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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DFZX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00213

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245084**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA**
(L4) **15409 WAYZATA BOULEVARD**
(L5) **WAYZATA, MN** (L6) **55391**

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 **10/12/2015** (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 **84** (L18)

13.Total Certified Beds **84** (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
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/29/2015 (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
01/16/1967
(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 11/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/28/2015
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5084
Item 16 Continuation for CMS-1539

The facility's request for a continuing waiver involving the deficiency cited at K67 was previously forwarded. Approval of the waiver request was recommended.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245084
October 29, 2015

Ms. Allison Murkowski, Administrator
Golden Livingcenter - Hillcrest of Wayzata
15409 Wayzata Boulevard
Wayzata, Minnesota 55391

Dear Ms. Murkowski:

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 October 6, 2015 the above facility is certified for or recommended for:

84 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

Your request for waiver of K067 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 29, 2015

Ms. Allison Murkowski, Administrator
Golden Livingcenter - Hillcrest of Wayzata
15409 Wayzata Boulevard
Wayzata, Minnesota 55391

RE: Project Number S5084025

Dear Ms. Murkowski:

On September 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 27, 2015. 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 October 12, 2015, 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 August 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 27, 2015, effective October 6, 2015 and therefore remedies outlined in our letter to you dated September 10, 2015, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245084	A. Building B. Wing	10/12/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **10/06/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/06/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/06/2015**
ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **10/06/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **10/06/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/06/2015**
ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **10/06/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/06/2015**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **10/06/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	10/29/2015	29249	10/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/27/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DFZX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00213

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(L1) **245084**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA**
(L4) **15409 WAYZATA BOULEVARD**
(L5) **WAYZATA, MN** (L6) **55391**

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 **08/27/2015** (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 **84** (L18)

13.Total Certified Beds **84** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(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):

Page 2
Provider Number: 24-5084
Item 16 Continuation for CMS-1539

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended.

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 09/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/27/2015 (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
01/16/1967
(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
AW K67 sent to Rochi (CMS) 10/28/2015 Co.

Posted 10/28/2015 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 # 7011 0470 0000 5262 2205
September 10, 2015

Ms. Allison Murkowski, Administrator
Golden Livingcenter - Hillcrest Of Wayzata
15409 Wayzata Boulevard
Wayzata, Minnesota 55391

RE: Project Number S5084025

Dear Ms. Murkowski:

On August 27, 2015, 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;

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

<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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
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 October 6, 2015, 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 October 6, 2015 the following remedy will be imposed:

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

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.

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 November 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 27, 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 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. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

PRINTED: 09/10/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING _____ B. WING _____	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**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 of 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.**	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess ability to safely self administration medication for 1 of 1 resident (R159) observed self administering medication. Findings include: R159's admission Minimum Data Set (MDS) dated 7/9/15, indicated R159 had severe cognitive impairment. R159's Physician orders dated 8/27/15, listed R159 had diagnoses including dementia, depression, and constipation. The physician order did not indicate the resident was able to self-	F 176	**F 176** 1. Residents will not self administer medications without a physician order and appropriate interdisciplinary team assessment. 2. All licensed nurses and TMA's will be re-educated on medication administration policy and procedure. 3. A weekly audit will be performed to ensure residents are not self administering medication without a physicians order and IDT assessment. 4. The Director of Nursing and/or designee is responsible for monitoring compliance. 5. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 6. Date of Compliance 10/6/15.	

approved 9/24/15

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

Allison Murkowski | Sr. Executive Director | 9/23/15

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING _____ B. WING _____	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

(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 176	Continued From page 1 administer medication. R159's Care Plan dated 8/5/15, did not indicate the resident was able to, or had been assessed, to self-administer any medications. During observation of medication pass on 8/26/15, at 9:02 a.m. licensed practical nurse (LPN)-A mixed R159's Miralax (a powered medication used for constipation) in a chocolate nutritional shake and brought it with R159's other medications to the dining room table. R159 took her oral medications and drank half of the shake which contained the Miralax. LPN-A set the shake next to R159 on the dining room table and told her to finish it, and then LPN-A left the dining room. On 8/26/15 at 9:39 a.m., R159 was observed being wheeled out of the dining room after she was done with breakfast. The chocolate nutritional shake with Miralax remained at the dining room table and was still half full. During interview on 8/26/15, at 9:44 a.m. LPN-A stated she usually stays with R159 until she is finished with the Miralax, however, she, "Forgot today." LPN-A stated the glass with the Miralax in the shake was still on the dining room table, and it appeared R159 had not finished the medication. During interview on 8/26/15, at 12:31 p.m. director of nurses (DNS) stated if a resident did not have a physician order for self administration and a self-administration assessment completed, it would not be acceptable to leave a resident with Miralax unsupervised. The facility policy/ procedure titled AlixaRX Medication Preparation and General Guidelines	F 176		

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F 176	Continued From page 2 Self-Administration of Medications dated 05/12, instructed staff: "In order to maintain the residents high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer... If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process...If the resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and the resident is deemed to have deferred this right to the facility."	F 176		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruises and/or skin conditions were identified, described in detail, assessed for potential cause, and monitored for change, with interventions	F 309	**F 309** 1. Non-pressure related skin conditions will be identified, described in detail, assessed for potential cause, and monitored for change, with interventions attempted to promote healing and/or prevent additional injury. 2. The facility has revised their weekly skin check form to include a more detailed description of non-pressure related skin conditions, potential causes and interventions attempted to promote healing. 3. Licensed Nurses will be trained on the new form and expectations for completion.	

