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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EMO0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245290**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OLIVIA**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

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)

6. DATE OF SURVEY **07/09/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (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
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Whitlock, HFE NE II — 07/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 07/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(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.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245290

July 16, 2014

Ms. Tracy Hendrickx, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, Minnesota 56277

Dear Ms. Hendrickx:

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 June 17, 2014 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds.

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 Brenda Fischer, Unit Supervisor at (320)223-7338 if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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

July 16, 2014

Ms. Tracy Hendrickx, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, Minnesota 56277

RE: Project Number S5290023

Dear Ms. Hendrickx:

On May 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 8, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 7, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 8, 2014, effective June 17, 2014 and therefore remedies outlined in our letter to you dated May 21, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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
245290	A. Building B. Wing	7/9/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/03/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/03/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/03/2014**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **06/03/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/03/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	07/16/2014	28588	07/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/8/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245290	A. Building B. Wing 01 - MAIN BUILDING 01	7/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/17/2014	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 06/17/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 07/16/2014	Signature of Surveyor: 22373	Date: 07/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/6/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EMO0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245290**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OLIVIA**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

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)

6. DATE OF SURVEY **05/08/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(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 :
Carol Bode, Hfe NE II — 06/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(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.
00040
(L31)

30. REMARKS
Posted 06/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed 05/08/14, the facility was not in substantial compliance and the most serious deficiencies were found 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 as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0341

May 21, 2014

Ms. Amanda Gentilli, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, Minnesota 56277

RE: Project Number S5290023

Dear Ms. Gentilli:

On May 8, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
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 June 17, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 17, 2014 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 August 8, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ MN Dept of Health St.Cloud B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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

6/18/14

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

see addendum for signature and date

TITLE

(X6) DATE

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

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	245290	A. BUILDING _____ B. WING _____	05/08/2014

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F 225	Continued From page 1	F 225		

violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure a report of abuse/ mistreatment was reported to the state agency immediately for 1 of 4 (R63) resident allegations that were reviewed.

Findings include:

R63 stated during an interview on 5/5/14, at 7:02 p.m. a nursing assistant had been rough with her during personal cares. A nursing assistant (NA) was turning her in bed and "grabbed my side and twisted me". R63 stated, "it really hurt" and told a staff member but was unsure of whom she reported the incident to. She requested this particular nursing assistant not work with her again. R63 stated she was not able to remember the nursing assistant's name who was rough but knew what she looked like. She was unsure of what happened as a result of her reporting the incident. She was upset when talking about and incident and the treatment she received.

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Review of the diagnostic record of 2/14 indicated R63 was admitted to the facility on 2/14 with had diagnoses that included acute cerebrovascular disease (stroke), spasm of muscle, atrial fibrillation, depressive disorder, cardiac pacemaker, and unspecified renal dysfunction.

An admission Minimum Data Set (MDS) completed on 3/4/14 indicated R63 was cognitively intact and had no communication barriers. She needed extensive assistance of two staff with all other activities of daily living (ADLs), including bed mobility. She had functional loss of one side of her body and used a wheelchair for mobility throughout the facility.

A second interview was completed with R63 on 5/7/14, at 12:22 p.m. She verified the discussion of 5/5/14 at 7:02 p.m. and again reported she did not know the name of the nursing assistant that was "rough." She was unsure of what staff member she told about the incident but thought she had discussed the incident with the nursing coordinator. She reported the incident had occurred shortly after she moved into her current room.

An interview on 5/7/14, at 12:31 p.m. the care coordinator who was a registered nurse (RN)-B verified R63 had told her about a nursing assistant being rough with her. RN-B stated she told the director of nursing (DON) about the allegation but was unable to specify when the incident occurred as she had not completed any paperwork about the allegation.

