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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ETSN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **05/15/2012** (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 IMR	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 **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	49			
(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 :
Teresa Ament, HFE-NEII 07/25/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 07/25/2012 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2012
(L33)

DETERMINATION APPROVAL

CCN: 24-5348

Item 16 Continuation for CMS-1539

Based on the May 1, 2012 revisit, the facility had corrected the deficiencies issued pursuant to our March 1, 2012 standard survey and was found to be in substantial compliance, effective April 8, 2012. There was one deficiency outstanding, but because the deficiency cited at F0249 was found to be widespread deficiencies that constituted no actual harm with potential for no more than minimal harm (Level C) the facility was considered to be in substantial compliance at the time of the May 1, 2012 revisit.

A follow-up of the remaining deficiency cited at F0249 was completed on May 15, 2012 and the deficiency was found to be corrected as of May 15, 2012.

See attached CMS-2567B for the results of the May 15, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 25, 2012

Ms. Kelsey Callahan, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348021

Dear Ms. Callahan:

On May 10, 2012, we notified you that, based on our follow-up visit completed May 1, 2012, we determined that your facility had corrected the deficiencies issued pursuant to our March1, 2012 standard survey. Based on the May 1, 2012 revisit, your facility was found to be in substantial compliance, effective April 8, 2012. Because the deficiency cited at F0249 was found to be widespread deficiencies that constituted no actual harm with potential for no more than minimal harm (Level C) your facility was considered to be in substantial compliance at the time of the May 1, 2012 revisit.

A follow-up of the remaining deficiency cited at F0249 was completed on May 15, 2012 and the deficiency was found to be corrected as of May 15, 2012. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing	5/15/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 F0249 Reg. # 483.15(f)(2) LSC	Correction Completed 05/15/2012	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PH/NCS	Date: 7/25/12	Signature of Surveyor: 29433	Date: 5/15/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/1/2012		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: ETSN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **05/01/2012** (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 IMR	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 **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,1** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	49			
(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 :
Teresa Ament, HFE-NEII 05/14/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 07/25/2012 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2012
(L33)

DETERMINATION APPROVAL

CCN: 24-5348

Item 16 Continuation for CMS-1539

On February 28, 2012, an abbreviated standard survey was completed, which found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required.

On March 1, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, which found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), whereby corrections were required.

On April 30, 2012 the Office of Health Facility Complaints, May 1, 2012, the Licensing and Certification Program, and on April 11, 2012, the Minnesota Department of Public Safety completed revisits to verify that the facility had achieved and maintained compliance with federal certification deficiencies. Based on our visit, it was determined that the facility has obtained substantial compliance with, but had not totally corrected, the deficiencies issued pursuant to our abbreviated standard survey, completed on February 28, 2012, and our standard survey completed March 1, 2012 effective April 8, 2012.

The deficiency not corrected is as follows:

F0249 -- S/S: C -- 483.15(f)(2) -- Qualifications Of Activity Professional

The most serious deficiency was found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C).

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter dated March 20, 2012 will not be imposed.

See attached CMS-2567 and CMS-2567B's for the results of the April 30, 2012, May 1, 2012 and April 11, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5348

July 25, 2012

Ms. Kelsey Callahan, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Dear Ms. Callahan:

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 April 8, 2012 the above facility is recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4051

May 10, 2012

Ms. Kelsey Callahan, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348021 & H5348008

Dear Ms. Callahan:

On February 28, 2012, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required.

On March 1, 2012, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), whereby corrections were required.

On April 30, 2012 the Office of Health Facility Complaints, May 1, 2012, the Licensing and Certification Program, and on April 11, 2012, the Minnesota Department of Public Safety completed revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2012. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our abbreviated standard survey, completed on February 28, 2012, and our standard survey completed March 1, 2012 effective April 8, 2012. The deficiency not corrected is as follows:

F0249 -- S/S: C -- 483.15(f)(2) -- Qualifications Of Activity Professional

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567, whereby corrections are required.

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter to you dated March 20, 2012 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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637

Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5348R12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing	5/1/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **04/08/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/08/2012**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/08/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/08/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/08/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/08/2012**	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	Date:	Signature of Surveyor:	Date:
	PH/NCS	5/10/12	29433	5/1/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

PRINTED: 05/10/2012
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
	245348	A. BUILDING _____ B. WING _____	R 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}	dc 5/14/12 RLH	
{F 249} SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity program was directed by a qualified activity director. This had the potential to affect all 39 residents residing in the facility. Findings include: The designated activity director (AD)-A lacked the credentials required to be an activity director. On 4/30/12, at 1:22 p.m., the Executive Director (ED) was interviewed and stated AD-A is a licensed social worker, and has been the activity	{F 249}	**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 249 SS=C** **The facility has hired a CTRS-(Certified Therapeutic Recreation Specialist) to oversee and ensure that all residents are receiving activity programming as identified by assessment and care plan.** **The Activities Assistant is currently enrolled in a Therapeutic Recreation Certification Program, with the newly hired CTRS as the assigned preceptor.**	~~4/8/12~~ 5/8/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsey Callahan, LNHA | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 5/11/12

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.

PRINTED: 05/10/2012
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
	245348	A. BUILDING _____ B. WING _____	R 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	660 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 249}	Continued From page 1 director since April 4, 2012. On 5/1/12, at 2:47 p.m., AD-A was interviewed, and verified she has not worked full time in a patient activities program in a health care setting within the past 5 years, and she is not a Recreational Therapist, an Occupational Therapist or an Occupational Therapist Assistant. The job description for the Activity Director dated 12/28/11, identified the qualifications included: must hold or acquire state required licenses and/or certifications; and must be currently certified as Therapeutic Recreation Specialist or have relevant experience in social or recreational program within the last 5 years, one of which was full-time in a patient activities program in a health care setting."	{F 249}	**Weekly Audits of the Activity Programs will be completed, to ensure activities are being provided to meet the assessment/care plan needs of the residents. The results of the audits will be reviewed at the Monthly QA&A meeting.** **The date for completion is May 8th. Executive Director is responsible for ensuring compliance.**	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing 01 - MAIN BUILDING 01	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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 K0038	Correction Completed 04/08/2012	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/NCS	Date: 5/10/12	Signature of Surveyor: 03005	Date: 4/11/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/28/2012		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: ETSN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **03/01/2012** (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 IMR	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 **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X 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	IMR
	49			
(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 :
Cynthia Green, HFE-NEII 04/03/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/06/2012 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
POSTED 4/9/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5348
Item 16 Continuation for CMS-1539

On February 28, 2012, an abbreviated standard survey completed by the Office of Health Facility Complaints and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required.

At the time of the standard survey completed on March 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4129

March 20, 2012

Ms. Kelsey Callahan, Administrator
Golden Livingcenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348021

Dear Ms. Callahan:

On February 28, 2012, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections are required.

On March 1, 2012, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;**

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637

Fax: (218) 723-2359

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 April 8, 2012, 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 April 8, 2012 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 May 28, 2012 (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 August 28, 2012 (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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5348S12.rtf

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

RECEIVED
APR 02 2012
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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	OK with addendums 4/3/12 PLH **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 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	**F 164 SS=E** **All residents' identified in this deficiency have their medical information consistently protected and kept private.** **All residents who reside in this facility have the potential to be affected by this same practice.** **All staff will be re-educated regarding the protection and privacy of the resident medical record and medical information.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 1a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsey Callahan, LNHA
TITLE: EXECUTIVE DIRECTOR
(X6) DATE: 3/28/12

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.

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 164 SS=E

All residents' identified in this deficiency have their medical information consistently protected and kept private.

All residents who reside in this facility have the potential to be affected by this same practice.

Staff will be re-educated regarding the protection and privacy of the resident medical record and medical information.