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F 309	Continued From page 3 attempted to promote healing and/or prevent additional injury for 3 of 4 residents (R95, R97 and R45) reviewed for non-pressure related skin conditions. Findings include: R95's admission Minimum Data Set (MDS) dated 7/21/15, identified the resident had moderately impaired cognition and required extensive assistance for most activities of daily living (ADL's), including bed mobility, transfers, locomotion, and toilet use. R95's Admission Skin Assessment dated 7/14/15, noted bruises and discoloration to the bilateral upper arms, elbows, and forearms. The assessment lacked further description of these skin conditions, including the size, color, shape, specific location, the number of sites identified and the likely cause of any bruising. R95's physician orders signed 8/20/15, identified diagnoses including dementia, seizure disorder, muscle weakness, generalized pain and post-surgical repair of a fractured hip. No anticoagulant medications were included in these orders. During observation and interview on 8/24/15, at 7:34 p.m. R95 was seated in her wheelchair in her room. Numerous, dark purple/ red bruises were observed to her bilateral, outer arms and hands. The bruises varied from tennis ball to pea-sized, with irregular edges. R95 denied any concerns of abuse or rough/ rushed cares. R95 stated she bruised quite easily and often bumped her arms/ hands on doorways, rails or equipment as she went about her day. R95 stated she had no pain related to the bruising. Review of R95's Comprehensive Weekly Skin Assessments indicated the following: - On 7/24/15, the assessment identified an alteration to R95's upper extremities. The	F 309	4. Nursing assistant will immediately report changes in resident's skin to the nurse on duty. 5. The facility will continue to complete incident reports per protocol. 6. Non-pressure related skin conditions will be care planned to include interventions attempted to promote healing and/or prevent additional injury. 7. R95, R97 and R45 have all discharged from the facility. 8. A weekly audit will be performed to ensure weekly skin checks are accurately completed and any new or changed skin conditions are care planned. 7. The Director of Nursing and/or designee is responsible for monitoring compliance. 8. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 9. Date of Compliance 10/6/15.	

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F 309	Continued From page 4 assessment noted, "Discoloration/ bruising to bilat [bilateral] arms/ hands." - On 7/31/15, the assessment identified an alteration to R95's upper extremities. The assessment noted, "Discolored/ dusky bilat arms." - On 8/7/15, the assessment identified an alteration to R95's upper extremities. The assessment noted, "Has several discolored areas to bilat arms/ hands." - On 8/21/15, the assessment identified an alteration to R95's upper extremities. The assessment noted, "Several discolored areas to bilat arms [and] hands." The assessments lacked further description of these skin conditions, including the size, color, shape, specific location, the number of sites identified, and the likely cause of any bruising. The assessments also did not evaluate whether any changes had occurred to these areas since the prior assessment. Review of R95's medical record lacked further detail or description of these skin alterations. The record also lacked evaluation of possible causes, monitoring for changes, and implementation of interventions to promote healing and/or prevent further injury. During interview on 8/27/15, at 2:42 p.m. licensed practical nurse/ clinical manager (CM)-A stated there was no additional information, assessments, or monitoring regarding R95's upper extremity bruising/ discoloration. R97's admission record, dated 12/31/14, identified diagnoses including dementia, anemia, and colitis. R97's quarterly MDS, dated 7/7/15, identified the resident had severe cognitive impairment and	F 309		

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F 309	Continued From page 5 required extensive assistance of one to two staff for all ADL's, including bed mobility, transfers, toilet use and personal hygiene. During observation on 8/24/15, at 6:35 p.m., R97 was seated in his wheelchair in the common area of the unit. Steri-strips (thin adhesive strips that can close cuts and incisions without stitches) were noted on the back of R97's right hand, a dime sized red/purple area was noted between the first and second fingers of the left hand, and two quarter sized red/purple areas were noted on the outer left forearm. In addition, a nickel size dark red/black area was noted on the outer aspect of the left hand with reddened, inflamed skin around the perimeter of the darkened area. R97's care plan dated 6/30/15, included R97 was, "At risk for skin breakdown d/t [due to] impaired mobility, fragile skin, and hx [history] of CA [cancer] (skin) and g [gastrostomy]-tube." R97's medical record lacked any evidence of the identification or monitoring of R97's altered skin conditions. During observation and interview on 8/27/2015, at 3:55 p.m., clinical manager (CM)-D verified the steri-strips to R97's right hand, the bruising on his left hand and forearm, and the dark red/black area with the reddened perimeter on the outer aspect of R97's hand. CM-D stated she was not aware of these areas and indicated she could not find any documentation or incident reports that identified R97's altered skin conditions, and verified there was no evidence the areas were being monitored. During interview on 8/27/2015, at 4:54 p.m.,	F 309		

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F 309	Continued From page 6	F 309		

licensed practical nurse (LPN)-A stated she had not noted the steri-stripped area on R97's right hand, the dark red/purple area on the left hand, or the bruising on the left hand and forearm. LPN-A stated she observed R97's skin on 8/25/15, and hadn't noticed these skin alterations. LPN-A stated NA's were to report any alterations in skin condition to the nurse, and no one had reported these areas to her.

R45's admission MDS dated 8/13/15, indicated the resident had severe cognitive impairment, and required limited assist of one staff for personal hygiene. No skin issues were noted.

R45's Order Summary Report dated 8/19/15, indicated the resident was to have a weekly skin assessment on Tuesdays.

R45's Progress noted dated 8/26/15, noted a weekly skin check was completed by a licensed nurse, and daily observations of skin with cares were reported to physician as needed with any changes. There was no information any skin conditions were identified.

R45's Comprehensive Weekly Skin Assessment had only one week completed, which was dated 8/18/15, and head and scalp were noted as intact at that time.

R45's admission Skin Assessment (undated) noted bruises/ecchymosis (discoloration) of the right anterior forehead. The Skin assessment did not identify the measurements, cause, or any further monitoring.

