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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CG8S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245400**

2. STATE VENDOR OR MEDICAID NO.
(L2) **854542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WABASSO**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

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

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

6. DATE OF SURVEY **03/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 03/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

Posted 04/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/19/2016
(L33)

DETERMINATION APPROVAL

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

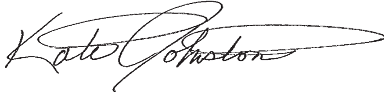
Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

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.

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:

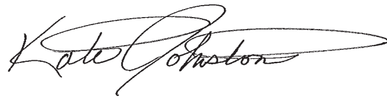
On January 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with 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.

Sincerely,



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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245400	A. Building B. Wing	3/8/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WABASSO	660 MAPLE STREET WABASSO, MN 56293

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 02/23/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 02/23/2016	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 02/23/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 02/23/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) BF/KJ	DATE 03/11/2016	SIGNATURE OF SURVEYOR 27955	DATE 03/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00949 Y1	A. Building B. Wing Y2	3/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WABASSO	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 02/23/2016	ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 A-I LSC	Correction Completed 02/23/2016	ID Prefix 21435 Reg. # MN Rule 4658.0900 Subp. 1 LSC	Correction Completed 02/23/2016
ID Prefix 21990 Reg. # MN St. Statute 626.557 Subd. 4 LSC	Correction Completed 02/23/2016	ID Prefix 22000 Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c) LSC	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) BF/KJ	DATE 03/11/2016	SIGNATURE OF SURVEYOR 27955	DATE 03/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON		
1/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CG8S
Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245400**

2.STATE VENDOR OR MEDICAID NO.
(L2) **854542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WABASSO**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

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

6. DATE OF SURVEY **01/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mardelle Trettel, HFE NE II 02/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

Posted 02/19/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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

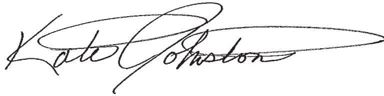
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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
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Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING ______ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		2/23/16

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

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.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator and state agency, then comprehensively investigated for 1 of 1 residents (R45) who reported she had been abused during the survey. Findings include: R45's quarterly minimum data set (MDS) dated 11/19/15, indicated she was cognitively intact and was independent with all activities of daily living. During an interview on 1/14/15, at 11:53 a.m. R45 stated registered nurse (RN)-D had "assaulted" her, and grabbed R45's forearm and spoke harshly at her. R45 stated she was "too scared to fill out a grievance form," but added she reported the incident to the facility administrator. Further, R45 stated the incident occurred during the month of September 2015.	F 225	Preparation, submission and implementation of this Plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. GLC-Wabasso realizes the importance of immediate reporting of allegations of abuse to the administrator and State agency. The performing a comprehensive investigation. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #45. All residents have the potential to be	

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F 225	Continued From page 2 During an interview on 1/14/15, at 2:07 p.m. the facility administrator stated he thought the incident between R45 and RN-D occurred on 9/9/15, but was not made aware of the allegation of abuse until 9/21/15 (12 days later). The administrator stated he was unaware who brought the concern to his attention, adding he doesn't document, "Who told me something, [or] when someone tells me something." Further, the administrator stated he did not report it to the State agency, "I do not believe I reported it to the state agency." During an interview on 1/14/15, at 3:51 p.m. RN-A stated R45 approached her and was, "Disturbed" because RN-D grabbed a hold of her arm and thought she was possibly angry with her. RN-A stated she did not report the allegation of potential abuse to the administrator or State agency though. R45's progress notes dated 9/19/15, identified R45 had approached staff and reported that RN-D had grabbed her arm "the other day" and when she asked RN-D to let go, RN-D said "no." The note did not identify if the administrator or State agency was notified of the allegation of abuse. R45's Verification of Investigation report dated 9/21/15, consisted of several hand written notes made by staff. RN-A was told of the potential abuse by R45 on 9/9/15, however the report had not been initiated until 9/21/15 according to the documents. The provided form identified a space to include a, "Detailed description of the event/allegation," which staff identified as, "Resident reported tha [sic] some time last week,	F 225	affected by the deficit practice. To prevent further incident to other residents reeducation will be provided to staff on timely reporting of abuse allegations to the administrator and state agency then performing a comprehensive investigation. To monitor its performance and to make sure solutions are sustained, random bimonthly audits until June 1 2016 and randomly there after as needed on the following: immediate reporting of abuse allegations and comprehensive investigations and if reported to the MDH will be performed by the E.D./Designee with audit results reviewed in QAPI quarterly and as needed.	

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F 225	Continued From page 3 RN-D grabbed her right arm." Further, the form provided spacing to describe a, "Resident interview summary," which staff identified, "[RN-D] grabbed my arm [right] sometime last week." The forms spacing to identify what, "immediate resident protection," was initiated was left blank. The collected notes and form did not identify any interviews of other staff to rule out abuse concerns, or follow up to R45 on her reported concerns. A facility Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source policy dated 3/2012, identified all allegations of abuse, neglect or mistreatment were to be, "reported immediately to the Executive Director [administrator] of the facility... [and] to the Minnesota Department of health [State agency] and to the Common Entry Point by the Executive Director." Further, the policy directed staff to, "Investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and Common Entry Point as required by State and Federal law."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		2/23/16