A weekly audit will be completed to assure compliance
Moved the S.S. desk out of the sunroom. Removed staff phone from sunroom. Arranged the nurses desk for optimum privacy for the computer screen.
Removed Fax machine from sunroom. Removed residents charts from sunroom. Phone line for family and resident access only. ACU director will monitor privacy in the sunroom and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure privacy was maintained for residents on the Alzheimer's Care Unit (ACU) this had the potential to affect 16 of 16 residents (R42, R21, R18, R4, R48, R19, R28, R2, R64, R26, R32, R24, R31, R20, R61, and R35) living on the unit. Findings include: Resident privacy of medical information was not consistently protected for R42, R21, R18, R4, R48, R19, R28, R2, R64, R26, R32, R24, R31, R20, R61, and R35. The ACU had two public areas for residents to visit. One area was a dining space with a small kitchenette; the other was referred to as a sunroom which contained a television, couch and chair for resident activities. The sunroom also contained two desks each of which had a phone, computer and three ring binders on the desktops. In addition the desks contained hutches which held the resident medical records. The hutches could be locked. At 2:00 p.m. on 2/26/12 registered nurse (RN)-B was on the phone at the nursing desk in the sunroom. RN-B was heard speaking with the hospice agency regarding R42 medical	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 164	Continued From page 2 information. RN-B provided an update on the overall condition and respiratory rate/O2 sats (oxygen saturation levels) for R42. There were two residents (R61 and R28) in the sunroom at the time of conversation. Although the television was on, the conversation with the hospice agency could easily be overheard by the two residents. At 2:30 p.m. a surveyor asked to interview RN-B regarding resident's on the unit. The surveyor asked RN-B to go to a private area, however RN-B indicated the sunroom would be fine. Again R61 and R28 remained in the sunroom and overheard the conversation between the surveyor and RN-B as RN-B spoke loudly across the room while she went to the other desk to obtain a medical record. At 7:25 a.m. on 2/27/12 the resident ' s medical records were found to be unlocked with no staff in the room. The records remained unlocked until 9:00 a.m. From 2/26/12 until 2/28/12 a resident ' s communication book (three ring binder) was observed to be on the nurse ' s desk in the sunroom. In addition, on the desktop of the social worker (SW) a three ring binder contained resident specific information for assessments. The room was not consistently monitored by staff and residents were observed to come and go from the sunroom. When interviewed at 8:30 a.m. on 2/28/12, the SW and license practical nurse (LPN)-A agreed these issues were a concern stating, "You need to have confidentiality. You need to have a space for residents and families. You need to respect HIPAA (Health Information Portability and Accounting Act)."	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 164	Continued From page 3 Interview with the Corporate RN and the Executive Director (ED) at 3:10 p.m. on 2/29/12 the ED said I think the intent with that (having the SW and nurse work out of the sunroom) was to have oversight for that unit. If there were any conversations that need to happen with families or something there is opportunity to use other offices. The area is needed for the residents it's a bright open room. We see some of the same hitches that you have identified. We've had a capital acquisition request to try and build a partial wall or partial room but it hasn't happened yet. We have gotten a bid on the half room so we are working toward it. We're trying to work diligently to ensure the privacy for all residents on the unit.	F 164		
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	F 225	**F 225 SS=D** **Resident #31 and #26 are not currently involved in any abuse investigations or reporting.** **All residents who reside in this facility have the potential to be affected by this same practice.** **All staff has been re-educated on the abuse/neglect policy as it relates to resident protection, reporting and investigation. The education includes implementation of the policy when a family member is suspected of abuse and/or neglect.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 4a	

F 225 SS=D

Resident #31 and #26 are not currently involved in any abuse investigations or reporting.

All residents who reside in this facility have the potential to be affected by this same practice.

Staff has been re-educated on the abuse/neglect policy as it relates to resident protection, reporting and investigation. The education includes implementation of the policy when a family member is suspected of abuse and/or neglect.

A weekly audit will be completed to assure compliance. Recorded by Executive Director or designee weekly. Results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure a thorough investigation was completed and reported as appropriate for alleged violations of abuse for 2 of 3 residents (R26 and R31) in the sample who were reviewed for abuse. Findings include: R26 had her breasts touched by a male visitor and this incident was not thoroughly investigated or reported. R26 had multiple diagnoses including senile dementia. Her most recent cognitive assessment dated 10/14/11 identified her as non-verbal with staff attempting to keep her safe in her surroundings.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 Review of facility forms related to abuse/neglect investigations titled "Verification of Investigation" (VOI) revealed R26 experienced an incident on 4/6/11. According to the VOI, at 5:15 p.m. on 4/6/11 a staff member observed a visiting family member (F1) of R32 place a hand on R26's breast and the other hand on her shoulder as R26 was leaving the dining room. As F1 was leaving the unit, he again placed a hand on R26's breast and the other hand on her shoulder. According to the investigation report, 8 staff members interviewed at the time stated they had never seen F1 touch any female resident's inappropriately before. However, one staff interview revealed "There have been no incidents with (F1) since December 2010." There was no further investigation of this statement. The investigative findings concluded "It was determined that (F1 ' s name) inadvertently touched the resident on her breast. It was not on purpose." The interventions taken to prevent a reoccurrence were "Staff educated to observe (F1 ' s name) for any inappropriate touching towards any residents and if witnessed to ask him to stop and notify the Charge Nurse ED [executive director] and DON [director of nursing] immediately." The VOI indicated R26 revealed no changes in behavior or activities of daily living. However, the medical record contained no progress notes between 4/2/11 and 4/14/11. There was no evidence that the residents were safe during the investigation and there were no restrictions concerning F1 ' s visits. F1 continued to visit privately making it difficult for staff to supervise F1 ' s interactions with residents. According to the VOI, F1 visited routinely, twice a	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 day. This incident was not reported to the state agency (SA). Interview with the social worker (SW) at 9:15 a.m. on 2/29/12 verified this information was accurate. She stated, "The ED determined it was not reportable. That is something we would typically have reported; looking back it was not an adequate intervention to just observe and monitor, he still visited in private resident rooms." Another incident occurred at 10:15 a.m. on 7/9/11. R26 again had her breast touched by F1. However, this incident was thoroughly investigated and reported to the SA. In addition, restrictions were placed on F1 ' s visits in that he was only allowed supervised visits. The VOI for this incident identified F1 had other incidents of inappropriate touch with female residents on 11/10, 12/4/10, and 6/12/11 in addition to the incident with R26 on 4/6/11. R31 had an incident of alleged abuse which was not thoroughly investigated or reported. R31 had multiple diagnoses including Alzheimer's disease. According to her most recent cognitive assessment dated 11/11/11, R31 was non-verbal and staff ensures she remains safe and her needs are met. According to the VOI dated 6/12/11 right after lunch F1 was observed to rub R31's arm and breast with the back of his hand. During the investigation on 6/13-14/11 staff stated they didn't witness any inappropriate touch. However one staff member stated she witnessed F1 "touch [R31 name] inappropriately 4 months ago." This statement and incident was not investigated further. The ED concluded in his summary " [F1 '	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 s name] greets residents by tapping them on the shoulder in his friendly way." The interventions to prevent reoccurrence included "[F1 ' s name] was instructed not to touch any female resident in greeting and he agreed." Staff was to continue to observe for any inappropriate touch. The VOI indicated F1 visited routinely, twice a day. There was no evidence residents were kept safe during the investigation, a thorough investigation was not completed and the incident was not reported to the SA. Interview with the SW at 9:15 a.m. on 2/29/12 it was learned that the incident had not been reported to the SA and the ED did the investigation and indicated it wasn't reportable. SW continued to say, " It would be reportable now and knowing what we know now we would have done things differently, which we did in July." The facility policy for abuse/neglect dated as revised on 10/11 and the contents indicated the ED would be notified immediately of all alleged violations and would determine if the incident should be reported to the SA. The policy further indicated reports would be made to the SA immediately, not to exceed 24 hours and the results of the investigation would be reported to the SA within 5 working days of the incident. The policy identifies the investigation should be thorough. However, although the policy indicates how residents will be kept safe from resident to resident and staff allegations, there is no information in the policy on how to ensure residents will be kept safe during the investigation when the alleged perpetrator is a family member.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 226	Continued From page 8 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 follow their abuse and neglect policy for allegations of suspected abuse concerning 2 of 3 residents (R26 and R31) in the sample reviewed for abuse. Findings include: The facility policy, dated as revised on 10/11 and provided by the facility as current, failed to be operationalized for R26 and R31. On review of the policy it was noted for abuse/neglect indicated the Executive Director (ED) would be notified immediately of all alleged violations and would determine if the incident should be reported to the state agency (SA). The policy further indicated reports would be made to the SA immediately, not to exceed 24 hours and the results of the investigation would be reported to the SA within 5 working days of the incident. The policy identifies the investigation should be thorough. However, although the policy indicated how residents will be kept safe from resident to resident and staff abuse, there is no information in the policy on how to ensure residents will be kept safe during the investigation when the alleged perpetrator is a family member. Review of facility forms related to abuse/neglect	F 226	**F 226 SS=D** **The facility policy for abuse/neglect is being operationalized for resident #31 and #26.** **All residents who reside in this facility have the potential to be affected by this same practice.** **All staff has been re-educated regarding the facility policy for abuse and neglect with added attention to resident protection, reporting and investigation. The education includes implementation of the policy when a family member is suspected of abuse and/or neglect.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA meeting for review and discussion.** **The date for completion is 4/8/12** POC page 9a	

F 226 SS=D

The facility policy for abuse/neglect is being operationalized for resident #31 and #26.

All residents who reside in this facility have the potential to be affected by this same practice.

Staff has been re-educated regarding the facility policy for abuse and neglect with added attention to resident protection, reporting and investigation. The education includes implementation of the policy when a family member is suspected of abuse and/or neglect.