R45's Discharge summary from Maple Grove Hospital dated 8/13/15, noted past medical

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F 309	Continued From page 7 history of squamous cell cancer affecting the scalp and neck. During observation on 8/25/15, at 10:28 a.m. a scabbed area, approximately 2 centimeter (cm) in diameter was noted on R45's right forehead. During interview on 8/26/15, at 7:16 a.m. R45 stated he had this area on his head for a long time, and denied knowledge of staff doing any monitoring. R45 stated at home he put cream on it, but does not know of any treatment being provided at the facility. During interview on 8/27/15, at 2:20 p.m. CM-A stated weekly head to toe skin assessments are done on all residents, and any sores, open areas, scratches, dryness, etc. would be monitored, and should be documented on the Comprehensive Weekly Skin Assessment Form. In addition, staff would be expected to create a progress note to document anything abnormal found with the skin. CM-A stated R45 had only one week of the Skin assessment completed. CM-A observed the area on R45 scalp, and stated this is something that should be monitored and referred to the wound nurse. The facility's Skin Integrity Guideline dated 1/11, directed optimal care to promote healing to residents with all identified alterations in skin integrity. The policy directed an interdisciplinary plan of care to address problems, goals, and interventions directed toward prevention of identified skin integrity concerns.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 8 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure justification for the use of Zyprexa (an antipsychotic medication) were identified for 1 of 6 residents (R95) who received antipsychotic medications. Findings include: R95's admission Minimum Data Set (MDS) dated 7/21/15, listed diagnoses of dementia and depression. The MDS identified R95 had	F 329	**F 329** 1. The facility will ensure the medical record for each resident reflects indication and justification for use of antipsychotic medications. 2. R95 has discharged from the facility. 3. All Charge Nurses will be re-educated to ensure correct diagnosis and indications for use of antipsychotic medications are obtained on admission and/or with new orders for antipsychotic medications. If an attempt to obtain the information is not successful they will continue to follow-up until resolved. 4. The manager or designee for each unit will review all admission records and/or new orders for antipsychotic medications to ensure this information is obtained and documented. 5. The Director of Nursing or designee is responsible for monitoring compliance. 6. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 7. Date of Compliance 10/6/15.	

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F 329	Continued From page 9 moderately impaired cognition, signs of disorganized thinking, displayed verbal behavioral symptoms directed toward others, and behavioral symptoms not directed toward others, for one to three days during the assessment period. The MDS indicated these behavioral symptoms posed no significant risk for physical illness/ injury to herself or others, no interference with her cares or participation in activities/ social interactions, no significant intrusion on the privacy/ activity of others, and no significant disruption of care or the living environment. R95's Physician orders signed by physician-B on 8/20/15, indicated Zyprexa 2.5 milligrams (mg) daily at bedtime, for agitation and restlessness. The order start date was noted as 7/22/15. The order lacked any indication of psychosis, or justification for the listed indications of agitation and restlessness, and there were no measurable definitions of R95's agitation and restlessness. R95's medical record included a fax sent to physician-B on 7/21/15, which noted, "Order was received on 7/18/15, for resident to start Zyprexa for agitation. This is not a specific diagnosis for the use of this med. Please give specific dx [diagnosis] for use____." However, the medical record lacked a response to this fax, or any additional follow-up regarding this inquiry. An informed consent form for R95's use of Zyprexa was signed by family member (F)-D on 7/23/15. The consent noted the target behaviors for this medication as delirium/delusions and paranoia. The medical record lacked any corroborating evidence, supporting these target behaviors as physician endorsed diagnoses/ indications for use.	F 329		

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F 329	Continued From page 10 Behavior monitoring forms for R95's use of Zyprexa dated 7/24/15, through 8/13/15, noted target behaviors of paranoia and delusions, along with additional hand-written notes of verbally abusive behavior toward staff, yelling, swearing, and hitting staff. The medical record lacked any documentation regarding these target behaviors occurring. During observation on 8/24/15, at 7:34 p.m. R95 was seated in her wheelchair in her resident room, interacting with F-D. R95 demonstrated no signs/ symptoms of delusions, hallucinations, delirium, paranoia, or other behaviors. During observation on 8/25/15, at 8:30 a.m. R95 was seated in her wheelchair in the hallway of the facility. R95 demonstrated no signs/ symptoms of delusions, hallucinations, delirium, paranoia, or other behavior concerns. During interview on 8/27/15, at 2:42 p.m. licensed practical nurse/ clinical manager (CM)-A stated R95's medical record lacked documentation the resident had past behaviors of delusions, hallucinations, delirium or paranoia. CM-A stated R95's medical record lacked physician justification suggesting attempts at non-pharmacological interventions and other non-antipsychotic medications had been exhausted. CM-A stated the nurse who took the verbal Zyprexa order from the physician should have sought clarification to identify acceptable, identifiable, and measurable target behaviors as indications for R95's use of this antipsychotic medication prior to its administration. The facility's Provider Pharmacy Requirements	F 329		

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F 329	Continued From page 11 policy dated 5/12, directed each new medication order be screened for appropriate indication or diagnosis. If a diagnosis or indication was not available the nursing staff were to obtain the information from the prescriber prior to administering the drug.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were provided in accordance with signed physician orders for 2 of 4 residents (R171 and R159), observed during medication administration pass which resulted in 9.7% (percent) medication error rate. Findings include: R171's admission Minimum Data Set (MDS) dated 7/3/2015, indicated R171 had severe cognitive impairment. During medication pass observation on 08/24/2015, at 7:13 p.m. licensed practical nurse (LPN)-B prepared medications for R171, which included Gabapentin, 300 mg capsule which LPN-B opened and mixed the contents of the capsule in applesauce, and Risperidone 0.5 mg tablet, which LPN-B crushed and added to the applesauce. Surveyor intervened prior to the	F 332		

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F 332	Continued From page 12 administration of R171 medication and requested LPN-B check the physician orders. During interview on 8/24/15, at 7:21 p.m. LPN-B verified Gabapentin and Risperdal were both ordered to be given as a solution (liquid form). LPN-B verified the doses were correct, however, the form of the medication was not. LPN-B reviewed R171's physician orders signed 7/30/15, and stated the medication administration record (MAR) did not match the physician orders. LPN-B stated both medications were available in the facility in the liquid solution form, and LPN-B re-dispensed the Gabapentin and Risperdal in the liquid form and administered it to R171. During interview on 8/24/15, at 7:32 p.m. Registered Nurse (RN)-B and director of nursing (DON) stated R171's physician orders directed to administer the Gabapentin and Risperdal in the liquid form, not a capsule or tablet. During interview on 8/25/15, at 3:32 p.m. RN-B stated she spoke to the dispensing pharmacy, and the pharmacy indicated they did not check back to see what form they had sent previous months, and just sent the tablets. During interview on 8/26/15, at 12:00 p.m. Physician-A, who is also the facility Medical Director, stated R171 had physician orders to specifically receive liquid Gabapentin and Risperdal, and the pharmacy sent out tablets and/ or capsules, which is the wrong form of the medication. R159's admission MDS dated 7/9/15, indicated R159 had severe cognitive impairment.	F 332	**F 332** 1. Medications will be administered according to physician orders. 2. All Licensed Nurses and TMA's will check medications against the physician order prior to administering. If the medication sent from the pharmacy does not match the physician order the medication will not be given until the appropriate medication form is obtained or the order is changed. 3. Residents will not self administer medications without a physician order and appropriate interdisciplinary team assessment. 4. All Licensed Nurses and TMA's will be re-educated on Medication Administration policy and procedure. 5. A weekly audit will be performed to ensure residents are not self administering medication without a physicians order and IDT assessment and medication are being administered per the physician order. 6. The Director of Nursing or designee is responsible for monitoring compliance. 7. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 8. Date of Compliance 10/6/15.	