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F 226	Continued From page 4 by: Based on interview and document review, the facility failed to implement policies and procedures to ensure allegations of abuse were immediately reported to the administrator and state agency, and comprehensively investigated for 1 of 1 residents (R45) who reported she had been abused during the survey. Findings include: A facility Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source policy dated 3/2012, identified all allegations of abuse, neglect or mistreatment were to be, "reported immediately to the Executive Director [administrator] of the facility... [and] to the Minnesota Department of health [State agency] and to the Common Entry Point by the Executive Director." Further, the policy directed staff to, "Investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and Common Entry Point as required by State and Federal law." R45's quarterly minimum data set (MDS) dated 11/19/15, indicated she was cognitively intact and was independent with all activities of daily living. During an interview on 1/14/15, at 11:53 a.m. R45 stated registered nurse (RN)-D had "assaulted" her. RN-D grabbed R45's forearm and spoke harshly at her. R45 stated she was "too scared to fill out a grievance form," but added she reported the incident to the facility administrator. Further, R45 stated the incident occurred during the	F 226	GLC-Wabasso realizes the importance of immediate reporting of allegations of abuse to the administrator and State agency. The performing a comprehensive investigation. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #45. All residents have the potential to be affected by the deficit practice. To prevent further incident to other residents reeducation will be provided to staff on timely reporting of abuse allegations to the administrator and state agency then performing a comprehensive investigation. To monitor its performance and to make sure solutions are sustained, random bimonthly audits until June 1 2016 and randomly there after as needed on the following: immediate reporting of abuse allegations and comprehensive investigations and if reported to the MDH will be performed by the E.D./Designee with audit results reviewed in QAPI quarterly and as needed.	

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F 226	Continued From page 5 month of September 2015. During an interview on 1/14/15, at 2:07 p.m. the facility administrator stated he thought the incident between R45 and RN-D occurred on 9/9/15, but was not made aware of the allegation of abuse until 9/21/15 (12 days later). The administrator stated he was unaware who brought the concern to his attention, adding he doesn't document, "Who told me something, [or] when someone tells me something." Further, the administrator stated he did not report it to the State agency, "I do not believe I reported it to the state agency." During an interview on 1/14/15, at 3:51 p.m. RN-A stated R45 approached her and was, "Disturbed" because RN-D grabbed a hold of her arm and thought she was possibly angry with her. RN-A stated she did not report the allegation of potential abuse to the administrator or State agency though. R45's progress notes dated 9/19/15, identified R45 had approached staff and reported that RN-D had grabbed her arm "the other day" and when she asked RN-D to let go, RN-D said "no." The note did not identify if the administrator or State agency was notified of the allegation of abuse. R45's Verification of Investigation report dated 9/21/15, consisted of several hand written notes made by staff. RN-A was told of the potential abuse by R45 on 9/9/15, however the report had not been initiated until 9/21/15 according to the documents. The provided form identified a space to include a, "Detailed description of the event/allegation," which staff identified as,	F 226		

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F 226	Continued From page 6 "Resident reported tha [sic] some time last week, RN-D grabbed her right arm." Further, the form provided spacing to describe a, "Resident interview summary," which staff identified, "[RN-D] grabbed my arm [right] sometime last week." The forms spacing to identify what, "immediate resident protection," was initiated was left blank. The collected notes and form did not identify any interviews of other staff to rule out abuse concerns, or follow up to R45 on her reported concerns.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of interest were offered/provided for 3 of 3 residents (R15, R5 and R21) who had concerns about the facility activity program. Findings include: R15's significant change Minimum Data Set (MDS), 1/6/16, identified she was cognitively intact was independent with activities of daily living. The activity preference identified it was very important for R15 to have reading material, be involved with a group of people, go outside for fresh aid and to be involved in her favorite	F 248	GLC-Wabasso realizes the importance of providing ongoing programs of activities designed to meet the interest and the physical, mental and psychsocial well-being of its residents. The activities assessment for residents #5, 15 and 21 have been reviewed and reassessed, with identified appropriate activities put in place. All residents have the potential to be affected by deficit activity assessments and not completing of scheduled activities. To prevent further incident to	2/23/16

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F 248	Continued From page 7 activity. The MDS also indicated R15 was able to express ideas and wants and could understand others. R15's Activities Assessment of 10/27/15 identified prior to admission R15 spent time watching television, reading, puzzles and computer video games. Even though the assessment identified R15 did these activities before admission, the computer/video games were " present: not now. " R15 had no activity suggestions for activity staff at this time. During interview on 1/11/16 at 07:21 p.m. R15 stated that she enjoyed participating in Resident Council and has made several suggestions of different activities such as Wii video game (gamin system that has sports and other games). The Wii video game was listed on the Activity Calendar but she has not seen since this game since she arrived at this facility. The staff do not know how to set up the game so residents can use it. Bingo is played every day except for Wednesday, and they make sure this activity was available. During follow up visit on 01/14/16 at 8:46 a.m. R15 again expressed concerns that activities posted on the activities calendar were not provided. Review of the Resident Council Meeting Minutes from June 2015 to January 2016 were reviewed and on 10/12/15 the council wanted to have a Wii bowling tournament, and on 06/08/15 residents wanted to move the Wii games to 7:00 p.m. on non-bingo nights, and have a bean bag tournament.	F 248	other residents all resident assessment have been reviewed to ensure accuracy and have been updated as needed further staff involved with activities have been reeducated on appropriate assessment of activities and the completion of scheduled activities. To monitor its performance and to make sure solutions are sustained random bimonthly audits will be completed until June 1st 2016 and randomly there after as needed of activity assessments and performing scheduled activities will be performed by the ED/designee with audit results reviewed in QAPI quarterly and as needed.	

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During interview on 1/13/16 at 8:29 a.m. with activities director (AD) the facility activity calendar from June 2015 to January 2016 were reviewed. The Wii video games were routinely scheduled her Sunday evenings. The AD stated that activity staff work Monday through Friday 8:00-3:30 p.m., the evening bingo activity was led by a resident volunteer and other community volunteers, since the activity staff are not working. AD continued to state they have a Wii video gaming system that has tennis, bowling, and other sports along with Wheel of Fortune, Deal and No Deal games. The gaming system was hooked to the main lobby television but "no one knows how to run it". She was unsure when the Wii video game was last played, but thought it was June 2015 when she first started her position.
The AD stated residents bring ideas about activities either individually or through the Resident Council. She was aware residents wanted to play the bean bag toss game, but she was unable to find the game until sometime this fall. Even though she was aware the residents wanted to play this game and was identified in the June 2015 Resident Council Minutes, she never added it to the activity calendar. The AD stated she would add the bean bag toss game to the February calendar, and make sure the Wii video game system gets set up for the residents to use.