A weekly audit will be completed to assure compliance. Recorded by ED or designee and reviewed weekly. Results will be brought to the QA meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 226	Continued From page 9 investigations titled "Verification of Investigation" (VOI) revealed the following: R26 experienced an incident on 4/6/11. According to the VOI, at 5:15 p.m. on 4/6/11 a staff member observed a visiting family member (F1) of R32 place a hand on R26's breast and the other hand on her shoulder as R26 was leaving the dining room. As F1 was leaving the unit, he again placed a hand on R26's breast and the other hand on her shoulder. According to the investigation report, 8 staff members interviewed at the time stated they had never seen F1 touch any female resident's inappropriately before. However, one staff interview revealed "There have been no incidents with (F1) since December 2010." There was no further investigation of this statement. The investigative findings concluded "It was determined that (F1 ' s name) inadvertently touched the resident on her breast. It was not on purpose." The interventions taken to prevent a reoccurrence were "Staff educated to observe (F1 ' s name) for any inappropriate touching towards any residents and if witnessed to ask him to stop and notify the Charge Nurse ED [executive director] and DON [director of nursing] immediately." The VOI indicated R26 revealed no changes in behavior or activities of daily living. However, the medical record contained no progress notes between 4/2/11 and 4/14/11. There was no evidence that the residents were safe during the investigation and there were no restrictions concerning F1 ' s visits. F1 continued to visit privately making it difficult for staff to supervise F1 ' s interactions with residents. According to the VOI, F1 visited routinely, twice a	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 226	Continued From page 10 day. This incident was not reported to the state agency (SA). Interview with the social worker (SW) at 9:15 a.m. on 2/29/12 verified this information was accurate. She stated, "The ED determined it was not reportable. That is something we would typically have reported; looking back it was not an adequate intervention to just observe and monitor, he still visited in private resident rooms." Another incident occurred at 10:15 a.m. on 7/9/11. R26 again had her breast touched by F1. However, this incident was thoroughly investigated and reported to the SA. In addition, restrictions were placed on F1 ' s visits in that he was only allowed supervised visits. The VOI for this incident identified F1 had other incidents of inappropriate touch with female residents on 11/10, 12/4/10, and 6/12/11 in addition to the incident with R26 on 4/6/11. R31 had an incident of alleged abuse which was not thoroughly investigated or reported. R31 had multiple diagnoses including Alzheimer's disease. According to her most recent cognitive assessment dated 11/11/11, R31 was non-verbal and staff ensures she remains safe and her needs are met. According to the VOI dated 6/12/11 right after lunch F1 was observed to rub R31's arm and breast with the back of his hand. During the investigation on 6/13-14/11 staff stated they didn't witness any inappropriate touch. However one staff member stated she witnessed F1 "touch [R31 name] inappropriately 4 months ago." This statement and incident was not investigated further. The ED concluded in his summary " [F1 '	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 226	Continued From page 11 s name] greets residents by tapping them on the shoulder in his friendly way." The interventions to prevent reoccurrence included "[F1 ' s name] was instructed not to touch any female resident in greeting and he agreed." Staff was to continue to observe for any inappropriate touch. The VOI indicated F1 visited routinely, twice a day. There was no evidence residents were kept safe during the investigation, a thorough investigation was not completed and the incident was not reported to the SA. Interview with the SW at 9:15 a.m. on 2/29/12 it was learned that the incident had not been reported to the SA and the ED did the investigation and indicated it wasn't reportable. SW continued to say, " It would be reportable now and knowing what we know now we would have done things differently, which we did in July." The facility policy for abuse/neglect dated as revised on 10/11 and the contents indicated the ED would be notified immediately of all alleged violations and would determine if the incident should be reported to the SA. The policy further indicated reports would be made to the SA immediately, not to exceed 24 hours and the results of the investigation would be reported to the SA within 5 working days of the incident. The policy identifies the investigation should be thorough. However, although the policy indicates how residents will be kept safe from resident to resident and staff allegations, there is no information in the policy on how to ensure residents will be kept safe during the investigation when the alleged perpetrator is a family member.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 12 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure an ongoing program of activities designed to meet the individualized needs of the residents had been developed for 3 of 3 residents (R26, R4, and R48) in the sample reviewed for activities. Findings included: R26 did not receive an ongoing program of activities designed to meet her assessed needs and interests. R26 had multiple diagnoses including senile dementia and depression. Her most recent cognitive assessment dated 10/14/11 identified R26 was non-verbal and staff anticipated her needs and kept her safe in her surroundings. On 2/26/12 from 1:00 p.m.. through 4:00 p.m. R26 was observed not to be actively engaged in activities. Again from 7:00 a.m. to 10:30 a.m. on 2/27/12 R26 was in her room and no television or radio music was playing. Although there were manicures offered in the dining room during this time, R26 did not attend. At 8:45 a.m. on 2/28/12 R26 was observed back in bed after breakfast with her TV on watching animal planet. At 10:00 a.m. she remained in bed with her television playing animal planet, although there was an	F 248	**F 248 SS=D** **Resident #26, #4 and #48 have an ongoing program of activities that are designed to meet their individualized needs.** **All residents who reside in this facility have the potential to be affected by this same practice.** **All staff has been re-educated regarding the development of ongoing activity programming that meets the individualized needs of the resident.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 13a	

F 248 SS=D

Resident #26, #4 and #48 have an ongoing program of activities that are designed to meet their individualized needs.

All residents who reside in this facility have the potential to be affected by this same practice.

Staff has been re-educated regarding the development of ongoing activity programming that meets the individualized needs of the resident.

A weekly audit will be completed to assure compliance. Activities Director or designee to record and monitor that activities are being done each day.
ED or designee to review recorded audits and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 13	F 248		

activity going on in the dining room with other residents from her unit. At 2:45 p.m. there was a music activity in the main dining room and R26 had not been offered the chance to attend. Even though R26 was identified as enjoying music.

Review of resident ' s activity participation records for January and February 2012 they revealed R26 had attended a total of 17 activities and received two 1:1 activities during that time. The records further identified R26 had watched TV or listened to the radio on a daily basis. There were no formal records for activity attendance prior to 1/2012. Review of the latest care conference review sheet, dated 1/25/12, it was noted that it was blank for recreation therapy and there was no 1/12 quarterly progress note entered in the medical record for R26. Although other quarterly progress notes identified R26 attended activities, these notes failed to include the frequency of attendance, level of interest, and attention span. Identified in her Recreation Services Assessment dated 10/13/11, R26 was noted to enjoy the outdoors, animals, TV sitcoms, musical activities, pretty nails and hand massages.

At 9:00 a.m. on 2/27/12 R34 indicated he often assisted with activities, especially in the evening and on weekends when less staff are available. R34 stated that when the code was changed for entering the Alzheimer Care Unit (ACU), he was no longer to go onto the unit and assist residents to activities. "I have to ask staff to bring residents out - but then they never show up." R34 stated that since the code was changed to enter the ACU he rarely has residents attend activities from the ACU "They never show up."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 14 The Activities Coordinator (AC), interviewed at 1:00 p.m. on 2/29/12 indicated that activities unique to the ACU included poetry reading, old time movies, 1:1's and sensory stimulation for the less cognitively intact residents. At 1:50 p.m. when interviewed again, the AC verified the activity preferences for R26 and that no 1:1's had occurred with R26 since she began working in 1/12. Interview with the Social Worker (SW)/ ACU Coordinator at 8:30 a.m. on 2/28/12 indicated "We structure their activities on the unit that are led by an activity coordinator, some do go out [off the secured unit] to the west side depending on their cognitive ability and how they adjust to being off the unit. Normally we bring residents out to activities on both sides - on eves [evenings] and w/e's [week ends] the expectation is to have nursing make sure that activities happen and residents are brought off the unit to attend activities." Review of the facility policy for the Recreational Services Guide dated 2009 and provided by the Executive Director (ED) as current indicated "Programs are designed to provide opportunities for each resident to meet their social, physical, cognitive and emotional needs, recreational interests, and developing leisure skills." The policy indicated that "Programs will be scheduled at hours conducive to the participation of all residents including morning, afternoon, evenings, and weekends." Although the policy provides a variety of domains for programming, there was no programming defined in the policy for residents with cognitive impairment including those resident's with advanced dementia.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 15 R4, whose diagnoses included senile dementia, dementia with behavioral disturbances, and chronic pain, was not provided activities as determined by the comprehensive activity assessment. Observations on 2/26/12, established R4 was not provided any activity programs from 1:00 p.m. to 3:30 p.m. Random observations throughout the day on 2/27/12 from 8:00 a.m. to 2:30 p.m. did not note R4 engaged in any facility organized activities. R4 was noted to attend a music program on 2/28/12 at approximately 2:30 p.m. The music program was not in the ACU, but in the main dining room of the facility. R4's care plan dated 11/5/11 directed staff to "use strong encouragement when inviting [him] to activities and re-approach if needed, remind [him] that [his] wife may be at the activity of interest in order to encourage [him] to leave [his] room and involve [him] in smaller group activities for more assistance and less distractions." The Care plan also noted that R4 lived in the ACU because of the "programs designed for this population" and directed staff to "allow resident to propel throughout the ACU at will, provide environmental cues throughout the ACU to minimize cognitive deficits, Shadow Box, Orientation Board" and, "Provide normalized programming based on patient assessment and interests. See TR [Therapeutic Recreation] assessment for details." The annual Recreation Services Assessment, dated 11-5-11, noted R4's Leisure Preferences as watching sports, ball toss, occasional television, enjoys music, reminiscing, dogs, sitting outdoors, taking lunch with his wife, seeing	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 16	F 248		

children and back rubs. Program preferences were independent, 1:1, large and small groups, with his family, outside and in and out of his room.