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F 332	Continued From page 13 R159's Physician orders dated 8/27/15, indicated diagnoses including dementia, depression, and constipation. There was no physician order for self- administration of medication. During medication pass observation on 8/26/15, at 9:02 a.m. LPN-A mixed R159's Miralax (a medication for constipation) in chocolate nutritional shake and brought it to R159's who was sitting at the dining room table. R159 took her oral medication, and drank half of the shake which contained the Miralax. LPN-A set the shake next to R159 on the dining room table and told her to drink it, and LPN-A left dining room. On 8/26/15 at 9:39 a.m. R159 had left the dining room, and the chocolate shake with Miralax remained at the dining room table half full. During interview on 8/26/15, at 9:44 a.m. LPN-A stated she usually stands with R159 until she takes all of the Miralax, and she stated it appeared half the Miralax was still sitting at the dining room table and R159 did not take all of the medication. During interview on 8/26/15, at 12:31 p.m. DON stated if a resident did not have a physician order for ability to self administer medication and a self-administration assessment completed, it would not be acceptable to leave Miralax with the resident unsupervised.	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization,	F 334		

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F 334	Continued From page 14 each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334	**F 334** 1. The facility will ensure influenza and pneumococcal immunizations are offered and documented for all residents according to facility policy. 2. Immunization consent/refusal forms for R130, R30 and R171 have been reviewed and completed. 3. The manager or designee for each unit will review all admissions to ensure influenza and pneumococcal immunizations are offered and documented according to facility policy. 4. All Licensed Nurses will be re-educated on the facilities expectation for completion of the immunization consent form. 5. The Director of Nursing or designee is responsible for monitoring compliance. 6. Date of Compliance 10/6/15.	

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F 334	Continued From page 15 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: The facility failed to ensure influenza and pneumococcal immunizations were offered and documented in the medical record for 3 of 6 residents (R130, R30, R171). Findings include: R130 was admitted to the facility on 2/22/15, during the influenza season (October 1 through March 31). Upon review of the clinical record, the facility Immunization: Consent or Refusal form identified R130 had refused the pneumococcal vaccine, but there was a handwritten question mark, "??" noted next to the influenza vaccine. There was no documentation in R130's clinical	F 334		

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F 334	Continued From page 16 record to indicate whether or not R130 had received, been offered, or refused the influenza vaccine. R30 was admitted to the facility on 5/20/15. Upon review of the clinical record, there was no Immunization: Consent or Refusal form found. There was no documentation in R30's clinical record to indicate whether or not R30 had received, been offered, or refused a pneumococcal vaccine. R171 was admitted to the facility on 6/26/15. Upon review of the clinical record, the Immunization: Consent or Refusal form included R171's name, but was blank. There was no documentation in R171's clinical record to indicate whether or not R171 had received, been offered, or refused a pneumococcal vaccine. During an interview on 8/27/15, at 9:32 a.m. assistant director of nursing (ADON) stated the clinical record for R130 lacked evidence of having received, been offered, or refusing the influenza vaccine, and also R30 and R171's clinical records lacked evidence of having received, been offered, or refusing the pneumococcal vaccine. ADON was unable to locate any further information regarding the immunization status of the residents. The facility procedure titled Influenza/Pneumococcal Immunization Guideline, dated 12/1/14, included, "Upon admission to the center the resident and/or responsible party will be given education of the risks and benefits of receiving the Influenza and Pneumococcal immunization vaccine...The resident and/or responsible party will be required to sign the	F 334		

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F 334	Continued From page 17 Immunization Consent or Declination Form..."	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 356	**F 356** 1. The posted nursing schedule has been revised to reflect actual hours worked by shift and discipline to meet the requirements of 483.30(e). 2. The Executive Director or designee is responsible for monitoring compliance. 3. Date of Compliance 10/6/15.	

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F 356	Continued From page 18 facility failed to ensure the posted nursing staff hours included the actual shift hours worked. This had the potential to affect all 50 residents who resided in the facility. Findings include: The facility's Daily Staffing Worksheets from 8/20/15, through 8/26/15, detailed the number of hours worked by each category of nursing staff, for the day shift, evening shift and overnight shift. The posting only listed the shifts as, "days," "P.M.'s," and "NOC." However, the postings lacked actual shift times and/or partial shift times which would identify the actual hours worked. During interview on 8/27/15, at 5:33 p.m. the facility administrator confirmed the shift times were not included on the posting. No further information was provided.	F 356		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide the correct therapeutic diet prescribed by the physician for 1 of 1 resident(R 171) reviewed for therapeutic diets. Findings include:	F 367		

