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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CLNU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**

2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING 907**
(L4) **MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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 **08/06/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 07/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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 08/26/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5540

August 14, 2014

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

Dear Ms. Gedde:

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 August 1, 2014 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 13, 2014

Ms. Joan Gedde, Administrator
Golden Livingcenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540024

Dear Ms. Gedde:

On June 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 20, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On August 6, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 20, 2014, effective August 1, 2014 and therefore remedies outlined in our letter to you dated June 30, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245540	A. Building B. Wing	8/6/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	08/01/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	08/01/2014	ID Prefix F0285 Reg. # 483.20(m), 483.20(e) LSC	08/01/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GA/mm	Date: 08/13/2014	Signature of Surveyor: 28034	Date: 08/06/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/20/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

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(L1) **245540**

2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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 **06/20/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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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

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To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Miriam Thornquist, HFE NE II — 07/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/19/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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3. Both of the Above :
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04/01/1990
(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 08/22/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1959

June 30, 2014

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540024, H5540008

Dear Ms. Gedde:

On June 20, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5540008. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5540008 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

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 July 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 20, 2014 (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 December 20, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File 5540s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint #H5540008 was completed. The complaint was not substantiated.			
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	F 225	RECEIVED JUL 14 2014 MN Dept of Health Fergus Falls	7/28/14 OK

LABORATORY DIRECTOR'S/OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Beddy, EdD. — Executive Director — (X6) DATE: 07-11-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure allegations of staff abuse for 1 of 1 resident (R28) was reported to the State agency (SA). In addition, the facility failed to ensure an injury of unknown origin for 1 of 1 resident, (R20), was immediately reported to the SA and thoroughly investigated. Findings include: R28's admission Minimum Data Set (MDS) dated 2/28/14, identified R28 was cognitively intact and required extensive assistance with toileting and bed mobility. Review of a facility Incident Report for R28 dated 3/3/14, documented by the director of nursing	F 225	F 225: It is the intent of Golden Living Center-Henning to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. R20 has been interviewed and denies having been abused or mistreated by staff, family or other residents. Unable to interview R28 as resident has since discharged. The facility has investigated alleged violations of abuse/mistreatment and, if verified, has reported the results and corrective action taken to the appropriate state agency. All residents have the potential to be affected by the deficient practice. Facility staff have been educated to report any incident of potential abuse/mistreatment to the charge nurse. Licensed staff have been educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately to the ED. ED has been educated to initiate an investigation into any allegations of abuse/mistreatment, and	

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	245540	A. BUILDING _____ B. WING _____	06/20/2014

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F 225	Continued From page 2 (DON) indicated the following: "Factual description of the incident: On 3/3/14, resident stated to social worker that, "I can't handle these kids anymore." When asked to clarify she stated she was referring to the staff. [Resident] stated that in the early mornings, around 3:00 a.m., a staff person comes in and "hollers" at me. She continues to state that a staff member has to change her at this time due to bladder incontinence. [Resident] also stated that the staff person is too rough and they are hurting me." The facility provided investigation of the incident which indicated R28, "Felt rushed by one staff member. Resident states that only one staff member makes her feel this way and that this particular staff member works on nights every day including today. During interview, resident was noted to be an inconsistent historian and gave conflicting information. When attempting to recall events, she stated 'my mind is going faster than I wanted it to.' Residents previous living arrangement had 6 children. Resident is noted to have intermittent confusion. Resident is noted to have occasional bladder incontinence and requires assist with toileting. Resident had an episode of uncontrolled seizure-like activity while in the bathroom the previous evening (3/2/14), while transferring with stand up lift. Staff had difficulty transferring her with stand up lift and had to switch from stand up lift to total lift. During this seizure-like event, resident was tearful and had a worried expression on her face. Resident has a diagnoses of presenial dementia. Resident has a diagnoses of mild cognitive impairment... Staff education given regarding customer service... DON followed up with resident on 3/4/14	F 225	report, if verified, results of the investigation and corrective actions taken, to appropriate officials, in accordance with state law. Audits will be completed immediately on reported incidents to ensure initiation of report to MDH as appropriate. Any required follow-up or re-education will be completed at that time. Audit results will be presented at QA&A for review. ED or Designee is the responsible party. Corrective Action will be completed by 08-01-2014.	