During interview on 1/14/16 at 9:11 a.m. nursing assistant (NA)-D stated they have not been given instructions to assist with any activities, on weekends. If the residents want a board games, we will get those. The Wii video game is on the activity calendar, but she had never been asked to set this system up for residents to use even though she was aware of how to operate this system.

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On 01/14/16 at 9:17 a.m. NA-A stated the Wii video game system is available for residents to sue but she was unsure how to operate the game, nor has anyone asked her to do this.

Although R15 had told facility staff she wanted to use the Wii video gaming system, and had used video/computer games at home. The Wii gaming system was not available to be used by residents even though this was on the monthly activity calendar since June 2015. The resident council also suggested bean bag tournament, and to change the Wii video game to Wednesday evenings, these requests were never acted upon.

The Recreation Services Guide: Calendar Policy dated 2009 indicates that that each activity should start at the scheduled time, and activities will be offered that reflect the schedules, choices, and rights of the residents at hours convenient to the residents, including afternoons and weekends.

R5's significant change Minimum Data Set (MDS) dated 12/4/15, identified R5 had intact cognition and R5 was independent with activities of daily living. The MDS further identified activity preferences that were "very important" to R5 included having books, newspapers and magazines to read; listening to preferred music; doing things with groups of people; participating in favorite activities; and going outside to get fresh air in good weather. The MDS also indicated R5 was able to express ideas and wants and could understand others.

R5's quarterly Recreation Services Assessment,

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dated 10/2/15, identified R5's program preferences included activities done independently, with friends/family, large group, small group, in-room, out of room, outside, or in the community. The assessment also indicated R5 occupied her time with independent activities, crafts or games with other residents, and showed good participation in group activities. In addition, R5's leisure preferences included bingo, table games, puzzles, word searches, computer games, walking, television, music, reading, gardening, arts and crafts, shopping, and movies.

R5's care plan, dated 12/16/15, indicated, "I would like to continue participating in the recreational activities I currently enjoy such as; crafts, bingo, outings, watching tv, reading. Life's simple pleasure: Crafts." The goal for R5 was, "I will continue to express my enjoyment and satisfaction with the activities." Staff were instructed to, "Check in with me to make sure I can still do activities independently and have any 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

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concerns" about the activity program on several 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.

When interviewed on 1/14/16, at 8:26 a.m. the activity director (AD) stated R5 frequently participated in activities such as bingo, Farkle (a dice game), school visits, Lucky Dice, table games, and entertainment. The AD further stated she was aware that several residents were "unhappy" with the activity program and it was taking her some time to figure out how to meet the activity needs of the residents. The AD further referenced that there was "no activity staff"at the facility on the weekends as a factor of limitation.

During an interview on 1/14/16, at 8:58 a.m. NA-D stated R5 liked to play bingo, Farkle, and Yahtzee. NA-D also stated there were days that

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WABASSO	**660 MAPLE STREET** **WABASSO, MN 56293**

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scheduled activities on the activity calendar were not provided because there were no staff available. In addition, NA-D stated, "Several residents have told me they are not happy with our activity program."

When interviewed on 1/14/16, at 9:15 a.m. the director of nursing (DON) stated R5 played a lot of Farkle, Lucky Dice, loved to garden in the summer, enjoyed going out in the community, going to the thrift store, and she loved to do arts and crafts. The DON added, with our activities, for example, if only three residents sign up, the activity may get canceled. The DON also stated at least three residents must be signed up in order for an activity to be held.

R21's quarterly MDS dated 11/24/15, identified R21 was cognitively intact. The MDS also indicated R21 was independent with locomotion on the unit.

R21's care plan, dated 3/10/14, indicated he preferred independent activities or spending time with my family and friends rather than doing things in groups and left the facility one to two times a week with friends. The care plan goal was to continue participating in independent activities or things with friends and family. Staff were instructed to invite R21 to sit in during activity programs that they may think R21 would enjoy, monitor R21's participation level, offer activities and supplies for activities in R21's room, assist R21 in participating in his favorite activities and encourage R21 to attend scheduled appointments rather than going out with friends.

R21's Recreation Services Assessment dated

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11/30/15, indicated R21's past occupation was a junk dealer and he worked with iron and steel. The assessment further indicated R21's vision was impaired, hearing was intact, had clear speech, was alert, cooperative and interacts with others. The assessment indicated R21 did not have any present leisure preferences that he participated in. Program preferences listed R21 as independent and preferred large groups, being out of the room and outside. The assessment further indicated R21 had attended some life skills groups but often refused. In addition, R21 had no real interest in other group activities other than popcorn on Fridays and oven cooking on Wednesdays. R21 had not given any suggestions as to other activities that he would like to see offered.

When interviewed on 11/11/16, at 7:01 p.m. R21 stated that the facility does not offer activities that are interesting to him. R21 further stated that all his life he worked with his hands and the facility does not offer anything like that here. R21 explained he did not enjoy bingo because he could longer read the cards.

R21 was observed on 1/14/16, at 2:22 p.m. sitting in his wheelchair by the front door of the facility, while a dice game was being played in the day room.

During follow up interview on 11/14/16, at 2:28 p.m. R21 stated he had not participated in any activities at the facility all week, and no one had asked him to attend either. R21 stated, it was not a big deal because there were no activities that interested him. R21 could not recall if any staff members had suggested alternate activities that he would enjoy.