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F 367	Continued From page 19 R171 significant change Minimum Data Set (MDS) dated 8/18/15, indicated R171 was severely cognitively impaired, and required extensive assistance with eating. R171's Physician orders dated 7/29/15, indicated the resident was on a mechanical soft texture diet with thickened liquids; nectar consistency. R171's Care Plan dated 8/25/15, instructed the resident had swallowing difficulty related to Alzheimer's disease and was on a Mechanical soft diet with Nectar thick liquids. R171's Nutrition Assessment, Change of Condition, dated 8/25/15, indicated R171 had swallowing difficulty related to Alzheimer and dysphasia as evidenced by need for mechanically altered diet of mechanical soft with nectar thickened liquids. During observation on 8/26/15, at 12:45 p.m. social worker (SW)-A was assisting R171 to eat in the memory care unit. The resident had a sandwich, and minestrone soup which was a thin brown, regular consistency liquid. During interview on 8/26/15, at 12:46 p.m. RN-C observed R171's current meal and stated the soup was not nectar thick, and should not be served to the resident without thickening the soup first. During observation on 8/26/15, at 12:48 p.m. R171 was observed being assisted to drink a nectar thick cranberry juice, and was coughing after swallowing.	F 367	**F 367** 1. The facility will provide the correct therapeutic diet as prescribed by the attending physician to each resident. 2. All staff will be re-educated on the facilities protocol and communication method of prescribed diets and when menu items must be thickened to meet their therapeutic diet. 3. A weekly random audit will be performed to ensure prescribed diets and menu items are served. 4. The Director of Nursing or designee is responsible for monitoring compliance. 5. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 6. Date of Compliance 10/6/15.	

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F 367	Continued From page 20 During interview on 8/26/15, at 12:50 p.m. SW-A stated she had not given R171 any soup yet, and stated she was aware R171's juice had to be nectar thick, but was not aware the soup needed to be thickened, also. During interview on 8/26/15, at 12:55 p.m. RN-D stated she spoke with the kitchen staff and was told the soup had not been thickened prior to being sent to the memory care unit for R171. RN-D stated R171 required the soup to be thickened or she could aspirate, and RN-D thickened the soup and reheated it and gave it to R171. During interview on 8/26/15, at 2:20 p.m. dietician (D)-A stated the dietary manager prints off a list of resident diets which is kept in a folder next to the steam table during meal service. D-A stated the soup is thickened when serving, except for the memory care unit, which the staff need to thicken before the resident is served. D-A stated training had been provided to nursing staff in the memory care unit on how to thicken liquids and soup. During interview on 8/26/15, at 2:28 p.m. dietary manager (DM)-B stated the diet sheets for all residents are sent to the memory care unit when passing meals. DM-B stated the diet sheet for R171 indicated to staff to thicken the soup, and DM-B stated if R171's soup was not thickened, the resident could aspirate on it. During interview on 8/27/15, at 2:35 p.m. director of nursing (DON) stated all staff are expected to feed residents the diet that is ordered for them, and all staff (including the social worker) were just trained again on feeding residents the correct diet as ordered 2 days ago, 8/25/15.	F 367		

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F 367	Continued From page 21 During interview on 8/27/15, at 2:50 p.m. the Speech Therapist (ST) stated R171 was coughing a lot during meals because he ate so fast and was unable to follow commands consistently while on speech therapy. ST stated she assessed R171 in July 2015, and downgraded R171's diet from regular to mechanical soft, and also down graded R171's liquids from thin to nectar thick because R171 was coughing and aspirating on thin liquids. ST stated soup should be thickened for R171 or the resident was at risk for, "Developing aspiration pneumonia." No further information was provided.	F 367		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431	Continued From page 22 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review facility failed to ensure expired insulin was not used for 1 of 2 residents (R121) observed receiving insulin. In addition, the facility failed to ensure Aplisol (Mantoux solution-tuberculin skin test [TST] solution) was labeled and dated when opened to prevent expired solution from being used. This had the potential to effect all recent and any new admits to the facility. Findings include: During Medication storage observation of the transitional care unit (TCU) medication cart 4, on 8/25/15, at 10:03 a.m. a Humolog flex pen (a medication used for the control of blood sugars) for R121 was found in the medication cart labeled with the date opened of 7/25/15. During interview on 8/25/15, at 10:12 a.m. Registered nurse (RN)-E stated the insulin pen expired 28 days after opening, which was 4 days	F 431	**F 431** 1. When necessary, medications will be dated when opened according to facility policy and will not be administered past pharmacy guidelines. 2. If a medication is opened and undated it will not be administered. 3. All Licensed Nurses and TMA's will be re-educated on dating necessary medications when opened and checking for expiration dates prior to administering. 4. A weekly audit will be performed to ensure medication is dated when opened and is not administered past pharmacy guidelines. 5. The Director of Nursing or designee is responsible for monitoring compliance. 6. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 7. Date of Compliance 10/6/15.	

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F 431	Continued From page 23 ago. RN-E stated R121 received the medication last on 8/22/15, and the medication was expired at that time and should not have been used. During Medication storage observation of the TCU medication room with RN-A on 8/25/15, at 11:25 a.m., 1 vial of Aplisol was located in the medication room refrigerator which was not labeled with the date it was opened or when it would expire. RN-A stated she thought she had just opened it yesterday, and verified it should have been dated when opened, and then disposed of the Aplisol. During Medication storage observation of the Memory Care medication room on 8/26/15, at 11:36: a.m. with RN-C, the medication refrigerator contained an opened, undated vial of Aplisol which was about half full. RN-C stated she did not know when the vial was opened, and stated, I must assume it is expired." RN-C stated Aplisol is only good for 28 days after opening. No further information was provided.	F 431		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review facility failed to ensure resident toilets and floors in the bathrooms were in good repair for 2 of 9 residents (R103 and R45) reviewed for	F 456		

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GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

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F 456	Continued From page 24 environmental concerns. Findings include: R103's significant change Minimum Data set (MDS) dated 6/23/15, indicated the resident was alert and oriented and required extensive assistance with using the bathroom. During the environmental tour of facility on 8/27/15, at 9:00 a.m. with the Administrator, the toilet tank cover in R103's bathroom had a large chip on the right lower edge. The administrator verified area was rough and stated maintenance should replace the toilet tank cover. R45's admission MDS dated 5/28/15, indicated the resident was alert and oriented and required supervision when walking in his room. R45's floor was missing tiles at the transition between the bathroom and the resident room. During the environmental tour of facility on 8/27/15, at 9:00 a.m. the administrator verified the tiles were missing and stated the facility will replace the tiles immediately. During interview on 8/27/15, at 9:15 a.m. administrator stated staff should be reporting all repair issues to maintence either through the facility system of care tracker, or reporting directly to maintance personal. The facility did not have any repair requests for R103 or R45's room repairs.	F 456	**F 456** 1. The facility will ensure toilets and bathrooms floors are in good repair. 2. All staff will be re-educated on the use of building engines to report any/all repairs they observe or are informed about. 3. Maintenance employees will continue to prioritize all resident room /care related repairs. 4. A weekly audit will be performed on a random sampling of resident rooms to ensure items needing repair are reported and addressed/repaired timely. 5. The Executive Director is responsible for monitoring compliance. 6. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 7. Date of Compliance 10/6/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