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F 225	Continued From page 3	F 225		

regarding cares and staff interactions and resident stated that she had a good night..." The incident report indicated the state agency had not been notified.

During interview on 6/18/14, at 1:25 p.m. social worker (SW) stated she had been talking with R28 the morning of 3/3/14, and the resident had told her a "staff member was rough with their approach." SW stated she does not submit reports to the state agency and she just reported R28's alleged staff abuse to the DON who took over the investigation. SW stated she was not aware if R28's allegation of staff abuse had been reported because she just reports concerns to the DON and "assumes" if something needs to be investigated or reported "staff will do it."

During interview on 6/20/14, at 10:05 a.m. DON stated she did the investigation and incident report regarding R28's allegation of staff abuse. DON stated when SW reported the concerns to her, she immediately went and spoke with R28. DON felt R28 was inconsistent with her complaints, so she did not feel it needed to be reported. DON verified "looking back" a report should have been filed with the state agency, and then an investigation should have begun.

R20's admission MDS dated 5/6/14, identified R20 had severe cognitive impairment, required extensive assistance with toileting, and limited assistance with locomotion.

Review of a facility Incident Report dated 5/11/14, with a time of "between 4:00 a.m.- 5:30 a.m." indicated the following:

"Resident was in bathroom knocking on door.

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F 225	Continued From page 4	F 225		

Staff responded and observed resident covered with blood all over head, hand, neck, arm. Notified nurse. Blood was partially dried on resident..." When the resident was asked what happened he stated, "It exploded. I don't know." The summary and investigative findings were, "Staff heard resident knocking on bathroom door between rooms. Went to help resident and observed resident had blood on his face, head, neck, arms, hands...Blood was partially dried. Gave resident a shower. Observed laceration on left side of back of head... Resident is confused unable to explain how it happened or what happened... Resident has cognitive impairment, unbalanced gait. Interventions applied are bed alarm. Chair alarm." The resident was sent to the emergency room and received stitches in the back of his head. There was no further investigation of this incident.

During interview on 6/20/14, at 10:05 a.m. DON stated she saw the fall report and just "assumed" that if staff filled out a fall report they had witnessed him fall. The DON had not reviewed the fall report close enough to notice the resident's fall was documented as happening sometime within an 1 1/2 hour time period, as well as the resident had dried blood on his face. DON verified after reviewing the incident for R20 on 5/11/14 this should have been reported immediately to the state agency and investigated.

The facility policy titled, "Policies and procedures regarding investigation and reporting of alleged violations of federal or state laws involving maltreatment, or injuries of unknown source in accordance with federal and Minnesota state vulnerable adult act requirements," dated 3/2012 instructed the following:

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F 225	Continued From page 5 "It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations... are reported immediately to the executive director (ED) of the facility. Such violations shall be reported to the [state agency]...The ED (or the director of nursing services if the ED is not available) shall determine if the internal report must be reported to the state... Reportable incidents must be reported immediately... Unexplained injury (injury of unknown source): an injury sustained by a resident that is not reasonably explained. The source of the injury may not have been observed and/ or the resident may not be able to explain the source of the injury. The injury may be suspicious because of the extent or the location of the injury or the number of injuries observed at one time or over a period of time."	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 by: Based on interview and record review, the facility failed to ensure 1 of 1 resident, (R28), who made allegations of staff abuse was reported to the state agency per facility policy. In addition, the facility failed to ensure an injury of unknown source for 1 of 1 resident, (R20), reviewed for	F 226	F 226 It is the intent of Golden Living Center-Henning to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. R20 denies having been abused or mistreated by staff, family or other residents. Unable to interview R28 as resident has since discharged. The facility has investigated alleged violations of abuse/mistreatment and, if verified, has reported the results and corrective action taken to the appropriate state agency.	