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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 that the only activities R21 participates in is popcorn on Fridays and when there are music groups on site performing. During interview on 1/14/16, at 3:59 p.m. the AD stated she had offered R21 building blocks and that there were large print bingo cards available for use. The AD further stated there were no organized scheduled activities specific to men. The AD stated that R21 refuses group activities and that R21 was difficult to please. In addition R21 had not given the facility any suggestions on what he would like to do. The AD also stated the activity program does not provide 1:1 time with R21.	F 248		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents had adequate supervision/assistance to prevent accidents when navigating the facility exit doorway to the outdoor smoking area for 1 of 5 residents (R55) observed who used the outdoor	F 323	GLC-Wabasso realizes the importance of providing an environment that is free of accidents and hazards and providing adequate supervision and assistive devices to prevent accidents.	2/23/16

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F 323	Continued From page 15 smoking area. Findings include: R55's undated face sheet identified he was newly admitted to the facility with diagnoses of cognitive impairment, abnormalities of gait and mobility, and cerebral vascular infarction (stroke). R55's undated care plan identified he was dependent with wheelchair (w/c) mobility and received assistance of one staff for transfers and toileting. R55 was observed on 01/11/16, at approximately 3:00 p.m. outside the facility smoking in his wheelchair. When R55 finished smoking, he pulled the facility glass door open, and was thrusting his body forward, while scooting in the wheelchair (w/c) going around the glass door and digging his left heel into the floor to propel himself over the threshold. He continued in this jerking, scooting motion, getting his wheelchair over the doorway threshold, while holding the facility door open to get inside. 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. On 1/13/16, at 8:10 a.m. R55 was observed in the exit doorway going outside to smoke. He was standing up, with the wheelchair directly behind him with one hand on the door handle, while	F 323	Resident #55 has been reassessed for safety and maneuvering of the use of the smoking door. All residents have the potential to be affected by the deficit practice. All smokers have been reassessed for safety Staff have been reeducated on appropriately assessing residents ability to maneuver the smoking door threshold. To prevent further incident the threshold to the smoking door has been replaced. To monitor its performance and to make sure solutions are sustained, random bimonthly audits will be completed until June 1st 2016 and then randomly as needed of resident safety of maneuvering the smoking door threshold will be performed by the ED/designee with audit results reviewed in QAPI quarterly and as needed	

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F 323	Continued From page 16 trying to walk outside over the doorway threshold. R55 legs were shaky and unstable while trying to walk through the doorway pulling his wheelchair behind him. Registered nurse, (RN)-A was walking down the hallway, with medications in her hands yelled to R55, "Be careful." RN-A , proceed down the hallway into another residents room, and did not assist R55. The activity director (AD) who was in the activity room, adjacent to the smoking area exit door came hurriedly out of the room, and held the door open for R55. R55 sat back in his wheelchair and proceeded to wheel himself over the threshold but became stuck with the wheels of his chair. AD assisted R55 over the threshold while holding the exit door to the outside smoking area. When interviewed on 1/13/16, at 8:14 a.m. the AD stated, she helped R55 around the door a few minutes ago, because he was standing trying to get out the door, and it looked like his foot was going to get caught on his foot pedal. She further stated that residents who smoke must be able to do this independently. Review of R55 physical therapy (PT) notes, dated 1/09/16, identified R55 had poor safety mechanics and was impulsive during functional transfer. R55's Smoking Safety Assessment, dated 1/11/16 identified he was able to independently move without assistance to and from the smoking area. R55's primary mode of locomotion was listed as wheelchair, and was able to wheel himself. There was no indication that R55 had difficulty maneuvering the doorway to the outdoor smoking area.	F 323		

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The 1/12/16 PT Daily Treatment Note identified, "Nursing reported [R55] had increased difficulty with safety with getting in and out smoking door. Observe [R55] with this and did struggle to set [sic] out of facility and leaning. Unable to get door open to come back in facility without assistance. Spoke to DON about increased difficulty with this, as at this time he is unsafe to be smoking unsupervised."

During interview on 1/12/16, at 3:38 p.m. certified occupational therapy assistant (COTA)-A stated R55 had problems propelling his w/c, because of his stroke history. COTA-A stated she received a phone call from physical therapy assistant (PTA)-B this morning about R55's ability to go in and out of smoking exit door. The facility's policy was that residents needed to able to independently go in and out of the building to smoke.

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.

On 01/13/2016 at at 12:15 p.m. (NA)-A stated the overnight staff have reported that R55 had attempted to self-transfer and they were supposed to monitor for this. She had not

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F 323	Continued From page 18 received any direction to assist, or monitor R55 going in and out of the smoking area. They have not told us anything. The above observations were discussed with director of nursing (DON) on 01/13/2016 at 12:40 p.m. The DON stated she was unaware of any concerns that R55 had difficulty getting in and out of the facility to smoke. The facility smoking assessments are completed with each resident to determine if they are able to get in and out of the designated smoking area safely. They would be reassessing (R55) ability to maneuver through the smoking door so he would remained safe. The Golden Living Wabasso Smoking Policy And Procedure, last revised on 4/13 identified, "Every resident who desires to smoke is permitted to so so if the facilities IDT [interdisciplinary] team has determined that the practice would be safe for the resident. All residents shall be assessed for their ability to safely smoke independently..." The policy does not identify, if resident are assessed to manipulate the doorway to the resident smoking area, to prevent any potential accident hazards.	F 323		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		2/23/16

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F 441	Continued From page 19 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This 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:	F 441	GLC-Wabasso realizes the importance of maintaining an infection control program designed to provide safe, sanitary comfortable environment to prevent the development and transmission of disease and infection. All residents have the potential to be affected by the deficit practice, to prevent	

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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
- Unit
- Name
- Admission date
- Type of infection
- If UTI (urinary tract infection), catheter present? (yes or no)
- Symptoms/ Date
- Cultures: Date/Site/ Results
- Treatment
- Other actions (if needed)
- Does not meet infection criteria
- HAI (healthcare associated infection)
- CAI (community associated infection)

Review of the infection control flowsheet's dated July 2015, through December 2015, typically identified the resident name, type of infection, treatment, whether it met infection criteria, and whether the infection was HAI or CAI. However, the forms lacked consistent documentation of room number, whether a catheter was present for an UTI, start of symptoms, actual symptoms, culture results with organism, and the date the infection was resolved.