(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	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 19, 2013. At the time of this survey, Golden Livingcenter Hillcrest of Wayzata was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

APPROVED
By Gary Schroeder at 9:03 am, Oct 24, 2015

RECEIVED
SEP 28 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

Allison Muskovin — Sr. Executive Director — 9/23/15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

(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	Continued From page 1	K 000		

By E-Mail to:
Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Golden Livingcenter Hillcrest Wayzata is a 2-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1958, is 1-story, without a basement and was determined to be Type II (222) construction. In 1960 a two-story addition was constructed to the southwest of the original building down the hill and determined to be of Type II (111) construction. Another addition was constructed in 1973 to the east of the 1960 addition and determined to be Type II (222). In 1992 an in-fill addition was constructed to the east of the existing building, connecting an 2-story assisted living center which is a conforming construction and was determined to be of Type II (111) construction. The building is divided into 8 smoke zones by 1/2 hour fire barriers.

The building is fully fire sprinkler protected. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	15409 WAYZATA BOULEVARD WAYZATA, MN 55391

(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	Continued From page 2 department notification. The facility has a capacity of 84 beds and had a census of 50 at the time of the survey. Because the original building and the additions are of the conforming construction types the facility was surveyed as 1 building Type II (111). The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**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 of 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.**	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect the residents. Findings include: During the facility tour between 9 30 AM and 11.00 AM on 08/26/2015, observation revealed that the ventilation system for the 1958 building appears to be utilizing the egress corridor as the supply air plenum for the resident rooms. There is no ducted return system with the only return appearing to be through the resident room bathroom fans. The HVAC system shuts down	K 067	**K 067** Annual waiver requested. (See CMS-2786R Form)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING 01 - **MAIN BUILDING 01** B. WING _____	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREST OF WAYZATA	**15409 WAYZATA BOULEVARD** **WAYZATA, MN 55391**

(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 067	Continued From page 3 on fire alarm but the resident room bathroom fans continuously exhaust. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

Name of Facility	2000 CODE
Golden Living Center - Hillcrest of Wayzata	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum	A. An annual/continuing waiver is being requested for K-067. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: 1. The most recent cost estimate for a complying HVAC is ~~$350,000~~. $325.000.00 as of 10/23/15 2. A complying HVAC system will force disruptions to the facility residents due to room relation, generated project noise and use of common areas while the work is completed. 3. The building is currently 55 - 47 years old and is being assess for replacement. B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because: 1. The facility is Type II (222) and Type II (111) construction divided into 8 smoke zones by 1/2 hour fire barriers. 2. The building is fully fire sprinkler protected and the following life safety features are installed: Fire alarm monitoring system with addressable smoke detectors, Fire Dept. notification and Fire Extinguishers. 3. In accordance with LSC 18.7.2.2/19.7.2.2, the facility has a compliant fire safety plan. 4. The facility addresses the following operational plans: Housekeeping, Smoking, and Fire Watch. 5. There is a total of 8 smoke zones in the facility. 6. No residents reside on the lower level of the SNF. 7. The closest fire department is 2 miles away and has an average response time of less than 6 minutes.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Interim Fire Safety Supervisor	Office State Fire Marshal Division	Date 10/24/2015

Outland
BUILDERS

PROJECT: **GOLDEN LIVING WAYZATA**

DATE: **10/23/15**

RE: **HVAC AT NORTH CORRIDORS – 1ST AND 2ND FLOORS**

TO: **ALLISON MURKOWSKI – GOLDEN LIVING**

CC: **ADAM LARSON – GOLDEN LIVING**

FR: **WAYDE JOHNSON – OUTLAND BUILDERS, INC.**

As requested, Outland Builders, Inc. has prepared a budget to perform the work outlined in a design narrative and related sketch dated 10/14/15 provided by Steen Engineering. The narrative outlines the mechanical and electrical work, and we have made assumptions related to the general construction requirements. Should this work proceed, we would highly recommend a complete design be completed and the price revisited.

Our proposal includes the following:

General Conditions: We include building permit, plan review fees, state surcharge, design allowance of $10,000, liability insurance, project supervision, storage pod, dumpsters, and clean up.

Demolition: Outland Builders, Inc. will remove all plaster ceilings in the entire north 2nd floor corridor. It is assumed that this work will be done in phases, and we include protection poly on the walls and floor. We include daily cleanup. All lighting and speaker systems will be removed as required to necessitate demolition.

Ceilings: We include a $9,000 allowance to install new ceilings on the 2nd floor. No selections have been made, but we assume that the new ceiling would be lay-in grid to provide future access.

Paint: We include touch up painting in corridors.

Fire Protection: We have included an allowance of $10,000 to add and relocate piping and sprinkler heads to accommodate changes such as new ductwork, new lighting, new heads, etc....