Review of the activity attendance sheets for December 2011, noted that R4 attended a music social on 12/10/11, from 9:00 a.m. to 9:30 a.m. No attendance information was provided for the months before December of 2011. R4's attendance record for January, 2012 indicated that he participated in five facility activities. The Recreation Participation Record for January, 2012 indicated R4 declined to participate in five other activities. Further review of the Activity Attendance Tracking form noted that R4 was sleeping during four of those activities and declined to attend one. The Recreation Participation Record for February, 2012 indicated R4 attended nine activities which included one visit to the barber. The Record noted that R4 declined two programs.
The Activities Coordinator (AC), interviewed on 2/29/12 at 1:00 p.m., stated that "[R4] is not an easy person to get to activities. He goes to music stuff sometimes." She said that she did not complete his initial activities assessment but did review and update the assessment "at the end of January (2012)." The AC stated that activities unique to the ACU included poetry reading, old time movies, 1:1s and sensory stimulation for the less cognitively intact residents. When asked what individualized activities were provided for R4, she stated, "he likes communion, music programs and he gets to do stuff with his wife." She added that she had not had any 1:1 time with R4 since she started as activity coordinator in January, 2012.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 17	F 248		

R48, whose diagnoses included dementia with behavioral disturbances, depressive disorder and delirium was not provided activities as determined by the comprehensive activity assessment.

Observations on 2/26/12 established R48 was not provided any activity programs from 1:00 p.m. to 3:30 p.m. Random observations throughout the day on 2/27/12, from 8:00 a.m. to 2:30 p.m., R48 had her nails done and otherwise sat in her room in her recliner. R48 was noted to attend a music program on 2/28/12, at approximately 2:30 p.m. The music program was not in the ACU, but in the main dining room of the facility.

R48's care plan dated 7/18/11 indicated a diagnosis of Alzheimer ' s or related dementia with cognitive loss, diminished decision making capabilities, and safety and security issues. Placement in the secured Alzheimer ' s care unit with programs designed for this population is needed as evidenced by moderate to severe cognitive loss. It directed staff to "allow resident to walk through ACU at will, provide environmental cues throughout the ACU to minimize effects of cognitive deficits - shadow boxes and Orientation Board" and, "Provide normalized programming based on patient assessment and interests. Faith-based programs and reminiscing." A different focus of the care plan stated that R48 sometimes had "difficulty starting and staying involved in recreational activities" due to a short attention span. It directed staff to include her in shorter duration activities, call her name or gently touch her arm to help her stay aware of the activity, offer activities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 18	F 248		

that are familiar, "but also let me try new things you think I'd like to do" and offer smaller groups activities for more assistance at her highest level. The annual Recreation Services Assessment, dated 7/15/11, noted R48's Leisure Preferences included TV, baseball, old time music, newspaper, Birds and Blooms magazine, used to dance, dogs, gardening, outdoor walks, children and having nails done.
The activity attendance sheets for December of 2011 noted that R48 attended five activities during the month. No attendance information was provided for the months before December of 2011. R48's attendance record for January, 2012, indicated that she participated in six facility activities. The Recreation Participation Record for January, 2012, indicated R48 declined to participate in five other activities. Further review of the Activity Attendance Tracking form noted that R48 was sleeping during five activities. The Recreation Participation Record for February, 2012, indicated R48 attended 17 independent activities which included four visits to the beautician. The Record noted that R48 declined five programs. The Record also indicated that R48 was provided the TV or listened to the radio every day in February. Random observations throughout the days of 2/26/12, through 2/29/12, when R48 was resting in her recliner, the radio in her room was on a classic rock station, with the volume turned low. When interviewed on 2/29/12, at 2:14 p.m., R48 stated she did not hear the radio music and added she did not know it was on. She said that staff will turn it on and have the volume very low that she cannot hear it. The AC was interviewed on 2/29/12, at 1:00 p.m. and stated that R48 was "not always cooperative" with activities. The AC stated that R48 did like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 248	Continued From page 19 the exercise groups, the reminiscing group and a big book with pictures. She added that the reminiscing group was held three times since she started in the middle of January, 2012. The AC added that she had not had any 1:1 time with R48 since she started as activity coordinator, but "sometimes we chat a bit."	F 248		
F 249 SS=E	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the activity program was directed by a qualified activity professional who implemented individualized activity programs to meet the needs of residents assigned to her care. This had the potential to effect 16 of 16 residents (R42, R18 R21, R4, R48, R19, R28, R2, R64, R26, R32, R24, R31, R20, R61, and R35) residing on the	F 249	**F 249 SS=E** **All residents cited in this deficiency have individualized ongoing activity programming that is provided by a qualified activity professional.** **All residents who reside in this facility have the potential to be affected by this same practice.** **The facility has appointed a staff member to be the qualified activity program director.** **Through the yearly employee evaluation process it will be determined that the activity program director maintains the appropriate qualifications to continue in the job. This will be reviewed in a QA meeting.** **The date for completion is 4/8/12** POC page 20a	

F 249 SS=E

All residents cited in this deficiency have individualized ongoing activity programming that is provided by a qualified activity professional.

All residents who reside in this facility have the potential to be affected by this same practice.

The facility has appointed a staff member to be the qualified activity program director.

Through the yearly employee evaluation process it will be determined that the activity program director maintains the appropriate qualifications to continue in the job. This will be reviewed in a QA meeting.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 249	Continued From page 20 Alzheimer ' s Care Unit (ACU). Findings include: The facility Activity Coordinator (AC) does not meet the requirements for a qualified activity professional as director of the department. Although the facility has a qualified mentor for the AC, the facility failed to provide an effective activity program to meet the needs of the cognitively impaired residents on the Alzheimer's Care Unit (ACU). See F248: 3 of 3 residents (R26, R4, and R48) reviewed with advanced dementia on the ACU did not receive an activity program designed to meet their needs and interests based on a comprehensive assessment. Interview with the AC at 1:50 p.m. on 2/29/12 revealed she functioned in the role of the activity director for the facility and reported to the ED as her supervisor. The AC further indicated she did not have the credentials that would qualify her to be the activity director for the facility. "I did computer stuff and I managed a vet clinic. I am the activity coordinator. I've had no advanced school; I have CEC's (continuing education credits) in different areas of physical fitness. When asked specifically about the training she has had to fill the role of the activity department director she stated, "A lady form another facility came to familiarize me with how things are done here. As far as the activities themselves go they don't require a lot, you know calling bingo, doing a word game. If I have questions the staff have helped me out. The only bad question is the one that goes unasked. I worked at the facility for a number of years so I know all the residents pretty	F 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 249	Continued From page 21 well and they know me." The AC then stated she had gotten to know the resident's well while working in the dietary department prior to moving into the AC role. Interview with the Executive Director (ED) at 2:00 p.m. on 2/29/12 indicated she was aware the AC did not meet the requirements of an activity department director. ED stated, "I believe we have 5 years to complete the state ordered program. [AC ' s name] is supervised by [SW name] but runs the program. [SW ' s name] just reviews things with her as needed. The corporate consultant helps to oversee the program and guides [AC ' s name] - she kind of helps her to run the program. She's been here twice since [AC ' s name] started in January [2012]." The ED acknowledged that the activity consultant had not identified any issues with the activity program throughout the facility. The ED clarified the consultant was "just working on the basics with her [AC]." The job description provided by the ED as current for the Activity Coordinator/Director identified the AC reported to the ED and was to ensure " activity services and programs that meet the needs and interests of each resident." The qualifications included: Must hold or acquire state required licenses and/or certifications; and Must be currently certified as Therapeutic Recreation Specialist or have relevant experience in social or recreational program within the last 5 years, one of which was full-time in a patient activities program in a health care setting."	F 249		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 272	Continued From page 22 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F 272 SS=D** **Resident # 41 has the appropriate pressure reduction cushion in his w/c as assessed by OT.** **All residents at risk for or with skin breakdown have the potential to be affected by this practice.** **Therapy and nursing staff has been re-educated on completing an assessment for the appropriate cushion when the resident is at risk for or has skin breakdown.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** See POC page 23a	

F 272 SS=D

Resident # 41 has the appropriate pressure reduction cushion in his w/c as assessed by OT.

All residents at risk for or with skin breakdown have the potential to be affected by this practice.

Therapy and nursing staff has been re-educated on completing an assessment for the appropriate cushion when the resident is at risk for or has skin breakdown.

A weekly audit will be completed to assure compliance. Weekly audits will be monitored and reviewed by DNS or designee.