The facility Line Listing of Resident Infections for the month of October 2015, identified four residents had UTI's, three residents had respiratory infections, and two residents had unidentified infections. The listing did not identify any resident room numbers, consistent documentation of onset and resolving of

further incident staff have been reeducated on the consistent documentation of infection control surveillance flow sheets and line listings as well as analysis to determine cause, possible transmission risk or prevention

To monitor its performance and to make sure solutions are sustained random bimonthly audits until June 1st 2016 then randomly there after as needed of the following infection control documentations: infection control surveillance sheets and line listing will be performed by the ED/designee with results reviewed in QAPI quarterly and as needed

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F 441	Continued From page 21 symptoms, and/or applicable cultures obtained to determine which organism was identified, or type or location of the unidentified infections. 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. The facility Line Listing of Resident Infections for the month of November 2015, identified two residents had UTI's, one resident had a respiratory infection, and one resident had a unspecified MRSA (methicillin- resistant staphylococcus aureus) 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, and identify if a catheter was present with the UTI infections. 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. 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	F 441		

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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.

The facility January 2016, Line Listing of Resident Infections had not been started to track resident infections when requested on 1/14/16.

During interview on 1/14/16, at 1:28 p.m. director of nursing (DON), who was in charge of the facility infection control program, stated the floor nurses fill out an infection control surveillance data collection form, which differs per type of infection, and turns it into her. DON stated she placed the information onto the Line Listing of Resident Infections form to track the infection, cultures, and antibiotic use. The DON stated she added up the number of infections by type, and reported the information quarterly during the facility's quality assurance committee. The DON stated she knew the culture information of each infection because she looked it up, however, she stated she does not track it on the Resident Infection form, and stated that information should be used to accurately analyze the data collected.

A policy on the facility's infection control program was requested but not provided.

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F5400025

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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.	K 000		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

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

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

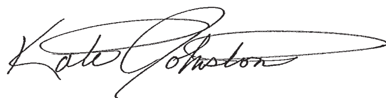
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00949	A. BUILDING: ______ 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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 11-14, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents had adequate supervision/assistance to prevent accidents when navigating the facility exit doorway to the outdoor smoking area for 1 of 5 residents (R55) observed who used the outdoor smoking area. Findings include: R55's undated face sheet identified he was newly admitted to the facility with diagnoses of cognitive impairment, abnormalities of gait and mobility, and cerebral vascular infarction (stroke). R55's	2 830	corrected	2/23/16

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2 830	Continued From page 3	2 830		

undated care plan identified he was dependent with wheelchair (w/c) mobility and received assistance of one staff for transfers and toileting.

R55 was observed on 01/11/16, at approximately 3:00 p.m. outside the facility smoking in his wheelchair. When R55 finished smoking, he pulled the facility glass door open, and was thrusting his body forward, while scooting in the wheelchair (w/c) going around the glass door and digging his left heel into the floor to propel himself over the threshold. He continued in this jerking, scooting motion, getting his wheelchair over the doorway threshold, while holding the facility door open to get inside.

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.

On 1/13/16, at 8:10 a.m. R55 was observed in the exit doorway going outside to smoke. He was standing up, with the wheelchair directly behind him with one hand on the door handle, while trying to walk outside over the doorway threshold. R55 legs were shaky and unstable while trying to walk through the doorway pulling his wheelchair behind him. Registered nurse, (RN)-A was walking down the hallway, with medications in her hands yelled to R55, "Be careful." RN-A , proceed down the hallway into another residents room, and did not assist R55. The activity director (AD) who was in the activity room, adjacent to the

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2 830	Continued From page 4	2 830		

Continued From page 4

smoking area exit door came hurriedly out of the room, and held the door open for R55. R55 sat back in his wheelchair and proceeded to wheel himself over the threshold but became stuck with the wheels of his chair. AD assisted R55 over the threshold while holding the exit door to the outside smoking area.

When interviewed on 1/13/16, at 8:14 a.m. the AD stated, she helped R55 around the door a few minutes ago, because he was standing trying to get out the door, and it looked like his foot was going to get caught on his foot pedal. She further stated that residents who smoke must be able to do this independently.

Review of R55 physical therapy (PT) notes, dated 1/09/16, identified R55 had poor safety mechanics and was impulsive during functional transfer.

R55's Smoking Safety Assessment, dated 1/11/16 identified he was able to independently move without assistance to and from the smoking area. R55's primary mode of locomotion was listed as wheelchair, and was able to wheel himself. There was no indication that R55 had difficulty maneuvering the doorway to the outdoor smoking area.

The 1/12/16 PT Daily Treatment Note identified, "Nursing reported [R55] had increased difficulty with safety with getting in and out smoking door. Observe [R55] with this and did struggle to set [sic] out of facility and leaning. Unable to get door open to come back in facility without assistance. Spoke to DON about increased difficulty with this, as at this time he is unsafe to be smoking unsupervised."

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2 830	Continued From page 5	2 830		

Continued From page 5

During interview on 1/12/16, at 3:38 p.m. certified occupational therapy assistant (COTA)-A stated R55 had problems propelling his w/c, because of his stroke history. COTA-A stated she received a phone call from physical therapy assistant (PTA)-B this morning about R55's ability to go in and out of smoking exit door. The facility's policy was that residents needed to able to independently go in and out of the building to smoke.

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.