HVAC: Our work includes the narrative, and is clarified as follows:

1. Remove existing condensing unit an associated piping
2. Remove existing make-up-air unit and associated ductwork
3. Provide and install new 20-ton condensing unit
4. Provide and install a new 5,000 CFM indirect MUA unit with coil and VFD

Outland
BUILDERS

5. Provide and install refrigeration piping
6. Provide and install gas piping for MUA unit
7. Provide and install venting for MUA unit
8. Provide and install new fresh air intake
9. Provide and install duct distribution for the lower level and main level
10. Provide and install ductwork to each residence room, corridor, and common rooms
11. Provide and install fire/smoke dampers when duct leaves a shaft and when duct penetrates a rated corridor (residence rooms should not need a damper)
12. Core drilling, test and balance, startup, engineering, sales tax, and permit

Electrical: Includes the following:

1. Disconnect for existing indoor and outdoor HVAC units for demolition
2. Demo 2nd floor hallway devices and lights and tie up for install of heating duct and ceiling
3. Furnish and install 20 fluorescent indirect 2 x 4 lights in new ceiling area
4. Furnish and install one combination exit light at short wing hall
5. Install five existing exit lights in former positions
6. Rewire for 26 nurse call lights in the new ceiling
7. Wire new MUA unit in existing location
8. Wire new summer/winter control and VFD
9. Wire to existing upper floor thermostat
10. Wire new temporary lower floor thermostat
11. Wire new outdoor condenser unit up to 200 amp feed and low voltage connection

Budget based on preliminary narrative: $325,000

If accepted, we anticipate payment to be made within 30 days of submittal of invoices, and we reserve the right to review this price if not accepted within 30 days.

Once again, thank you for the opportunity, and please call me on my cell phone at 612.220.0153 with any questions.

Sincerely,
Outland Builders, Inc.

Wayde Johnson
Reviewed and Accepted By:

4029 W 125th Street · Savage, MN 55378 · Phone (952) 224-9119 · Fax (888) 310-4912

OWNER'S PROJECT REQUIREMENTS
BASIS OF DESIGN & SYSTEMS NARRATIVE

GOLDEN LIVING CENTER - HILLCREST OF WAYZATA
WAYZATA, MN

GENERAL

- This facility consists of an existing nursing home and assisted living campus that was constructed in several phases spanning from the late 1950's to the early 1990's. The majority of the building is slab-on-grade 2-stories with the remainder of the building being single-story. The building is fully fire sprinkler protected.
- During multiple previous state and federal code inspections, it has been documented that the HVAC ventilation system serving a portion of the nursing home building does not comply with the Life Safety Code and NFPA 90A, which stipulate that egress corridors in health care facilities shall not be used as part of a supply, return, or exhaust air system serving adjoining areas.
- The purpose of this narrative is to outline the mechanical requirements necessary to bring the existing facility's HVAC systems into code compliance.
- Mechanical, Electrical and Plumbing Contractors shall coordinate with the construction team to seal all roof and wall penetrations and to maintain the integrity of all assemblies and vapor barriers.
- All work and materials shall meet the requirements of National, State and Local Codes and Ordinances, in every respect. This requirement shall not relieve the Contractor from meeting the requirements of Drawings and Specifications that may be in excess of all codes and ordinances and not contrary to them.
- Design shall comply with the latest edition of the Minnesota Energy Code, ASHRAE 90.1 or IECC. Verify with Architect.

MECHANICAL

Design Criteria

Building Envelope

- The project shall be designed to 91°F DB/73°F WB for summer temperatures and -20°F for winter temperatures.
- All occupied spaces shall be designed to 75°F cooling and 72°F for heating.
- All unoccupied spaces shall be maintained above 55°F for heating and below 85°F for cooling.
- All spaces shall meet the ventilation code requirements, including those outlined in MN Department of Health Nursing Home Rules, Chapter 4658.
- Duct Sizing:

Pressure drop	
Low Pressure Systems	0.08" per 100 equiv. Feet
Transfer Ducts	0.05" per 100 equiv. Feet
Velocity Criteria	
Low Pressure Systems	1200 FPM
Ducted Returns	1000 FPM
Transfer Ducts	500 FPM

Sound Control

Suggested ASHRAE Noise Criteria (NC) Levels:

Corridor, Lobby and Dining Room spaces	NC 35-45
Common Resident and Staff Areas	NC 35-40
Private residences	NC 30-35

Demolition

- Disconnect and remove existing indoor indirect fired make up air unit located in lower level and associated split DX condensing unit on grade, as well as all ductwork, gas piping and control wiring. Cap gas piping back at mains. Prepare indoor space for new makeup air unit. Prepare outdoor slab for new condensing unit.

HVAC

- Provide a new 5000 CFM indirect fired make up air unit (Weather-Rite, Reznor, Greenheck, Sterling, Rupp, Modine, AbsolutAire) completely factory assembled, piped wired and test fired.
  - Unit is sized to serve both levels of the building in the area impacted by remodeling. Unit shall initially be balanced and operate at approximately 2500 CFM to serve upper level only; if/when the lower level is finished and occupied, the unit shall be capable of providing up to 5000 CFM total serving both lower and upper floors.
  - Unit shall be suitable for indoor application and for operation on natural gas. Coordinate with equipment vendor for sections capable of being brought into the building via an existing 4 ft door. Field verify route prior to ordering equipment.
  - Unit shall contain furnace section(s) with each section not to exceed 400 MBH input. Burners shall capable of modulating with minimum 10 to 1 turndown.
  - Burners, heat exchanger and flue collector shall be constructed of type 409 stainless steel.
  - Provide ducted combustion air and flue piping from the unit to the exterior of the building. Re-use existing wall openings from old combustion air and flue piping.
  - Provided insulated ducted connection from existing intake louver and plenum to new make up air unit.
  - Provide with DX cooling coil section.
  - Supply fan shall be belt-driven centrifugal fan with adjustable pitch motor sheaves and shall be dynamically balanced for quiet operation. Fan shall be driven by a continuous duty, open drip-proof electric motor.
  - Provide with VFD for supply fan.
  - Provide single point power with non-fused disconnect.
- Provide a new 20 ton split DX condensing unit (Carrier, Trane, York, Daikin) to supply air conditioning for the make up air system.
  - The unit shall be UL listed, high-efficiency compressors, pre-charged line sets, crankcase heaters, and minimum 5 year compressor warranty.
  - The unit shall have minimum 2 stages of cooling and the first stage shall be equipped with hot gas by-pass.
  - Provide hot gas reheat coil for dehumidification control.
  - Provide low-temp lockout to prevent operation below 40°F (adj).
  - Provide hail guard panel(s) to protect condenser coils.
- Provide new ducted make up air distribution system, including all required ductwork, registers, grilles, diffusers, and life safety dampers, to serve each individual patient room, as well as all public/common areas requiring ventilation at the upper floor in the area of

remodel. Provided capped and sealed duct opening(s) to serve the lower level in the future. The outside air ductwork shall be insulated with 2" thickness external foil faced rigid board fiberglass insulation or thermal resistance of R-8, whichever is greater, for a minimum distance of 10 ft from the unit discharge. Coordinate with architect and general contractor for new shafts, soffits and lowered ceilings as required to accommodate new ductwork.