The assistant director of nursing (ADON) stated on 5/7/14 at 1:15 p.m. she had been instructed by the facility DON to investigate the incident and

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F 225	Continued From page 3 completed an initial investigation on 3/20/14. She stated she made no conclusion as to the result of the preliminary investigation. The purpose of her investigation was to gather the facts surrounding the incident and give the report to the DON, who would make a determination to report or not to report the allegation. The investigative report of 3/20/14 indicated R63 reported NA-D was "ruff with me with turning and repositioning," but there was no injury to the resident. R63 reported during an interview on 3/20/14 at 3:54 p.m. she was in her bed and needed to be turned toward the door and her left arm fell down. She told NA-D about this, who used both her hand to "throw the left arm back up to side". R63 reported this hurt the whole left arm. She reported that NA-D attempted to roll her onto her left side by grabbing her left shoulder; at which point NA-E pointed out that R63 had a pacemaker. R63 reported the NA-D "grabbed Rt [right] hip and pulled really hard," NA-D told R63 "you will be ok". R63 informed the ADON that she had pain from her right side into her abdomen, which increased with any position changes. NA-E (who was present during the repositioning) was interviewed on 3/20/14, at 4:23 p.m. by the ADON. She reported she had told NA-D to be careful with R63's left arm as she had a pacemaker. She reported she had picked up the arm and was supporting it. She reported NA-D was pushing from the back side and " I stated ' not so hard' and when R63 was asked if she was hurt, NA-D responded " I don't think she got hurt". NA-E reported R63 did not say anything "but could see a reaction on her face". NA-E reported R63 did not complaint of pain after the	F 225		

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F 225	Continued From page 4 turning and repositioning. NA-E reported [NA-D] seemed aggressive and told NA-D "Don't pull so hard and try to be slow and not push". NA-E was asked why NA-D was "pushing on resident when supposed to be using left sheet?". NA-E responded "That's what I was trying to tell her to do". The ADON interviewed NA-D on 3/20/14 at 5:00 p.m. NA-D reported that she and NA-E were going to turn R63 using an allgra sheet but R63's arm did not go, "but did stop and support arm." She reported they did not have enough allgra sheet and had to turn her back again. She reported when they turned her a second time and "we assured we supported the left arm" and NA-E ensured they "took it easy on that side (left) since she had a pacemaker". NA-D reported "The only time I touched her was when I lifted her leg to put pillow under her. I used the allgra to roll her side to side and did not grab her thigh or shoulder". NA-D stated " I would do everything the same again because I know I did everything right". The investigative report identified possible/contributing factors as staff not knowing their strength level with turning and positioning, having to turn the resident twice due to "allgra" may have increased pain and the resident had "stroke on LT. [left] side which can be difficult to turn and position." The investigative report recommended, "Follow up with each staff member involved using a Maxislide, turning and repositioning, strengths, use of allgra " and "Care Huddles with all staff on maxislide, turning and repositioning, strength and use of "allgra." During the interview the ADON on 5/7/14 at 1:15	F 225		

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F 225	Continued From page 5 p.m., stated she completed the initial portion of the investigation and gave the incomplete report to the DON; who determines if the abuse/neglect allegation was substantiated or not, and if there were any action steps. She stated she did not follow up with the DON regarding further action. An interview with the Administrator was completed on 5/7/14 at 2:44 p.m. She reported she was immediately contacted by the DON and informed of the R63's allegation on 3/20/14 via phone. She instructed the DON to "address the issue" and acknowledged she did not instruct the DON to notify the regulatory agency regarding the allegation and should have. As a result of the investigation, the DON determined staff education was appropriate and as a result, Care Huddles were implemented. This is when nursing assistant gather and determine the best course of care for a particular resident. The facility's policy Vulnerable Adult Maltreatment Plan, approved 3/27/14, directed staff, who had reason to believe a resident had been maltreated were to immediately report the information internally to the Executive Director (aka Administrator). The Executive Director (or the DON if the Executive Director was not available) was to determine if the internal report must be reported to the state and reportable incident must be reported immediately. Reportable incidents, according to the policy, included Abuse (infliction of injury that results in physical harm, pain or mental anguish. This also included mistreatment). The policy directed the Executive Director (or the DON if Executive Director was not available) to make an on-line report to the state agency and an oral report to the Common Entry Point.	F 225		