On 01/13/2016 at at 12:15 p.m. (NA)-A stated the overnight staff have reported that R55 had attempted to self-transfer and they were supposed to monitor for this. She had not received any direction to assist, or monitor R55 going in and out of the smoking area. They have not told us anything.

The above observations were discussed with director of nursing (DON) on 01/13/2016 at 12:40 p.m. The DON stated she was unaware of any concerns that R55 had difficulty getting in and out of the facility to smoke. The facility smoking assessments are completed with each resident to determine if they are able to get in and out of the

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2 830	Continued From page 6 designated smoking area safely. They would be reassessing (R55) ability to maneuver through the smoking door so he would remained safe. The Golden Living Wabasso Smoking Policy And Procedure, last revised on 4/13 identified, "Every resident who desires to smoke is permitted to so so if the facilities IDT [interdisciplinary] team has determined that the practice would be safe for the resident. All residents shall be assessed for their ability to safely smoke independently..." The policy does not identify, if resident are assessed to manipulate the doorway to the resident smoking area, to prevent any potential accident hazards. 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 CORRECTION: Twenty One (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		2/23/16

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21390	Continued From page 7	21390		

C. isolation and precautions systems to reduce risk of transmission of infectious agents;
D. in-service education in infection prevention and control;
E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;
F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;
G. a system for reviewing antibiotic use;
H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and
I. methods for maintaining awareness of current standards of practice in infection control.

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.

corrected

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

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- Unit
- Name
- Admission date
- Type of infection
- If UTI (urinary tract infection), catheter present? (yes or no)
- Symptoms/ Date
- Cultures: Date/Site/ Results
- Treatment
- Other actions (if needed)
- Does not meet infection criteria
- HAI (healthcare associated infection)
- CAI (community associated infection)

Review of the infection control flowsheet's dated July 2015, through December 2015, typically identified the resident name, type of infection, treatment, whether it met infection criteria, and whether the infection was HAI or CAI. However, the forms lacked consistent documentation of room number, whether a catheter was present for an UTI, start of symptoms, actual symptoms, culture results with organism, and the date the infection was resolved.

The facility Line Listing of Resident Infections for the month of October 2015, identified four residents had UTI's, three residents had respiratory infections, and two residents had unidentified infections. The listing did not identify any resident room numbers, consistent documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, or type or location of the unidentified infections. 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

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21390	Continued From page 9 facility, and if education was needed for staff and/ or residents. The facility Line Listing of Resident Infections for the month of November 2015, identified two residents had UTI's, one resident had a respiratory infection, and one resident had a unspecified MRSA (methicillin- resistant staphylococcus aureus) 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, and identify if a catheter was present with the UTI infections. 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. 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. The facility January 2016, Line Listing of Resident Infections had not been started to track resident	21390		

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21390	Continued From page 10 infections when requested on 1/14/16. During interview on 1/14/16, at 1:28 p.m. director of nursing (DON), who was in charge of the facility infection control program, stated the floor nurses fill out an infection control surveillance data collection form, which differs per type of infection, and turns it into her. DON stated she placed the information onto the Line Listing of Resident Infections form to track the infection, cultures, and antibiotic use. The DON stated she added up the number of infections by type, and reported the information quarterly during the facility's quality assurance committee. The DON stated she knew the culture information of each infection because she looked it up, however, she stated she does not track it on the Resident Infection form, and stated that information should be used to accurately analyze the data collected. A policy on the facility's infection control program was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established to include the analysis of collected data, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and	21435		2/23/16

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21435	Continued From page 11 recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of interest were offered/provided for 3 of 3 residents (R15, R5 and R21) who had concerns about the facility activity program. Findings include: R15's significant change Minimum Data Set (MDS), 1/6/16, identified she was cognitively intact was independent with activities of daily living. The activity preference identified it was very important for R15 to have reading material, be involved with a group of people, go outside for fresh aid and to be involved in her favorite activity. The MDS also indicated R15 was able to express ideas and wants and could understand others. R15's Activities Assessment of 10/27/15 identified prior to admission R15 spent time watching television, reading, puzzles and computer video games. Even though the assessment identified R15 did these activities before admission, the computer/video games were " present: not now. "	21435	corrected	

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21435	Continued From page 12	21435		

Continued From page 12

R15 had no activity suggestions for activity staff at this time.

During interview on 1/11/16 at 07:21 p.m. R15 stated that she enjoyed participating in Resident Council and has made several suggestions of different activities such as Wii video game (gamin system that has sports and other games). The Wii video game was listed on the Activity Calendar but she has not seen since this game since she arrived at this facility. The staff do not know how to set up the game so residents can use it. Bingo is played every day except for Wednesday, and they make sure this activity was available.

During follow up visit on 01/14/16 at 8:46 a.m. R15 again expressed concerns that activities posted on the activities calendar were not provided.

Review of the Resident Council Meeting Minutes from June 2015 to January 2016 were reviewed and on 10/12/15 the council wanted to have a Wii bowling tournament, and on 06/08/15 residents wanted to move the Wii games to 7:00 p.m. on non-bingo nights, and have a bean bag tournament.

During interview on 1/13/16 at 8:29 a.m. with activities director (AD) the facility activity calendar from June 2015 to January 2016 were reviewed. The Wii video games were routinely scheduled her Sunday evenings. The AD stated that activity staff work Monday through Friday 8:00-3:30 p.m., the evening bingo activity was led by a resident volunteer and other community volunteers, since the activity staff are not working. AD continued to state they have a Wii video gaming system that has tennis, bowling, and other sports along with

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Wheel of Fortune, Deal and No Deal games. The gaming system was hooked to the main lobby television but "no one knows how to run it". She was unsure when the Wii video game was last played, but thought it was June 2015 when she first started her position.
The AD stated residents bring ideas about activities either individually or through the Resident Council. She was aware residents wanted to play the bean bag toss game, but she was unable to find the game until sometime this fall. Even though she was aware the residents wanted to play this game and was identified in the June 2015 Resident Council Minutes, she never added it to the activity calendar. The AD stated she would add the bean bag toss game to the February calendar, and make sure the Wii video game system gets set up for the residents to use.