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F 226	Continued From page 6 injury of unknown source was reported to the state agency and thoroughly investigated per facility policy. Findings include: The facility policy titled, "Policies and procedures regarding investigation and reporting of alleged violations of federal or state laws involving maltreatment, or injuries of unknown source in accordance with federal and Minnesota state vulnerable adult act requirements," dated 3/2012 instructed the following: "It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations... are reported immediately to the executive director (ED) of the facility. Such violations shall be reported to the [state agency]...The ED (or the director of nursing services if the ED is not available) shall determine if the internal report must be reported to the state... Reportable incidents must be reported immediately... Unexplained injury (injury of unknown source): an injury sustained by a resident that is not reasonably explained. The source of the injury may not have been observed and/ or the resident may not be able to explain the source of the injury. The injury may be suspicious because of the extent or the location of the injury or the number of injuries observed at one time or over a period of time." R28 admission Minimum data set (MDS) dated 2/28/14, identified R28 was cognitively intact and required extensive assistance with toileting and bed mobility.	F 226	All residents have the potential to be affected by the deficient practice. Facility staff have been educated to report any incident of potential abuse/mistreatment to the charge nurse. Licensed staff have been educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately to the ED. ED has been educated to initiate an investigation into any allegations of abuse/mistreatment, and report, if verified, results of the investigation and corrective actions taken, to appropriate officials, in accordance with state law. Audits will be completed immediately on reported incidents to ensure initiation of report to MDH as appropriate. Any required follow-up or re-education will be completed at that time. Audit results will be presented at QA&A for review. ED or Designee is the responsible party. Corrective Action will be completed by 08-01-2014.	

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F 226	Continued From page 7	F 226		

Review of a facility Incident Report for R28 dated 3/3/14, documented by the director of nursing (DON) indicated the following:
"Factual description of the incident: On 3/3/14, resident stated to social worker that, 'I can't handle these kids anymore.' When asked to clarify she stated she was referring to the staff. [Resident] stated that in the early mornings, around 3:00 a.m., a staff person comes in and 'hollers' at me. She continues to state that a staff member has to change her at this time due to bladder incontinence. [Resident] also stated that the staff person is too rough and they 'are hurting me."

The facility provided investigation of the incident which indicated R28, "Felt rushed by one staff member. Resident states that only one staff member makes her feel this way and that this particular staff member works on nights every day including today. During interview, resident was noted to be an inconsistent historian and gave conflicting information. When attempting to recall events, she stated 'my mind is going faster than I wanted it to.' Residents previous living arrangement had 6 children. Resident is noted to have intermittent confusion. Resident is noted to have occasional bladder incontinence and requires assist with toileting. Resident had an episode of uncontrolled seizure-like activity while in the bathroom the previous evening (3/2/14), while transferring with stand up lift. Staff had difficulty transferring her with stand up lift and had to switch from stand up lift to total lift. During this seizure-like event, resident was tearful and had a worried expression on her face. Resident has a diagnoses of presenial dementia. Resident has a diagnoses of mild cognitive impairment... Staff

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education given regarding customer service... DON followed up with resident on 3/4/14 regarding cares and staff interactions and resident stated that she had a good night..." The incident report indicated the state agency had not been notified according to facility policy.

During interview on 6/18/14, at 1:25 p.m. social worker (SW) stated she had been talking with R28 the morning of 3/3/14, and the resident had told her a "staff member was rough with their approach." SW stated she does not submit reports to the state agency and she just reported R28's alleged staff abuse to the DON who took over the investigation. SW stated she was not aware if R28's allegation of staff abuse had been reported because she just reports concerns to the DON and "assumes" if something needs to be investigated or reported "staff will do it."

During interview on 6/20/14, at 10:05 a.m. DON stated she did the investigation and incident report regarding R28's allegation of staff abuse. DON stated when SW reported the concerns to her, she immediately went and spoke with R28. DON felt R28 was inconsistent with her complaints, so she did not feel it needed to be reported. DON verified "looking back" a report should have been filed with the state agency, and then an investigation should have begun according to the facility policy.

R20 admission MDS dated 5/6/14, identified R20 had severe cognitive impairment, required extensive assistance with toileting, and limited assistance with locomotion.

Review of a facility Incident Report dated 5/11/14, with a time of "between 4:00 a.m.- 5:30 a.m."