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F 225	Continued From page 6 The facility failed to follow their policy related to reporting of reported maltreatment for R63.	F 225	F 226: Facility's Vulnerable Adult policy and processes reviewed and updated to align. All staff were re-educated on the Vulnerable Adult policy. ED/designee will report all incidents of potential mistreatment/abuse to officials in accordance with State law and facility policy prior to completing an internal investigation. All investigations will be completed by ED/DNS or Designee and documented on internal Verification of Investigation form. ED will audit all Verification of Investigation forms for completeness 1 time per week for 90 days. Audit results and findings to be reviewed at QAPI meetings.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility implemented their abuse prevention policy to immediately notify the stage agency of alleged abuse for 1 of of 4 (R63) residents allegations reviewed. Findings include: The facility's policy Vulnerable Adult Maltreatment Plan, approved 3/27/14, directed staff, who had reason to believe a resident had been maltreated were to immediately report the information internally to the Executive Director (aka Administrator). The Executive Director (or the DON if the Executive Director was not available) was to determine if the internal report must be reported to the state and reportable incident must be reported immediately. Reportable incidents, according to the policy, included Abuse (infliction of injury that results in physical harm, pain or mental anguish. This also included mistreatment). The policy directed the Executive Director (or the DON if Executive Director was not available) to make an on-line report to the state agency and an	F 226		

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F 226	Continued From page 7 oral report to the Common Entry Point. R63 stated during an interview on 5/5/14, at 7:02 p.m. a nursing assistant had been rough with her during personal cares. A nursing assistant (NA) was turning her in bed and "grabbed my side and twisted me". R63 stated, "it really hurt" and told a staff member but was unsure of whom she reported the incident to. She requested this particular nursing assistant not work with her again. R63 stated she was not able to remember the nursing assistant's name who was rough but knew what she looked like. She was unsure of what happened as a result of her reporting the incident. She was upset when talking about and incident and the treatment she received. R63 was admitted to the facility on 2/14 and according to the diagnostic record had diagnosis that included acute cerebrovascular disease (stroke), spasm of muscle, atrial fibrillation, depressive disorder, cardiac pacemaker, and unspecified renal dysfunction. An admission Minimum Data Set (MDS) completed on 3/4/14 indicated R63 was cognitively intact and had no communication barriers. She needed extensive assistance of two staff with all other activities of daily living (ADLs), including bed mobility. She had functional loss of one side of her body and used a wheelchair for mobility throughout the facility. A second interview was completed with R63 on 5/7/14, at 12:22 p.m. She verified the discussion of 5/5/14 at 7:02 p.m. and again reported she did not know the name of the nursing assistant that was "rough." She was unsure of what staff member she told about the incident but thought	F 226		

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F 226	Continued From page 8	F 226		

she had discussed the incident with the nursing coordinator. She reported the incident had occurred shortly after she moved into her current room.

An interview on 5/7/14, at 12:31 p.m. the care coordinator who was a registered nurse (RN)-B verified R63 had told her about a nursing assistant being rough with her. RN-B stated she told the director of nursing (DON) about the allegation but was unable to specify when the incident occurred as she had not completed any paperwork about the allegation.

The assistant director of nursing (ADON) stated on 5/7/14 at 1:15 p.m. she had been instructed by the facility DON to investigate the incident and completed an initial investigation on 3/20/14. She stated she made no conclusion as to the result of the preliminary investigation. The purpose of her investigation was to gather the facts surrounding the incident and give the report to the DON, who would make a determination to report or not to report the allegation.