During interview on 1/14/16 at 9:11 a.m. nursing assistant (NA)-D stated they have not been given instructions to assist with any activities, on weekends. If the residents want a board games, we will get those. The Wii video game is on the activity calendar, but she had never been asked to set this system up for residents to use even though she was aware of how to operate this system.

On 01/14/16 at 9:17 a.m. NA-A stated the Wii video game system is available for residents to sue but she was unsure how to operate the game, nor has anyone asked her to do this.

Although R15 had told facility staff she wanted to use the Wii video gaming system, and had used video/computer games at home. The Wii gaming system was not available to be used by residents even though this was on the monthly activity calendar since June 2015. The resident council

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21435	Continued From page 14 also suggested bean bag tournament, and to change the Wii video game to Wednesday evenings, these requests were never acted upon. R5's significant change Minimum Data Set (MDS) dated 12/4/15, identified R5 had intact cognition and R5 was independent with activities of daily living. The MDS further identified activity preferences that were "very important" to R5 included having books, newspapers and magazines to read; listening to preferred music; doing things with groups of people; participating in favorite activities; and going outside to get fresh air in good weather. The MDS also indicated R5 was able to express ideas and wants and could understand others. R5's quarterly Recreation Services Assessment, dated 10/2/15, identified R5's program preferences included activities done independently, with friends/family, large group, small group, in-room, out of room, outside, or in the community. The assessment also indicated R5 occupied her time with independent activities, crafts or games with other residents, and showed good participation in group activities. In addition, R5's leisure preferences included bingo, table games, puzzles, word searches, computer games, walking, television, music, reading, gardening, arts and crafts, shopping, and movies. R5's care plan, dated 12/16/15, indicated, "I would like to continue participating in the recreational activities I currently enjoy such as; crafts, bingo, outings, watching tv, reading. Life's simple pleasure: Crafts." The goal for R5 was, "I will continue to express my enjoyment and satisfaction with the activities." Staff were instructed to, "Check in with me to make sure I can still do activities independently and have any	21435		

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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 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		

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21435	Continued From page 16 When interviewed on 1/14/16, at 8:26 a.m. the activity director (AD) stated R5 frequently participated in activities such as bingo, Farkle (a dice game), school visits, Lucky Dice, table games, and entertainment. The AD further stated she was aware that several residents were "unhappy" with the activity program and it was taking her some time to figure out how to meet the activity needs of the residents. The AD further referenced that there was "no activity staff"at the facility on the weekends as a factor of limitation. During an interview on 1/14/16, at 8:58 a.m. NA-D stated R5 liked to play bingo, Farkle, and Yahtzee. NA-D also stated there were days that scheduled activities on the activity calendar were not provided because there were no staff available. In addition, NA-D stated, "Several residents have told me they are not happy with our activity program." When interviewed on 1/14/16, at 9:15 a.m. the director of nursing (DON) stated R5 played a lot of Farkle, Lucky Dice, loved to garden in the summer, enjoyed going out in the community, going to the thrift store, and she loved to do arts and crafts. The DON added, with our activities, for example, if only three residents sign up, the activity may get canceled. The DON also stated at least three residents must be signed up in order for an activity to be held. R21's quarterly MDS dated 11/24/15, identified R21 was cognitively intact. The MDS also indicated R21 was independent with locomotion on the unit. R21's care plan, dated 3/10/14, indicated he preferred independent activities or spending time	21435		

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with my family and friends rather than doing things in groups and left the facility one to two times a week with friends. The care plan goal was to continue participating in independent activities or things with friends and family. Staff were instructed to invite R21 to sit in during activity programs that they may think R21 would enjoy, monitor R21's participation level, offer activities and supplies for activities in R21's room, assist R21 in participating in his favorite activities and encourage R21 to attend scheduled appointments rather than going out with friends.

R21's Recreation Services Assessment dated 11/30/15, indicated R21's past occupation was a junk dealer and he worked with iron and steel. The assessment further indicated R21's vision was impaired, hearing was intact, had clear speech, was alert, cooperative and interacts with others. The assessment indicated R21 did not have any present leisure preferences that he participated in. Program preferences listed R21 as independent and preferred large groups, being out of the room and outside. The assessment further indicated R21 had attended some life skills groups but often refused. In addition, R21 had no real interest in other group activities other than popcorn on Fridays and oven cooking on Wednesdays. R21 had not given any suggestions as to other activities that he would like to see offered.

When interviewed on 11/11/16, at 7:01 p.m. R21 stated that the facility does not offer activities that are interesting to him. R21 further stated that all his life he worked with his hands and the facility does not offer anything like that here. R21 explained he did not enjoy bingo because he could longer read the cards.

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R21 was observed on 1/14/16, at 2:22 p.m. sitting in his wheelchair by the front door of the facility, while a dice game was being played in the day room.

During follow up interview on 11/14/16, at 2:28 p.m. R21 stated he had not participated in any activities at the facility all week, and no one had asked him to attend either. R21 stated, it was not a big deal because there were no activities that interested him. R21 could not recall if any staff members had suggested alternate activities that he would enjoy.

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.

During interview on 1/14/16, at 3:59 p.m. the AD stated she had offered R21 building blocks and that there were large print bingo cards available for use. The AD further stated there were no organized scheduled activities specific to men. The AD stated that R21 refuses group activities and that R21 was difficult to please. In addition R21 had not given the facility any suggestions on what he would like to do. The AD also stated the activity program does not provide 1:1 time with R21.

The Recreation Services Guide: Calendar Policy dated 2009 indicates that that each activity should start at the scheduled time, and activities will be offered that reflect the schedules, choices, and rights of the residents at hours convenient to the residents, including afternoons and weekends.