The results of the audits will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 272	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide comprehensive assessment of seating needs for 1 of 3 residents (R41) reviewed for pressure ulcers. Findings include: R41 was not provided skin risk assessment to determine appropriate pressure reduction while seated in the wheelchair. R41 had diagnoses of right hemiparesis, diabetic neuropathy, diabetes, end stage renal disease and congestive heart failure. The admission Minimum Data Set (MDS) dated 10/21/11, indicated R41 had no cognitive impairment, was non-ambulatory, required extensive assist of two staff for transfers, was incontinent of bowel and bladder, and was at risk for pressure ulcers. The MDS indicated R41 had current pressure ulcers. The admission comprehensive assessment did not address skin pressure reduction while seated in the electric wheelchair for periods of time. The pressure ulcer Comprehensive Care Assessment (CAA) dated 10/28/11, identified pertinent risk factors of current pressures ulcers, medications used, urinary and bowel incontinence, impaired bed mobility, functional limitation in range of motion and bed fast or wheelchair bound. The Comprehensive Summary dated 11/4/11, indicated R41 had pressure reduction interventions while in bed and in the wheelchair The licensed practical nurse (LPN)-A, interviewed	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 272	Continued From page 24 on 2/29/12, at 8:10 a.m., stated she wrote the comprehensive assessment but did not know what kind of pressure reduction device was in R41's electric wheelchair. LPN-A suggested the occupational therapist (OT)-1 might have more information. OT notes dated 12/14/11, indicated the nurse practitioner requested a pressure reduction device to R41's electric wheelchair due to R41 having a pressure ulcer next to his tail bone. The note indicated R41 had a gel cushion in the electric wheelchair; however, there was no evidence to indicate the cushion was examined to determine effectiveness for pressure reduction. Observation of the electric wheel chair on 2/29/12, observed a foam cushion and not the jell cushion was being used. The facility registered nurse consultant, interviewed on 2/29/12, at approximately 11:30 a.m., verified the pressure reduction quality of the foam cushion had not been assessed for being adequate to relieve pressure for R41.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	**F 279 SS=D** **Resident # 26, # 4 and # 48 have a comprehensive activity care plan in place to meet their assessed activities needs.** **All residents who reside in this facility have the potential to be affected by this same practice.** **The IDT has been re-educated on the development of a comprehensive activity care plan based on the residents assessed needs.** **A random weekly audit will be completed to assure compliance and the results will be brought to the QA meeting for review and discussion.** **The date for completion is 4/8/12** see POC page 25a	

F 279 SS=D

Resident # 26, # 4 and # 48 have a comprehensive activity care plan in place to meet their assessed activities needs.

All residents who reside in this facility have the potential to be affected by this same practice.

The Inter-disciplinary Team has been re-educated on the development of a comprehensive activity care plan based on the residents assessed needs.

A random weekly audit will be completed to assure compliance. Audits will be monitored and reviewed by TR director or designee. and the results will be brought to the QA meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 279	Continued From page 25 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care to meet the assessed activities needs for 3 of 3 residents (R26, R4, and R48) in the sample who were reviewed for activities. Findings include: R26 did not have a plan of care developed for a program of activities to meet her assessed needs. R26 had multiple diagnoses including senile dementia and depression. Her most recent cognitive assessment dated 10/14/11 identified R26 was non-verbal and staff anticipated her needs and kept her safe in her surroundings. Multiple observations of R26 on 2/26/12 through 2/28/12 revealed she was not engaged in activities. Review of resident participation records for January and February 2012 revealed R26 had attended a total of 17 activities and received two 1:1 activities during that time. The records further	F 279		

(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 279	Continued From page 26 identified R26 watched television (TV) or listened to the radio on a daily basis. Identified in her Recreation Services Assessment dated 10/13/11, R26 was noted to enjoy the outdoors, animals, TV sitcoms, musical activities, pretty nails and hand massages. The plan of care dated as revised 1/23/12 and provided by the facility as current identified goals of "Resident will participate in ACU programming until next review, I will continue to make eye contact with group leader during recreation programs, and my life's simple pleasures will be provided throughout my next review." Interventions included "provide normalized programming based on patient assessment and interests, Help me to participate in my favorite activities, provide my simple pleasures to me as often as I request." Although R26 is identified with advanced dementia and is non-verbal, the care plan failed to identify interventions to meet her identified strengths and abilities and her cognitive limitation in addition to meeting her interests. The Activities Coordinator (AC), interviewed at 1:00 p.m. on 2/29/12 indicated that activities unique to the ACU included poetry reading, old time movies, 1:1's and sensory stimulation for the less cognitively intact residents. R4, whose diagnoses included senile dementia, dementia with behavioral disturbances, and chronic pain, did not have an activities care plan developed based on his individualized assessments and interests. Observations on 2/26/12 established R4 was not provided any activity programs from 1:00 p.m. to 3:30 p.m. Random observations throughout the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 279	Continued From page 27 day on 2/27/12 from 8:00 a.m. to 2:30 p.m. did not note R4 engaged in any facility organized activities. R4 was noted to attend a music program on 2/28/12 at approximately 2:30 p.m. The music program was not in the ACU, but in the main dining room of the facility. The annual Recreation Services Assessment, dated 11-5-11, noted R4's Leisure Preferences as; watching sports, ball toss, occasional television, enjoys music, reminiscing, dogs, sitting outdoors, taking lunch with his wife, seeing children, and back rubs. Program preferences were listed as; independent, 1:1, large and small groups, with his family, outside and in and out of his room. R4's care plan dated 11/5/11 directed staff to "use strong encouragement when inviting [him] to activities and re-approach if needed, remind [him] that [his] wife may be at the activity of interest in order to encourage [him] to leave [his] room and involve [him] in smaller group activities for more assistance and less distractions." The Care plan also noted that R4 was placed in the ACU was needed because of the "programs designed for this population" and directed staff to "allow resident to propel throughout the ACU at will, Provide environmental cues throughout the ACU to minimize cognitive deficits Shadow Box, Orientation Board" and, "Provide normalized programming based on patient assessment and interests. See TR [Therapeutic Recreation] assessment for details." The Activities Coordinator acknowledged on 2/29/12 at 1:00 p.m. that R4's care plan was not developed based on his personal interests, past experiences, or individualized assessment.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 279	Continued From page 28	F 279		

R48, whose diagnoses included dementia with behavioral disturbances, depressive disorder and delirium was not provided activities as determined by the comprehensive activity assessment.

Observations on 2/26/12 established R48 was not provided any activity programs from 1:00 p.m. to 3:30 p.m. Random observations throughout the day on 2/27/12 from 8:00 a.m. to 2:30 p.m., R48 had her nails done and otherwise sat in her room in her recliner. C48 was noted to attend a music program on 2/28/12 at approximately 2:30 p.m. The music program was not in the ACU, but in the main dining room of the facility.
The annual Recreation Services Assessment, dated 7/15/11, noted R48's Leisure Preferences as included TV, baseball, old time music, newspaper, Birds and Blooms magazine, used to dance, dogs, gardening, outdoor walks, children, having nails done.
R48's care plan dated 7/18/11, indicated has the diagnosis of Alzheimer ' s or related dementia. Due to cognitive loss diminished decision making capabilities and safety and security issues, and placement in the secured Alzheimer ' s care unit with programs designed for this population is needed as evidenced by: moderate to severe cognitive loss. It directed staff to "allow resident to walk through ACU at will, provide environmental cues throughout the ACU to minimize effects of cognitive deficits - shadow boxes and Orientation Board" and, "Provide normalized programming based on patient assessment and interests. Faith-based programs and reminiscing." A different focus of the care plan stated that the resident sometimes has "difficulty starting and staying involved in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 279	Continued From page 29 recreational activities" due to a short attention span. It directed staff to include her in shorter duration activities, call her name or gently touch her arm to help her stay aware of the activity, offer activities that are familiar, "but also let me try new things you think I'd like to do" and offer smaller groups activities for more assistance at her highest level. The Activities Coordinator acknowledged on 2/29/12 at 1:00 p.m. that C48's care plan was not developed based on his personal interests, past experiences, or individualized assessment.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the care plan was followed for 2 of 2 residents (R41 and R32) reviewed for pressure ulcers and 1 of 2 residents (R32) reviewed for falls. Findings include: R41 did not receive repositioning to prevent pressure ulcers as the plan of care directed on the morning of 2/28/12. The care plan revised date of 2/4/12, stated, "Turning and repositioning schedule offer to assist resident to offload hourly and avoid back laying." The care plan indicated that the pressure	F 282	**F 282 SS=D** **Resident #41's care plan is being followed for skin integrity. Resident # 32's care plan is being followed for skin integrity and safety.** **All resident with skin integrity and safety care plans have the potential to be affected by this practice.** **All nursing staff has been re-educated regarding the need to follow the residents care plan for safety and skin integrity.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** See POC page 30a	

F 282 SS=D

Resident #41's care plan is being followed for skin integrity. Resident # 32's care plan is being followed for skin integrity and safety.

All resident with skin integrity and safety care plans have the potential to be affected by this practice.

Nursing staff has been re-educated regarding the need to follow the residents care plan for safety and skin integrity.