The investigative report of 3/20/14 indicated R63 reported NA-D was "ruff with me with turning and repositioning," but there was no injury to the resident. R63 reported during an interview on 3/20/14 at 3:54 p.m. she was in her bed and needed to be turned toward the door and her left arm fell down. She told NA-D about this, who used both her hand to "throw the left arm back up to side". R63 reported this hurt the whole left arm. She reported that NA-D attempted to roll her onto her left side by grabbing her left shoulder; at which point NA-E pointed out that R63 had a pacemaker. R63 reported the NA-D "grabbed Rt [right] hip and pulled really hard."

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F 226	Continued From page 9	F 226		

NA-D told R63 "you will be ok". R63 informed the ADON that she had pain from her right side into her abdomen, which increased with any position changes.

NA-E (who was present during the repositioning) was interviewed on 3/20/14, at 4:23 p.m. by the ADON. She reported she had told NA-D to be careful with R63's left arm as she had a pacemaker. She reported she had picked up the arm and was supporting it. She reported NA-D was pushing from the back side and " I stated ' not so hard' and when R63 was asked if she was hurt, NA-D responded " I don't think she got hurt". NA-E reported R63 did not say anything "but could see a reaction on her face". NA-E reported R63 did not complaint of pain after the turning and repositioning. NA-E reported [NA-D] seemed aggressive and told NA-D "Don't pull so hard and try to be slow and not push". NA-E was asked why NA-D was "pushing on resident when supposed to be using left sheet?". NA-E responded "That's what I was trying to tell her to do".

The ADON interviewed NA-D on 3/20/14 at 5:00 p.m. NA-D reported that she and NA-E were going to turn R63 using an allgra sheet but R63's arm did not go, "but did stop and support arm." She reported they did not have enough allgra sheet and had to turn her back again. She reported when they turned her a second time and "we assured we supported the left arm" and NA-E ensured they "took it easy on that side (left) since she had a pacemaker". NA-D reported "The only time I touched her was when I lifted her leg to put pillow under her. I used the allgra to roll her side to side and did not grab her thigh or shoulder". NA-D stated " I would do everything

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F 226	Continued From page 10 the same again because I know I did everything right". The investigative report identified possible/contributing factors as staff not knowing their strength level with turning and positioning, having to turn the resident twice due to "allgra" may have increased pain and the resident had "stroke on LT. [left] side which can be difficult to turn and position." The investigative report recommended, "Follow up with each staff member involved using a Maxislide, turning and repositioning, strengths, use of allgra " and "Care Huddles with all staff on maxislide, turning and repositioning, strength and use of "allgra." During the interview the ADON on 5/7/14 at 1:15 p.m., stated she completed the initial portion of the investigation and gave the incomplete report to the DON; who determines if the abuse/neglect allegation was substantiated or not, and if there were any action steps. She stated she did not follow up with the DON regarding further action. An interview with the Administrator was completed on 5/7/14 at 2:44 p.m. She reported she was immediately contacted by the DON and informed of the R63's allegation on 3/20/14 via phone. She instructed the DON to "address the issue" and acknowledged she did not instruct the DON to notify the regulatory agency regarding the allegation and should have. As a result of the investigation, the DON determined staff education was appropriate and as a result, Care Huddles were implemented. This is when nursing assistant gather and determine the best course of care for a particular resident.	F 226		

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F 226	Continued From page 11 The facility failed to follow their policy related to reporting of reported maltreatment for R63.	F 226		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide appropriate interventions to prevent a change in urinary incontinence for 1 of 2 residents (R42) reviewed who had a change in continence. Findings include: R42's quarterly Minimum Data Set (MDS) dated 1/15/14, indicated she was occasionally incontinent of urine. R42's annual MDS dated 4/16/14, indicated she was moderately cognitively impaired, needed supervision set up with toileting, had no toileting plan and was frequently incontinent of urine. R42's care area assessment undated, indicated she was frequently incontinent of bladder. R42's current care plan dated 4/23/14, indicated	F 315	F 315: All appropriate staff re-educated on facility Bowel and Bladder Policy, resident toileting plans and the necessity to have a plan in place for all residents. Director of Nursing Services reviewed with and re-educated appropriate staff on the initial bowel and bladder assessment process. Director of Nursing Services or designee will audit Bowel and Bladder Assessments 1 time per week for 90 days. Audit results and findings to be reviewed at QAPI meetings.	