- Existing central exhaust fan systems serving patient rooms and public/common areas shall remain and run continuously. Service and repair fans as required.
- Both existing exhaust systems and new make up air system in area of remodel shall be tested and balanced to provide continuous ventilation per code.

Plumbing

- Existing natural gas service will be maintained. Extend gas piping from closest existing main to new make up air unit.

Fire Sprinkler System

- A fire sprinkler contractor shall be hired to modify the existing fire sprinkler system as required to accommodate mechanical improvements and new ductwork. Wherever possible, avoid disruptions to the existing fire sprinkler system. Relocate existing sprinkler heads and extend piping from existing mains as required. Coordinate with architect.
- The contractor for the fire sprinkler design and installation must be a qualified Fire Sprinkler Contractor regularly engage in this type of work. Contractor must be certified with the National Institute of Certified Engineering Technicians. (NICET level IV).
- Fire sprinkler system to be installed as per latest NFPA and local codes.

Automatic Temperature Control

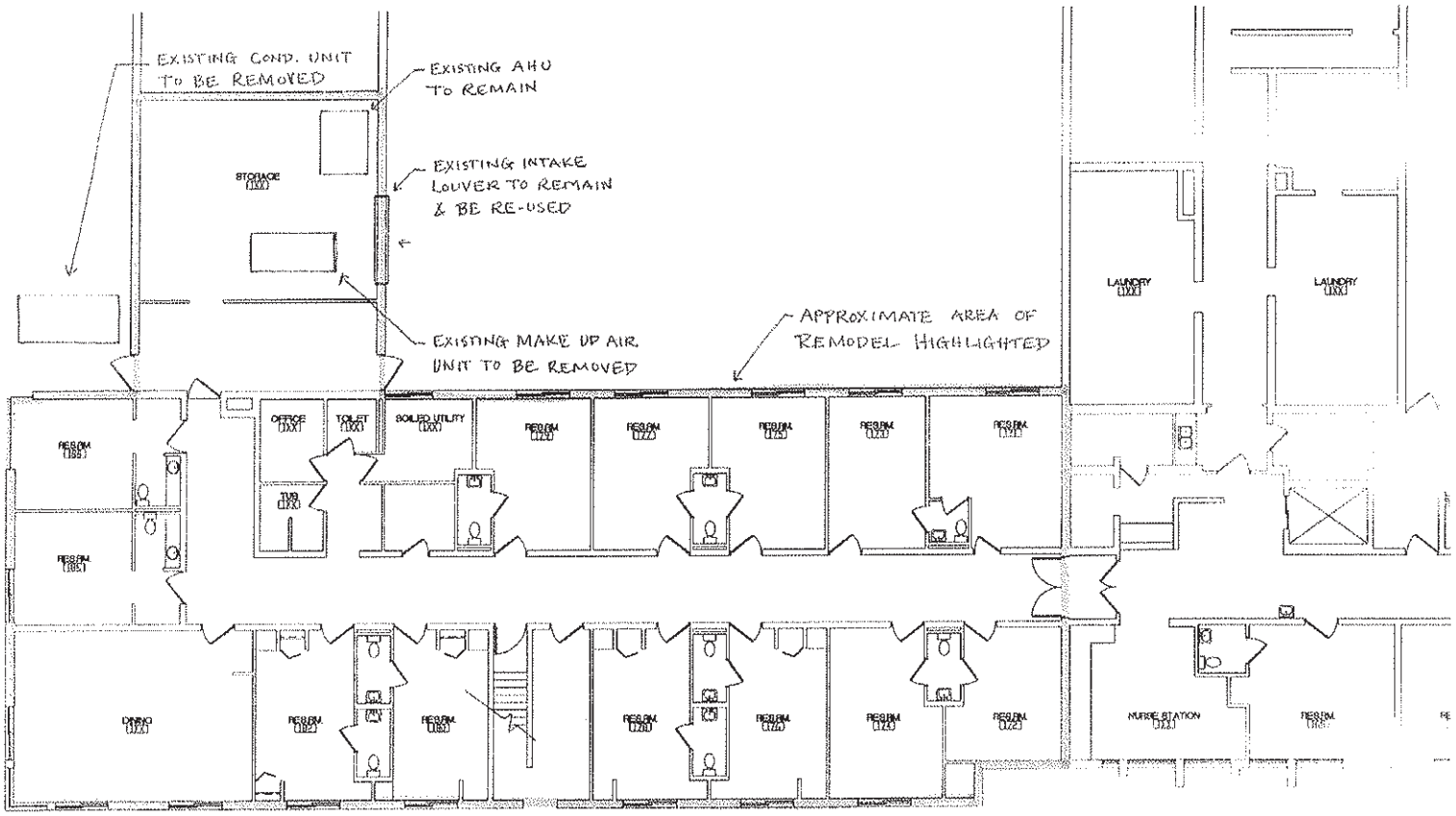
- The new make up air unit shall be provided with a remote control panel user interface complete with operating lights to indicate blower on and burner on, discharge air temperature adjustment including modulating cooling, modulating heating, and dehumidification controls, as well as summer-off-winter selector switch. During normal operation, the make up air unit supply fan shall run continuously. Provide interlock with existing exhaust fans at the same portion of the building served by the new make up air unit.

ELECTRICAL

Power

- Field verify existing electrical power distribution system (voltage, phase, etc.) in the area impacted by remodeling. Make connections to mechanical equipment described in the mechanical portion of this narrative. Re-use existing electrical panels and extend wiring to new equipment wherever possible. Provide new equipment disconnects as required.

HILLCREST OF WAYZATA
LOWER LEVEL PLAN
(PARTIAL)



HILLCREST OF WAYZATA
UPPER LEVEL PLAN
(PARTIAL)