A weekly audit will be completed to assure compliance. Weekly audits will be monitored and reviewed by DNS or designee and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 282	Continued From page 30	F 282		

ulcers on the coccyx and buttocks had resolved and R41 remained at risk for developing pressure ulcers.
R41 had a history of developing ulcers and current pressure ulcers with diagnosis of right hemiparesis, diabetic neuropathy, diabetic, chronic kidney disease, and congestive heart failure. The admission Minimum Data Set (MDS) dated 10/21/11, and the quarterly MDS dated 1/17/12, indicated R41 needed extensive assist of more than two staff to be transferred and was at risk for developing pressure ulcer.

During review of the nursing assistant care guide, not dated, being used by nursing assistants (NAs) on 2/28/12 indicated R41 was to be repositioned every hour with assist of one staff and use of a mechanical lift.

On 2/28/2012, R41 was observed from 7:00 a.m. to 9:15 a.m. and had not been offered to be repositioned or repositioned for a total of 2 hours, 15 minutes. R41 sat in his electric wheelchair the entire time and did not reposition himself.

Interview with licensed practical nurse (LPN)-B on 2/26/12, at 8:20 a.m. regarding R41's needs for repositioning, she indicated that R41 was to be repositioned every hour and they use the sit to stand lift to lift him and remove pressure to the buttocks. During an interview with the consultant RN, director of nursing (DON) and LPN-B on 2/28/12, at 9:41 a.m. LPN-B confirmed that R41 had not been repositioned for 2 hours.

During an interview on 2/28/12, at 10:55 a.m. the facility's RN consultant, DON and assistant director of nursing (ADON) indicated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 282	Continued From page 31 interventions for R41 ' s repositioning schedule had remained every hour as the plan of care indicated. R32's plan of care for skin integrity was not followed. R32 had multiple diagnoses including diabetes mellitus (DM) and Alzheimer's dementia. On 2/22/12 R32 was identified with a 1.5 centimeter (cm) fluid filled blister on her right heel. R32 ' s plan of care provided by the facility as current and dated as initiated on 2/26/12 identified the use of heel boot to right foot when in bed, do not wear black shoes until right heel blister heals, gripper socks or slippers on feet until right heel blister heals. On 2/26/12 at 10:40 a.m. R32 was observed wearing black dress shoes which slipped on the tile floor. At 8:45 a.m. on 2/28/12 R32 was observed sitting in the recliner with her feet up on a stool with pressure directly on both heels. Although there was a decorative square pillow on the stool, her heels were observed to rest directly on the firm stool seat. At 10:40 a.m. on 2/29/12 the Director of Nursing stated, "I will check on her shoes. I had put her shoes up in the closet out of reach on Sunday (2/26/12)." The DON confirmed R32 should not have been wearing the black dress shoes and should not have pressure directly on the heels according to the care plan. R32's plan of care was not fallowed for safety	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 282	Continued From page 32 interventions related to frequent falls. During review of R32 records it was noted that R32 had 11 falls since 6/11. R32 had multiple diagnoses including Alzheimer's dementia, osteopathic of the knees and hypertension. R32 ' s plan of care provided by the facility as current had a target date of 4/24/12 and identified the problem of fall history with a goal of no fall related injuries. Interventions included footwear to prevent slipping, pressure pad alarm in bed, wheelchair and recliner, and anti-roll back brakes on wheelchair. On 2/26/12 at 10:40 a.m. R32 was observed to stand up from her wheelchair. She was wearing black dress shoes which slid on the tile floor, the pressure pad alarm did not sound when R32 stood, and the auto-lock brakes were not functioning. At 8:55 a.m. on 2/29/12 R32 was observed in the hallway attempting to stand independently. R32 was observed to wear slipper like shoes which also slid out from underneath R32 when independently standing and the auto-lock brakes did not engage allowing the wheelchair to roll away from R32 as she attempted to stand. Also the pressure pad alarm did not active when the resident stood. At 10:10 a.m. on 2/29/12 the DON confirmed the anti-lock brakes and alarms should have been on and working in the wheelchair. She further indicated the black shoes should not have been worn and would check on the issues identified.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 33 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide treatments and services to prevent pressure ulcers from developing or promote healing of existing pressure ulcers for 2 of 2 residents (R41 and R32) in the sample who had been reviewed for pressure ulcers. This resulted in actual harm for R41 who had a recurrence of a stage II pressure ulcer (Partial thickness tissue loss) on the right buttock. Findings include: R41 was not provided timely assistance with repositioning and developed a recurrent stage II pressure ulcer to the right buttocks. In addition, a pressure reducing device was not applied to the seat of the wheelchair as recommended in 12/11. R41's diagnoses included diabetes, right hemiparesis, diabetic neuropathy and end stage renal disease. The admission Minimum Data Set (MDS) dated 10/28/11, indicated R41 had no cognitive	F 314	**F 314 SS=G** **Resident # 41 has the appropriate cushion in his electric wheelchair and he is being repositioned timely per his care plan. Resident #32 has the appropriate pressure reducing intervention in place for both heels.** **All residents with skin issues present, at risk or history of have the potential to be affected by this same practice.** **All nursing staff has been re-educated to assure that all residents with skin concerns current, past or at risk have all of their skin interventions in place as care planned.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** See poc page 34a	

F 314 SS=G

Resident # 41 has the appropriate cushion in his electric wheelchair and he is being repositioned timely per his care plan. Resident # 32 has the appropriate pressure reducing intervention in place for both heels.

All residents with skin issues present, at risk or history of have the potential to be affected by this same practice.

Nursing staff has been re-educated to assure that all residents with skin concerns current, past or at risk have all of their skin interventions in place as care planned.

A weekly audit will be completed to assure compliance. Wound care nurse to do weekly skin assessments, Turn and reposition audits will be done daily, Weekly skin intervention audits, Weekly audits will be monitored and reviewed by DNS or designee. and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 34	F 314		

impairment and was able to communicate his needs. R41 was non-ambulatory, required extensive assistance of one to two staff for transfers and bed mobility and was incontinent of bowel and bladder. The MDS identified R41 as having pressure ulcers and was at risk for developing pressure ulcers.

The pressure ulcer Care Area Assessment (CAA) dated 10/28/11, identified R41 was at risk for pressure ulcers due to needing extensive assistance with bed mobility, frequent incontinence and having more than two, stage II or higher, pressure ulcers. Other risk factors included diabetes, hemiplegia/hemiparesis and end stage renal disease. The assessment indicated that R41 was admitted with two stage II pressure ulcers one located on the coccyx and the other on the right buttock. The CAA indicated R41 was provided a pressure reduction mattress on the bed and a pressure reduction cushion in the wheel chair. The comprehensive summary note dated 11/04/11 indicated R41's skin was always red at pressure points when sitting for extended periods of time and needed hourly offload (removing pressure to an area that is sensitive to pressure induced skin damage especially at the bony prominences which includes the buttocks.)

The "Braden Scale " a tool used to evaluate pressure ulcer risk dated 10/18/2011, indicated R41 was at moderate risk for developing pressure ulcers.