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F 315	Continued From page 12 she had functional occasional incontinence of urine. Staff are to use briefs/pads for incontinence protection, monitor and report any changes in ability to toilet or continence status. R42's Bladder Assessment Form dated 4/16/14, indicated she was incontinent of bladder and has functional urinary incontinence due to mobility impairments, medications and poor cognition. The form also indicated R42 was not appropriate for toileting or retraining program. The form did not provide a rational as to why R42 was not appropriate for toileting or retraining. R42's three day Bowel and Bladder Record Data Collection tool indicated the following: On 4/14/14 incontinent of urine at 6:00 a.m. On 4/15/14 incontinent of urine at 7:00 a.m. On 4/16/14 incontinent of urine at 7:00 a.m. There was no assessment completed to determine if R42 had a pattern of incontinence throughout the day. There were no other time frames assessed to determine if R42 had a specific voiding pattern, besides being incontinent at 6:00 and 7:00 a.m. During observation 05/05/14, at 6:26 p.m. R42 was observed to be sitting in her chair in her room with a urine odor. During interview 5/07/14, at 12:00 p.m. registered nurse (RN)-A stated R42 frequently hides soiled garments in her drawers and usually takes herself to the toilet. RN-A further stated R42 was frequently incontinent in the morning when they get her up, and confirmed R42 was not on a toileting plan. During interview 5/07/14, at 12:23 p.m. nursing	F 315		

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	245290	A. BUILDING _____ B. WING _____	05/08/2014

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GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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F 315	Continued From page 13 assistant (NA)-A stated R42 is frequently incontinent of urine in the morning and has incontinent episodes while she is sleeping. NA-A stated R42 did not have a toileting plan, and if staff reminded her to toilet early each morning she probably would not be wet at 6:00 and 7:00 a.m. During interview 5/08/14, at 8:35 a.m. the interim director of nursing (DON) verified R42's had urinary incontinence between 6:00 a.m and 7:00 a.m. and staff should attempt to have her toilet before 6:00 a.m. so she could remain continent of urine. Although R42 went from occasionally incontinent to frequently incontinent of urine the facility did not complete a comprehensive assessment of R42's bladder function, to determine what interventions should be implemented during specific time frames to prevent R42 from being incontinent of urine.	F 315		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a	F 411	F 411: Upon admission and quarterly, residents will be assessed for dental service needs. Requests and refusals of dental services will be documented.	

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F 411	Continued From page 14 dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents who refused to wear their dentures, received adequate dental service for 1 of 2 residents (R15) who had dental plates in the sample. Findings included: During observation on 5/5/14, at 7:52 p.m., R15 was observed to be sitting in her bedroom on a recliner chair and was missing four teeth on her lower jaw. A dental partial was found laying on R15's bathroom countertop, soaking in a dental cup. R15's quarterly Minimum Data Set (MDS), completed on 3/5/14, indicated R15 was severely cognitively impaired, was sometimes able to make herself understood and understand others. The MDS indicated R15 was totally dependent of facility staff with her oral cares. A progress note written on 3/18/2014 at 11:36 a.m. as part of the MDS assessment indicated R15 had diagnosis that included dementia, depression, adult failure to thrive, and nutritional deficiency. The progress note also identified R15 wore full upper and partial lower dentures, which she often refused to wear (lower partial denture). Her mucous membranes were moist and gum margins were intact. The referral information sheet identified R15 was seen by a dentist on 10/13/11 related to the	F 411		