SUGGESTED METHOD OF CORRECTION:

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21435	Continued From page 19 The activity director could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator and state agency, then comprehensively investigated for 1 of 1 residents (R45) who reported she had been abused during the survey.	21990	corrected	2/23/16

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Findings include:

R45's quarterly minimum data set (MDS) dated 11/19/15, indicated she was cognitively intact and was independent with all activities of daily living.

During an interview on 1/14/15, at 11:53 a.m. R45 stated registered nurse (RN)-D had "assaulted" her, and grabbed R45's forearm and spoke harshly at her. R45 stated she was "too scared to fill out a grievance form," but added she reported the incident to the facility administrator. Further, R45 stated the incident occurred during the month of September 2015.

During an interview on 1/14/15, at 2:07 p.m. the facility administrator stated he thought the incident between R45 and RN-D occurred on 9/9/15, but was not made aware of the allegation of abuse until 9/21/15 (12 days later). The administrator stated he was unaware who brought the concern to his attention, adding he doesn't document, "Who told me something, [or] when someone tells me something." Further, the administrator stated he did not report it to the State agency, "I do not believe I reported it to the state agency."

During an interview on 1/14/15, at 3:51 p.m. RN-A stated R45 approached her and was, "Disturbed" because RN-D grabbed a hold of her arm and thought she was possibly angry with her. RN-A stated she did not report the allegation of potential abuse to the administrator or State agency though.

R45's progress notes dated 9/19/15, identified R45 had approached staff and reported that RN-D had grabbed her arm "the other day" and

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when she asked RN-D to let go, RN-D said "no." The note did not identify if the administrator or State agency was notified of the allegation of abuse.

R45's Verification of Investigation report dated 9/21/15, consisted of several hand written notes made by staff. RN-A was told of the potential abuse by R45 on 9/9/15, however the report had not been initiated until 9/21/15 according to the documents. The provided form identified a space to include a, "Detailed description of the event/allegation," which staff identified as, "Resident reported tha [sic] some time last week, RN-D grabbed her right arm." Further, the form provided spacing to describe a, "Resident interview summary," which staff identified, "[RN-D] grabbed my arm [right] sometime last week." The forms spacing to identify what, "immediate resident protection," was initiated was left blank. The collected notes and form did not identify any interviews of other staff to rule out abuse concerns, or follow up to R45 on her reported concerns.

A facility Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source policy dated 3/2012, identified all allegations of abuse, neglect or mistreatment were to be, "reported immediately to the Executive Director [administrator] of the facility... [and] to the Minnesota Department of health [State agency] and to the Common Entry Point by the Executive Director." Further, the policy directed staff to, "Investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and Common Entry Point as required by

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21990	Continued From page 22 State and Federal law." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review, revise, develop and implement policies and procedures to ensure allegations of abuse are reported immediately. In addition random audits could be conducted and staff training provided to ensure all allegations are investigated and reported correctly. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the	22000		2/23/16

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specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to implement policies and procedures to ensure allegations of abuse were immediately reported to the administrator and state agency, and comprehensively investigated for 1 of 1 residents (R45) who reported she had been abused during the survey.

corrected

Findings include:

A facility Policies and Procedures Regarding

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Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or Injuries of Unknown Source policy dated 3/2012, identified all allegations of abuse, neglect or mistreatment were to be, "reported immediately to the Executive Director [administrator] of the facility... [and] to the Minnesota Department of health [State agency] and to the Common Entry Point by the Executive Director." Further, the policy directed staff to, "Investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and Common Entry Point as required by State and Federal law."

R45's quarterly minimum data set (MDS) dated 11/19/15, indicated she was cognitively intact and was independent with all activities of daily living.

During an interview on 1/14/15, at 11:53 a.m. R45 stated registered nurse (RN)-D had "assaulted" her. RN-D grabbed R45's forearm and spoke harshly at her. R45 stated she was "too scared to fill out a grievance form," but added she reported the incident to the facility administrator. Further, R45 stated the incident occurred during the month of September 2015.

During an interview on 1/14/15, at 2:07 p.m. the facility administrator stated he thought the incident between R45 and RN-D occurred on 9/9/15, but was not made aware of the allegation of abuse until 9/21/15 (12 days later). The administrator stated he was unaware who brought the concern to his attention, adding he doesn't document, "Who told me something, [or] when someone tells me something." Further, the administrator stated he did not report it to the State agency, "I do not believe I reported it to the

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state agency."

During an interview on 1/14/15, at 3:51 p.m. RN-A stated R45 approached her and was, "Disturbed" because RN-D grabbed a hold of her arm and thought she was possibly angry with her. RN-A stated she did not report the allegation of potential abuse to the administrator or State agency though.

R45's progress notes dated 9/19/15, identified R45 had approached staff and reported that RN-D had grabbed her arm "the other day" and when she asked RN-D to let go, RN-D said "no." The note did not identify if the administrator or State agency was notified of the allegation of abuse.

R45's Verification of Investigation report dated 9/21/15, consisted of several hand written notes made by staff. RN-A was told of the potential abuse by R45 on 9/9/15, however the report had not been initiated until 9/21/15 according to the documents. The provided form identified a space to include a, "Detailed description of the event/allegation," which staff identified as, "Resident reported tha [sic] some time last week, RN-D grabbed her right arm." Further, the form provided spacing to describe a, "Resident interview summary," which staff identified, "[RN-D] grabbed my arm [right] sometime last week." The forms spacing to identify what, "immediate resident protection," was initiated was left blank. The collected notes and form did not identify any interviews of other staff to rule out abuse concerns, or follow up to R45 on her reported concerns.

SUGGESTED METHOD FOR CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00949	A. BUILDING: ______ 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**

(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
22000	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 (21) days.	22000		