The quarterly MDS dated 1/17/12, indicated no change in cognitive or functional abilities from the admission MDS. The MDS identified R41 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 35 stage III and stage IV pressure ulcers located on R41 ' s feet and a stage II pressure ulcer on the right buttock. The Comprehensive Summary quarterly review dated 2/6/12 indicated R41 had ongoing wound care to a coccyx pressure ulcer which had healed. The plan had hourly off-loading; however, it also indicated R41 was "non-compliant with this plan and prefers to sit in his electric wheelchair for hours at a time." R41's care plan under skin integrity dated 2/4/2012 indicated R41 had several risk factors for skin breakdown and had a current pressure ulcer. The interventions included: provide pressure reduction wheel chair cushion, alternating air mattress on bed, provide thorough skin care after incontinent episodes and apply barrier cream, assisted off-load/repositioning every hour. On 2/28/12, at 7:00 a.m., R41 was observed in the wheelchair in the front hall and there was no pressure reduction cushion located under the resident's buttocks. At 7:10 a.m. R41 was down the hall by the medication cart waiting for medications. At 7:28 a.m. R41 went into his room and received an insulin injection. At 7:30 a.m. R41 left the building through the front door per in his electric wheel chair. R41 was observed outside in the smoking area. At approximately 7:43 a.m. R41 came inside and took his wheel chair down the hall. R41 stopped at the medication cart and then went directly to the dining room for breakfast. At 7:55 a.m. R41 remained in the dining room eating and visiting with table mates. At approximately 8:07 a.m. R41 went to the therapy room and stated that he was getting the right hand wheelchair tray looked at.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 36 At 8:11 a.m. R41 went outside to smoke. During an interview while smoking R41 stated he had not been offered or had been provided repositioning from 7:00 when he was helped to his wheel chair. After the interview at 8:15 a.m. R41 went into the facility and asked registered nurse (RN)-A if she could use the standing lift to help him reposition. RN-A responded that he would have to wait until she had finished passing medications to the residents. Then R41 went to his room and asked the licensed practical nurse (LPN)-B at 8:17 a.m. if she could help him go to the bathroom. LPN-B replied that two other residents were ahead of him so it would be about 20 minutes before the standing lift was available to help him go to the bathroom. Following this dialog with LPN-B at 8:20 a.m., she stated that R41 required use of the standing lift every hour for repositioning and toileting. R41 went directly back into the therapy room where the occupational therapist (OT)-I provided range of motion to his right hand. R41 remained in the therapy room until approximately 8:45 a.m. when the nursing assistant (NA)-C came in to ask R41 about toileting/repositioning. R41 left the therapy room at 9:05 a.m. and looked for LPN-B to help him go to the bathroom. R41 was taken into the tub room at 9:15 a.m. and assisted to transfer to the toilet with the assist of LPN-B and NA-C. On observing R41's skin there had been a stage II pressure ulcer located on the right buttocks. The assistant director of nursing measured the pressure ulcer on the right buttock to be 3.8 cm by 3.3 cm at that time. Occupational therapy (OT) notes dated 12/14/11 indicated the nurse practitioner requested a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 37 pressure reduction cushion for R41's electric wheelchair due to a pressure ulcer next to his tail bone. The OT note indicated that R41 stated there was a gel cushion in the cushion (pressure reduction) on his wheel chair. OT-A had been interviewed on 2/29/12, at 8:15 a.m., indicated she thought R41 had a gel cushion in the wheel chair. She indicated that she was unable to determine for sure if the cushion was a gel cushion. Observation of the electric wheel chair cushion on 2/29/12 indicated the cushion was made of urethane foam and had not been identified as a pressure reduction cushion. Review of the weekly Wound Evaluation Flow Sheets indicated the right buttocks pressure ulcer was present from 10/25/2011, to 11/29/11. The right buttock pressure ulcer re-opened from 12/18/11, to 1/19/12. From 2/2/12, until 2/6/12 the right buttock pressure ulcer again was open and measured 1.4 cm x 1 cm. On 2/6/12, the documentation indicated the ulcer had healed. There was no more documentation regarding the right buttock pressure ulcer status until it was observed to be open on 2/28/12 at 9:15 a.m. (during survey). The weekly Wound Evaluation Flow Sheets also indicated that R41 had a stage II pressure ulcer on the left heel which was 3 cm by 1.2 cm by 1 cm deep, measured on 2/20/12, being treated by off-loading boots. R41 had a stage IV pressure ulcer on the right lateral metatarsal that had been surgically repaired on 2/1/12 along with the removal of his small toe. Nursing progress notes on 2/2/12 at 9:39 a.m. indicated that R41 had a pressure ulcer on the right buttock, located in a previous pressure ulcer that healed on 2/6/12. The ADON, interviewed on	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 38 2/28/12, at 9:25 a.m., confirmed that the buttock pressure ulcer had been healed in January 2012, and now had reopened. The facility's skin integrity guideline policy revised January 2011 indicated that residents utilizing a wheel chair as a primary mode of transportation will have a pressure reducing cushion. It further indicated if there is a decline in skin integrity pressure redistribution surfaces will be reviewed for appropriateness. Residents will be observed by the NA daily for reddened/open areas, edema of feet or sacrum. Changes will be reported to licensed nurse and documented. R32 did not receive services to promote the healing and prevent infection of pressure ulcers. R32 had multiple diagnoses including Diabetes Mellitus osteoarthritis, and Alzheimer's disease. At 9:00 a.m. on 2/29/12 nursing assistant-F (NA-F) indicated that R32 needed more help with her mobility as her knees were "getting worse." Documentation revealed a quarterly nursing review dated 1/24/12 which identified a Braden skin risk of 22 identifying no skin issues. Tissue tolerances completed on 11/7/11 noted R32 to be independent with repositioning and off-loading. A wound evaluation flow sheet, initiated 2/22/12 identified a pressure ulcer on the right heel. On 2/23/12 the pressure ulcer was identified to be 1.5 cm in diameter and to be a DTI (Deep Tissue Injury). There was no drainage or pain identified. Prevention identified was leaving shoes off, and foam boots in bed. On 2/28/12 the wound is documented to be 1.3 cm in diameter with no drainage or pain, blanching tissue and soft edges. There was no staging identified for the 2/28/12	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 39	F 314		

entry. On 2/22/12 documentation indicated the GNP (Geriatric Nurse Practitioner) was updated as she was here at the time and the GNP informed staff to use a pressure relief boot at night. The plan of care was documented as initiated on 2/26/12 after the pressure ulcer developed.

On 2/26/12 at 10:40 a.m. R32 was observed wearing black dress shoes which slid on the tile floor. At 8:45 a.m. on 2/28/12 R32 was observed sitting in the recliner with her feet up on a stool with pressure directly on both heels. Although there was a decorative square pillow on the stool, R32 ' s heels were observed to rest directly on the hard surface of the stool.

At 10:30 a.m. on 2/28/12 the pressure ulcer was observed with licensed practical nurse (LPN)-C. According to LPN-C, the pressure ulcer was being left open to air and R32 wore a boot in bed. LPN-C further indicated the pressure ulcer did hurt R32 "some." When R32 was asked about pain with the ulcer she stated, "That hurts some" when the wound was touched but when left alone "it doesn't hurt." The pressure ulcer was observed to remain intact with significant redness surrounding the blister. LPN-C confirmed the observation.

At 9:00 a.m. on 2/29/12 nursing assistant (NA)-F identified the heel boot worn in bed by R32. NA-F confirmed the heel boot was only worn on the right heel and only worn when in bed. The heel boot observed with NA-F was a plaid, quilted heel boot which provided minimal pressure relief.

At 10:40 a.m. on 2/29/12 The Director of Nursing

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
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 314	Continued From page 40 (DON) stated she was unaware the heel boot currently being used was not a pressure relieving device. She further stated R32 ' s shoes had been put on the top shelf of the closet so they would not be used. The DON was surprised that the shoes were being used again. She further indicated the ADON was in charge of skin care and would know more about R32 skin needs. At 11:15 a.m. the ADON was interviewed regarding R32's pressure ulcer. The ADON stated, "She used to be a lot more mobile but she's not as much anymore. I'm thinking she's had a physical decline too in terms of doing things for herself. I told her she should have her heel protector on if she's got her feet up ... I need to include it to use on the recliner as well. She always wore those black dress shoes ... it was rubbing up and down on her foot. She probably shouldn't have been wearing them to begin with." The ADON was unaware the heel boot currently being utilized was not pressure relieving type. The ADON indicated she would work with therapy and obtain a pressure relieving boot, further indicating she would obtain boots for both feet.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F 323 SS=D** **Resident # 32 is receiving adequate supervision and assistive devices to prevent accidents.** **All residents who require supervision and/or assistive devices to prevent accidents are at risk for this same practice.** **All nursing staff and the maintenance director have been re-educated regarding the provision of supervision and properly functioning assistive devices to meet the safety needs of the resident and prevent accidents.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 41a	

F 323 SS=D

Resident # 32 is receiving adequate supervision and assistive devices to prevent accidents.

All residents who require supervision and/or assistive devices to prevent accidents are at risk for this same practice.

Nursing staff and the maintenance director have been re-educated regarding the provision of supervision and properly functioning assistive devices to meet the safety needs of the resident and prevent accidents.