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F 411	Continued From page 15 resident complaining of sore gums and refused to wear her dentures. A a small white spot was noted on her gums and the resident was not eating well due to pain with her gums. The dentist reported he had added material to the resident's lower left partial and if the discomfort did not improve; the facility was to contact the dentist. The dental notes identified R15 was again seen by the dentist on 12/5/11 due to a sore on the resident left lower gum. The dentist recommended if the sore area did not improve in two weeks, she was to return to the dental clinic for further evaluation. No further documentation was found in the clinical record regarding the resident receiving any additional dental services since 12/5/11. The plan of care, initially implemented on 6/27/11, directed staff to provide oral care to the resident's full upper and lower partial denture and to arrange for "dental exams/consults as necessary." During an interview on 5/7/13, at 7:11 a.m. nursing assistant (NA)-C reported R15 refused to wear her partial lower plate most of the time. The staff would put the dental plate into the resident's mouth and R15 would take them out. She indicated she did not know if the dental plate caused R15 pain or if the partial fit properly for R15 mouth. NA-C indicated she told the charge nurse the resident refused to wear the partial dental plate and was unsure anything has been completed about this concern. During an interview on 5/7/13, at 7:24 a.m. the	F 411		

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F 411	Continued From page 16 trained medication assistant (TMA)-A stated she was aware the resident refused to wear her lower denture. She was unsure if they fit correctly and as far as she knew, the resident had not complained of dental pain. TMA-A stated R15 seemed to eat well without her dentures. A second interview with NA-C was completed on 5/7/14, at 8:15 a.m. R15 was sitting in a wheelchair in her bedroom with NA-C and the partial dental plate was not in R15's mouth. The NA-C reported that she had just finished providing the resident with her morning personal cares and placed the lower dental plate in the resident's mouth but the resident immediately removed them. NA-C stated the partial dental plate did not seem to cause the resident pain but she could not tell for sure. During an interview on 5/7/14 at 12:36 p.m. the care coordinator who was a registered nurse (RN)-A reported she was aware that R15 would not wear her lower partial dental plate. She stated she was not aware that there was any problems with the fit of the denture and had observed the resident's denture which "seemed to fit well." RN-A stated at the annual care conference, the staff usually discuss with the family, resident or their representative, the need for dental service. RN-A was unable to find any documentation of this discussion for R15. RN-A reported she assumed the resident's refusal to wear the partial dental plate was related to her dementia. On 5/7/14, at 2:14 p.m. the social worker (SW)-A provided evidence of the discussion at R15's care conferences regarding preventative dental services. R15 had not received services since 2012. SW-A stated there had been a lot of	F 411		

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F 411	Continued From page 17 discussion about the resident's refusal to wear her lower partial plate and felt her refusals were related to her dementia. SW-A did acknowledge R15 dental care was not discussed at the 2014 care conference. A policy Care of Dentures was requested and received on 5/8/14 at 10:00 a.m. The policy, written in 2006, directed staff to report and document any unusual observations of the condition of the mouth, gums or dentures. The policy did not address the need for ongoing dental cares/services.	F 411		
F 431 SS=D	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 controls, and permit only authorized personnel to have access to the keys.	F 431	F431: Appropriate staff re-educated on storage, administration, and disposal of narcotic medications and narcotic patches. Additionally, appropriate staff re-educated on narcotic disposal policy. Director of Nursing Services or designee will audit narcotic count sheets and narcotic patch disposal 2 times per week for 90 days. Audit results and findings to be reviewed at QAPI meetings.	