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F 226	Continued From page 9 indicated the following: "Resident was in bathroom knocking on door. Staff responded and observed resident covered with blood all over head, hand, neck, arm. Notified nurse. Blood was partially dried on resident..." When the resident was asked what happened he stated, "It exploded. I don't know." The summary and investigative findings were, "Staff heard resident knocking on bathroom door between rooms. Went to help resident and observed resident had blood on his face, head, neck, arms, hands...Blood was partially dried. Gave resident a shower. Observed laceration on left side of back of head... Resident is confused unable to explain how it happened or what happened... Resident has cognitive impairment, unbalanced gait. Interventions applied are bed alarm. Chair alarm." The resident was sent to the emergency room and received stitches in the back of his head. There was no further investigation of this injury of unknown source per facility policy. During interview on 6/20/14, at 10:05 a.m. DON stated she saw the fall report staff had filled out and just "assumed" that if staff filled out a fall report they had witnessed R20 fall. The DON had not reviewed the fall report close enough to notice the resident's fall was documented as happening sometime within an 1 1/2 hour time period, as well as the resident had dried blood on his face. DON verified after reviewing the incident for R20 on 5/11/14, this injury of unknown source should have been reported immediately to the state agency and investigated per facility policy.	F 226		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR	F 285		

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A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

For purposes of this section:
(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).

7/25 4:38pm Don put NDcopy in chart

218-583-2965

Facility ensured that R30 had a level II in the chart.

New admissions can potentially be affected.

Social Services has devised a form that will be completed by that department. Items on the form include verification of level I and level II screening present in chart. This form will be completed with each admission.

Medical Records to review medical chart and ensure that this piece is in the chart. Audit results will be presented at QA&A for review.

Social Service, Medical Records or Designee is the responsible party.

Corrective Action will be completed by 08-01-2014.

Lisa. KeierLeber@goldenlivingcenter.com

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(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure a level 2 pre-admission screening and resident review (PASRR) was completed for 1 of 1 resident (R30) upon admission to the facility.

Findings include:

The quarterly Minimum Data Set (MDS) dated 5/30/14, identified R30 had diagnoses which included Schizophrenia (paranoid), depression and psychosis. The MDS indicated R30 had moderate cognitive impairment and had hallucinations and both physical and verbal behaviors directed at others.

Review of R30's clinical record revealed a form titled North Dakota Level 1 Form, completed on 1/13/12. The level 1 PASRR form identified R30 had mental illness and borderline intellectual functioning. The level 1 PASRR form identified R30 was to be referred for a level II evaluation for mental illness and mental retardation. The record lacked documentation of a level 1 PASRR or a level 2 PASRR completed upon admission, in the state of Minnesota.

During interview on 6/19/14, at 4:10 p.m. social worker (SW) stated R30 was transferred to the facility from another Minnesota long term care center and R30 had resided in North Dakota prior

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to that. SW stated she felt R30 did not qualify for a level II PASRR in Minnesota. SW stated she knew what the level I questions were and R30 would not "qualify" for a level II PASRR. The SW verified the facility had not completed a level 1 PASRR screening nor requested a level II PASRR be completed for R30 since admission on 4/10/12.

On 6/20/14, at 9:05 a.m. the SW indicated she found that the state of North Dakota had completed a level II PASRR for R30 and was waiting for a copy of the results of the PASRR 2. A copy of level 2 PASRR summary findings done by the state of North Dakota dated 1/18/12, was provided at 10:00 a.m. on 6/20/14. The SW confirmed the facility did not have a copy of the level II PASRR prior to that.

Review of the facility policy titled, Pre-Admission Screening, revised October 2009, identified a level 1 screening would be done for all potential admissions to the facility. The policy identified a review of resident's psychosocial status would be done, and listed various information such as a history of mental health, mental retardation, previous admissions to long-term care facilities, mental health/retardation facilities or other institutions. Further, the policy identified that if a level II PASAAR screening was warranted, the screening must be obtained prior to making a final admission determination.

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	245540	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2014**

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GOLDEN LIVINGCENTER - HENNING	**907 MARSHALL AVENUE. PO BOX 57 HENNING, MN 56551**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter - Henning 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Livingcenter - Henning is a 1-story building with out a basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 42 beds and had a census of 26 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	**907 MARSHALL AVENUE. PO BOX 57 HENNING, MN 56551**

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K 000	Continued From page 1 Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1959

June 30, 2014

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5540024, H5540008

Dear Ms. Gedde:

The above facility was surveyed on June 17, 2014 through June 20, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5540008. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

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 Gail Anderson at the phone number above.

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

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

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

Sincerely,

Mark Meath

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

cc: Original - Facility
Licensing and Certification File