of nurs review, revise, development of the director	aw." ETHOD FOR CORRECTION: sing (DON) or designee could elop and implement policies ensure allegations of abuse liately. In addition random ducted and staff training all allegations are investigated ettly. R CORRECTION: Twenty one	21990			0/00/40
22000	Subd. 14. Abuse facility, except hompersonal care atten establish and enfort prevention plan. Thassessment of the environment, and it factors which may eand a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or reaction to the plan shall contrassessment of: (1) abuse by other indivulnerable adults; (2)	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan	22000			2/23/16

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00949	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - WA	ARASSO	LE STREET O, MN 5629	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	specific measures to risk of abuse to that adults. For the purpterm "abuse" include (c) If the facility, and personal care at knows that the vuln violent crime or an atoward others, the inplan must detail the minimize the risk the reasonably be experimentally and persons unsupervised. Under the vulnerable aduring misconduct or physically and persons unsupervised and persons unsupervised. Under the vulnerable aduring another facility, and	to be taken to minimize the terson and other vulnerable poses of this paragraph, the	22000			
	by: Based on interview facility failed to impl procedures to ensuimmediately reported state agency, and continued in the state agency.	ure allegations of abuse were ed to the administrator and comprehensively investigated (R45) who reported she had		corrected		
	Findings include:					
	A facility Policies ar	nd Procedures Regarding				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00949	B. WING		01/1	4/2016		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET							
GOLDEN	N LIVINGCENTER - WA	ARASSO	O, MN 56293	3				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
22000	Investigation and R of Federal or State or Injuries of Unknot 3/2012, identified all or mistreatment we immediately to the I [administrator] of th Minnesota Department and to the Commor Director." Further, "Investigate each so thoroughly and repoinvestigations to the Health and Common State and Federal Is R45's quarterly min 11/19/15, indicated was independent where. RN-D grabbed harshly at here. R45 fill out a grievance of the incident to the farm R45 stated the incident to the farm R45 stated the incident of September During an interview facility administrator incident between R49/9/15, but was not of abuse until 9/21/1 administrator stated brought the concern doesn't document, when someone tells administrator stated administrator s	eporting of Alleged Violations Laws Involving Maltreatment, own Source policy dated Il allegations of abuse, neglect re to be, "reported Executive Director e facility [and] to the tent of health [State agency] in Entry Point by the Executive the policy directed staff to, such alleged violation out the results of all e Minnesota Department of on Entry Point as required by aw." imum data set (MDS) dated she was cognitively intact and ith all activities of daily living. on 1/14/15, at 11:53 a.m. R45 urse (RN)-D had "assaulted" R45's forearm and spoke stated she was "too scared to form," but added she reported acility administrator. Further, dent occurred during the	22000					

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AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		SURVEY LETED	
		00949	B. WING		01/1	4/2016	
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE			
GOLDEN L	GOLDEN LIVINGCENTER - WABASSO 660 MAPLE STREET WABASSO, MN 56293						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S D S b th S pa	tated R45 approace ecause RN-D grab nought she was potated she did not restand to the property of the property	on 1/14/15, at 3:51 p.m. RN-A hed her and was, "Disturbed" bed a hold of her arm and ssibly angry with her. RN-A eport the allegation of he administrator or State es dated 9/19/15, identified de staff and reported that her arm "the other day" and J-D to let go, RN-D said "no." entify if the administrator or otified of the allegation of f Investigation report dated of several hand written notes A was told of the potential 9/15, however the report had ntil 9/21/15 according to the ovided form identified a space end description of the hich staff identified as, tha [sic] some time last week, right arm." Further, the form describe a, "Resident "which staff identified, y arm [right] sometime last spacing to identify what, a protection," was initiated was exted notes and form did not ws of other staff to rule out follow up to R45 on her	22000				

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NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	SURVEY PLETED	
	00949	B. WING		01/	14/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
GOLDEN LIVINGCENTER - WABASSO 660 MAPLE STREET WABASSO, MN 56293						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE	
Continued From pa	ge 26	22000				
provide education a regarding reporting implementing the prevention Policy a	and training to all staff responsibilities and rocedures of the Abuse nd Vulnerable adult(s).					
(21) days.	R CORRECTION: Twenty one					
	PROVIDER OR SUPPLIER N LIVINGCENTER - WA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa The administrator of provide education as regarding reporting implementing the pa Prevention Policy and INTERIOR FOR	PROVIDER OR SUPPLIER STREET AD 660 MAP WABASS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one	DOPTOF CORRECTION IDENTIFICATION NUMBER: 00949 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S 660 MAPLE STREET WABASSO, MN 5629: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one	DOPTIFICATION NUMBER: O0949 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one	DOP CORRECTION IDENTIFICATION NUMBER: 00949 B. WING DO1/- PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 The administrator or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty one	

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