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F 431	Continued From page 18 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, the facility failed to ensure a policy and system had been implemented to reflect the receipt and disposition of all controlled medications. This affected 1 of 25 residents (R66) who were prescribed narcotic medications. In addition, the facility did not have a policy in place for appropriate disposition of used narcotic transdermal patches for 2 of 2 (R36, R10) resident who currently received a narcotic transdermal patch. Findings include: The content of the medication cart was checked in the presence of trained medication assistant (TMA)-A on 5/7/14 at 10:15 a.m. A plastic bag with two packets of Hydroco/APAP tablets 5-325 (a narcotic medication, combined hydrocodone and acetaminophen used for pain management) was found. Each packet contained two tablets, for a total of four tablets. Inside the plastic bag where the medication was stored was a form entitled Controlled Substance Count Sheet which showed eight tablets of Hydroco/APAP	F 431		

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F 431	Continued From page 19 5-325 had been dispensed on 5/7/14 at 8:13 p.m. by the computerized pharmacy machine. This form showed resident (R66) had received one tablet of the medication at 12 midnight, 4:00 a.m. and 8:00 a.m. on 5/8/14, for a total of three tablets administered. There were only four tablets, left in the baggies and not five tablets as the Controlled Substance Count Sheet identified. At 10:30 a.m. TMA-A verified there should been five tablets of Hydroco/APAP in the plastic bag and there were only four tablets remaining. She reported she had not counted this medication when she came on duty at 6:00 a.m. She stated the facility procedure is for all narcotic medication to be counted in her cart at the beginning and the end of her shift. She reported she questioned the previous nurse "this morning" about not counting the medication at the beginning of her shift and was told that it did not need to be completed. She stated she was not qualified to administer the medication to the resident because it was a narcotic and the facility policy was that all narcotic are only administered by nurses. She verified she signed the End of Shift Narcotic Count sheet this morning at 6:00 a.m. as the oncoming nurse and this signature indicated that all narcotics had been counted and accounted for. She was not aware of the missing tablet of Hydroco/APAP. There was no indication that on ongoing tabulation or count was completed for the Hydroco/APAP 5-325 that was in the plastic bag. During an interview on 5/7/14 at 10:55 a.m. the assistant director of nurses (ADON) stated she was able to account for all R66's medication. A staff nurse had given the medication and forgotten to write it down on the Controlled Substance Count Sheet. The ADON also reported	F 431		

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F 431	Continued From page 20 if narcotic medication were dispensed with the computerized pharmacy machine, the staff do not need to count the narcotics at the beginning and end of their shift, because the machine accounts for this record. An interview with the consultant pharmacist was completed on 5/7/14 at 11:15 a.m. She reported she would expect the facility to have an ongoing count of all narcotic medications. She was not aware the facility was not counting narcotic medications that were dispensed by the computerized pharmacy machine. During the examination of the contents of the medication cart, checked in the presence of trained medication assistant (TMA)-A on 5/7/14 at 10:15 a.m., Butrans 10 mcg (micrograms) transdermal patches (a narcotic medication used to treat moderate to severe pain) were observed in the narcotic locked box. There were six patches present, that were prescribed for R36 and there were 4 patches were present, that were prescribed for R10. TMA-A stated she does not administer these patches to residents as only licensed nurses were authorized to do this task. She reported she did not know how the licensed staff disposed of the used narcotic patches. An interview on 5/7/14 at 10:30 a.m. licensed practical nurse (LPN)-B initially reported that once the narcotic patch is removed for the resident, the nursing staff will put the used patch into a "baggie" and then dispose of it. LPN-B was unable to describe how the narcotic patch was "disposed of." At 10:45 a.m., a second interview was completed with LPN-B and stated she did not know how she was to dispose of the used narcotic transdermal patches because the night	F 431		

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F 431	Continued From page 21 nurses remove all the transdermal patches that resident's receive. She reported she did consult with the ADON, who told her she was to put the used patch into a plastic bag and put it in the garbage. During an interview on 5/7/14 at 10:55 a.m. the assistant director of nurses (ADON) stated the facility did not have a current policy regarding the disposition of narcotic transdermal patches. She currently expected two licensed staff to put the used patch into a plastic bag and put the patch into the facility's garbage. The facility policy Medication Storage in the Facility- Control Substance Storage, dated 5/12, directed staff, at the end of shift change or when keys were transferred to conduct a physical inventory of all controlled substances by two license nurses and document such. The policy also directed staff to report to the director of nursing immediately any discrepancy of controlled substance counts. The director of nursing was to investigate and make every reasonable effort to reconcile all reported discrepancies. The facility failed to follow their policy. There was no indication in the facility policy of how to properly dispose of a used narcotic transdermal patch.	F 431		

Addendum to Plan of Correction for Survey Exited 5.8.2014

F 225: Compliance achieved June 3, 2014.

F 226: Staff education complete and facility compliant by June 3, 2014. Audits will be completed on August 31, 2014.

F 315: Residents are screened for bowel and bladder function upon admission, annually, and when significant changes occur. Residents are assessed quarterly for appropriateness of plan of care. Director of Nursing Services reviewed plan of care for all current residents to ensure accuracy. Staff education complete and facility compliant by June 3, 2014. Audits will be completed August 31, 2014.

F 411: All resident charts audited by Director of Nursing Services/designee to ensure compliance for dental assessment and provision of dental services refusals and requests by June 19, 2014. Director of Nursing Services/designee will conduct audits 1 time per week for 90 days to ensure residents were offered dental services at quarterly care conference. Results will be reviewed at QAPI. Staff education complete and facility compliant by June 3, 2014. Audits will be complete by August 31, 2014.

F 431: Facility policy revised to include procedure for destruction of narcotic transdermal patches. Staff education completed and facility compliant by June 3, 2014. Audits will be completed August 31, 2014.

Executive Director Signature: Tracy Hendrickx Date: 6-18-14

Tracy Hendrickx

6/100 - OK - addendum

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

F5290020

PRINTED: 05/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS 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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 6, 2014. At the time of this survey, Golden LivingCenter Olivia was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, or,	K 000	POC ok FS 6-24-14 RECEIVED JUN 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-17-14
EXIT: 5-8-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	6-24-14

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

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K 000	Continued From page 1 By email 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 Olivia was constructed as follows: The original building was constructed in 1955, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1st addition was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2nd addition was constructed in 1967, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 3rd addition was constructed in 1976, is one-story height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a	K 000		

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K 000	Continued From page 2 capacity of 57 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 57 of 57 residents. FINDINGS INCLUDE: On 05/06/2014 at 10:45 AM, while reviewing fire drill reports for the previous year, it was confirmed that no fire drills were conducted on the Night-Shift during the 3rd Quarter of 2013, nor on the AM-Shift during the 1st Quarter 2014.	K 050	K 050: New template was created to accurately track fire drills. Fire drills will be conducted monthly ensuring that all shifts are completed quarterly. Maintenance will continue to monitor. Results will be monitored at monthly Safety Committee meetings.	6-17-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	246290	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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K 050	Continued From page 3 This deficient practice was confirmed with the chief building engineer.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, testing of the digital alarm communicator transmitter (DACT) had not been conducted during each month of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.6.1.4, and NFPA 70 (1999) and NFPA 72 (1999) and CMS policy. In a fire emergency, this deficient practice could adversely affect 57 of 57 residents. FINDINGS INCLUDE: On 05/06/2014 at 10:35 AM, during a review of available records provided by the chief building engineer, no documentation could be provided verifying the digital alarm communicator transmitter (DACT) was tested during the months	K 052	K 052: Fire alarm system will be tested during fire drills on a monthly basis. During simulated evening and overnight drills when the alarm will be disruptive to residents, the fire alarm system will be tested the following day. Fire alarm system tests will be documented by Maintenance or designee. Results will be monitored at monthly Safety Committee Meetings.	6-17-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/06/2014

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K 052	Continued From page 4 of July and December of 2013. This finding was confirmed with the chief building engineer.	K 052		