A weekly audit will be completed to assure compliance. Two audits weekly for proper function of equipment. Weekly audit on IDT falls intervention effectiveness. Monitored and reviewed by DNS or designee and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 323	Continued From page 41 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 1 of 2 residents (R32) reviewed for falls in the sample. Findings include: R32 had a history of frequent falls and there had not been an ongoing assessment following the falls for effectiveness of interventions and possible development of new interventions based on these assessments. Also there were no significant injuries as a result of the fall/s. R32 had multiple diagnoses including osteoarthritis, Alzheimer's disease and Diabetes Mellitus. The nursing quarterly review dated 1/24/12 identified no falls this quarter however contained addendums for falls on 2/14/12, 2/20/12 and 2/22/12. The medical record identified R32 to be at risk for falls and the care plan contained a goal of no fall related injuries. Therapy notes identified R32 was currently seeing occupational therapy (OT) for wheel chair (w/c) positioning as she was having more knee pain and using the wheelchair more. R32 had been seeing physical therapy (PT) in January 2012 for pain management, ambulation and transfers. On 2/26/12 at 10:40 a.m. R32 was observed to stand up from her wheelchair. She was wearing black dress shoes which slipped on the tile floor, the alarm did not sound, and the auto-lock brakes were not functioning. R32 was heard to comment on the floor being "slippery " . At 8:45 a.m. on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 323	Continued From page 42 2/28/12 when checked, the anti-rollback wheelchair brakes did not work. They continued to allow the chair to roll back and failed to engage. At 8:55 a.m. on 2/29/12 R32 was observed in the hallway attempting to stand independently. She wore slipper like shoes which slipped out from underneath her and her wheelchair wheeled away from her as she attempted to stand. Although she was able to get her buttocks off the chair, the alarm did not sound. At 10:30 a.m. on 2/29/12 the DON indicated she would check on the alarm, anti-roll back brakes and shoes for R32. "They should be working." R32 experienced falls on 6/6/11 at 9:00 a.m. and again at 8:20 p.m., 7/8/11, 7/18/11, and 8/6/11. According to the fall report summaries, 4 of the 5 falls were caused by a loss of balance. There was no evidence of an evaluation for a cause for the loss of balance. There was no evidence of a review of interventions following the falls. The Director of Nursing (DON) stated at 10:10 a.m. on 2/29/12 that the facility does a pharmacy review after every fall to see if any medications could have contributed to the fall. The DON further indicated staff completed neuro (neurological) assessments and reviewed the residents for injury but there was no further assessment for the loss of balance. "We would do orthostatic blood pressures if it was recommended by the pharmacist or NP (nurse practitioner) but we wouldn't just do them. We didn't look at that (the loss of balance) we wait for direction." The DON further indicated that after the fall in 8/11 it was determined R32 needed more assistance with mobility and would require staff stand by assist	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 323	Continued From page 43 with transfers and ambulation. The DON stated R32 needed more assistance due to a significant increase in knee pain then said, " She has horrible osteoarthritis in her knees, she's had injection, she's seen therapy." R32 had a fall from the wheelchair on 1/28/12 which was not reviewed by the Interdisciplinary Team (IDT) until 1/30/12. The recommendations taken by staff to avoid further reoccurrence were to educate staff and to be "diligent when hearing w/c alarms." The IDT identified the need for anti-roll back locks for the wheelchair following the fall. R32 fell from bed on 2/4/12 due to increased confusion and hallucinations according to the staff review. The incident was not reviewed by the IDT until 2/6/12. The staff identified alarms in place and provides reassurance. The IDT provided a matt at bedside. Although there was a change in condition, there was no evidence of an acute assessment and there was no evidence of a review of effectiveness of current interventions. On 2/13/12 R32 fell from her wheelchair, the alarm was sounding and she had a pummel cushion in her wheelchair. The IDT decided to replace the pummel cushion with a wedge cushion following this fall. R32 fell from bed trying to go to the bathroom on 2/18/12 which was reviewed by the IDT on 2/20/12. The immediate interventions of staff were to check and toilet R32 every 2 hours and provide a pain assessment. Although R32 should already have been on an every 2 hour toileting schedule, there was no evidence that toileting plan was reviewed for effectiveness. The IDT completed a pain assessment and requested OT services for wheelchair positioning. R32 had a fall from her w/c on 2/19/12 which was reviewed by the IDT on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 323	Continued From page 44 2/20/12. Although R32 has Alzheimer's dementia, the staff's immediate intervention was to educate the resident. R32 had another fall from bed on 2/21/12. The staff educated R32 to use the call light even though she has Alzheimer's and the IDT placed a concave mattress on the bed and lab work per MD order. There was no review of current interventions to assist with determining their effectiveness related to the falls. Interview with the DON at 10:10 a.m. on 2/29/12 indicated she was unable to say specifically what interventions were in place prior to each fall, "Some of them are dated here on the care plan but they're not all here." The DON further indicated there were a variety of places they documented the information from a fall: the incident report, the fall scene investigation, the post fall change in condition report and the progress notes. The DON stated the facility has been working on the fall process since summer and "it's getting better but we're not there yet." She confirmed the data to be accurate and indicated they do on the spot education with staff as needed and had done formal education on falls and completing incident reports and gathering data in 10/11.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329		

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
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 329	Continued From page 45 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 interview and document review, the facility failed to identify, assess and monitor clinical indications for ongoing use of pain medications for 2 of 10 residents (R28 and R32) reviewed in the sample. Findings include: R28 was receiving pain medications without adequate parameters for use. R28 had multiple diagnoses including a history of multiple fractures and Alzheimer's disease. R28 was receiving hospice services for end stage dementia. R28 had physician orders for as needed Tylenol and Morphine Sulfate (MS) for pain. However, there were no parameters for the administration of either pain medication as to when the Tylenol and MS was to be given.	F 329	**F 329 SS=D** **Resident # 28 has parameters in place for administration of prn Morphine and prn Tylenol. Resident # 32 has had her Abilify dose decreased and then discontinued.** **All residents on prn pain medications or Abilify have the potential to be affected by this practice.** **All Licensed Nurses and the IDT have been re-educated regarding the need for parameters for prn pain medication use. They were also re-educated to have adequate indications for use and the lowest possible dose for Abilify with documented risks and benefits discussion with the resident or responsible family by the MD.** **A weekly audit will be completed to assure compliance and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 46a	

F 329 SS=D

Resident # 28 has parameters in place for administration of prn Morphine and prn Tylenol. Resident # 32 has had her Abilify dose decreased and then discontinued.

All residents on prn pain medications or Abilify have the potential to be affected by this practice.

Nurses and the Inter-Disciplinary Team have been re-educated regarding the need for parameters for prn pain medication use. They were also re-educated to have adequate indications for use and the lowest possible dose for Abilify with documented risks and benefits discussion with the resident or responsible family by the MD.

A weekly audit will be completed to assure compliance. Weekly audits will be monitored and reviewed by DNS or designee and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 329	Continued From page 46 Review of the physicians order form it was noted that R28 received a physician ' s order on 10/18/11 for Tylenol 500 mg/15 ml 500 mg liquid by mouth three times a day as needed for pain. On 1/18/12 R28 received a physician's order for MS 20 mg/ml give 5 mg sublingually every 2 hours as needed. Review of the Medication Administration Records (MAR's) for 12/11, 1/12 and 2/12 revealed no Tylenol or MS had been administered in 12/11 or 1/12. In 2/12 only MS had been administered and no Tylenol had been given. Between 2/1/12 and 2/28/12 18 doses of MS had been given for back, hip, breast and knee pain. There was no evidence of the level of pain R28 was having at the time of the MS administration. Although a location of pain was identified, the pain intensity rating was blank. At 1:30 p.m. on 2/28/12 the director of nursing (DON) stated she was uncertain why there were no parameters for use on the Tylenol and MS pain medications but she would check into it. At 3:00 p.m. the DON stated she contacted hospice to seek clarification for when to use the medications. The DON then provided a copy of the faxed order from hospice to use the " dementia pain scale " and administer Tylenol for pain rated at 0-3 and MS for pain rated at 4-10. R32 was receiving an antipsychotic medication Abilify for an extended period of time without adequate indications for use and evidence it was at the lowest possible dose. There was also no risk vs. benefit review for the ongoing use of Abilify.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 329	Continued From page 47 R32 had multiple diagnoses including Alzheimer's dementia. R32 had an order for Abilify 10 mg every day since 12/10. Per the facility drug handbook 2012 Pharmerica "Specialized Long-Term Care Nursing Drug Handbook" noted for Abilify "Special Geriatric Consideration: Elderly patients have an increased risk of adverse response to antipsychotics. Aripiprazole [Abilify] has been studied in elderly patients with psychosis associated with Alzheimer's disease. Clinical data have shown an increased incidence of cerebrovascular events in the elderly, some fatal. In light of significant risks and adverse effects in the elderly population, an extensive risk benefit analysis should be performed prior to use. Abilify's delayed onset of action and long half-life may limit its role in treating older persons with psychosis. Not approved for the treatment of patients with dementia-related psychosis." R32 had a visit from the psychologist on 1/9/12. The psychologist recommends a reduction in the Abilify since R32 was no longer exhibiting signs of paranoia. A 2/20/12 consulting pharmacy recommendation suggested to the physician a reduction in Abilify to ensure the lowest possible dose. The Geriatric Nurse Practitioner (GNP) refused the dosage reduction indicating the "condition is not well controlled" but failed to provide the resident specific rationale for ongoing use. Interview with the (DON) on 2/28/12 at 2:45 p.m. identified she was able to find a signed consent for the medication from the family, however was	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 329	Continued From page 48 unable to find any additional information on the risk vs. benefit for the continued medication dose.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure drug irregularities were identified by the consultant pharmacist and acted upon by the director of nursing and the physician for 2 of 10 residents (R28 and R32) reviewed for unnecessary medications. R28 was receiving pain medications without adequate parameters for use. R28 had multiple diagnoses including a history of multiple fractures and Alzheimer's disease. R28 was receiving hospice services for end stage dementia. R28 had physician orders for as needed Tylenol and MS (Morphine Sulfate) for pain. There were no parameters for the administration of either medication identifying when to give the Tylenol and when to give the MS. R28 received an MD order on 10/18/11 for Tylenol 500 mg/15 ml 500	F 428	**F 428 SS=D** **Resident # 28 and # 32 has had their medications reviewed for any drug irregularities by the consultant pharmacist and acted upon by the Director of Nursing.** **All residents who receive medications in this facility have the potential to be affected by this same practice.** **The Consultant Pharmacist and the Director of Nursing has been re-educated on their roles related to identifying and correcting any drug irregularities.** **A monthly audit will be completed after the Consultant Pharmacist visits to assure compliance with this plan and the results will be brought to the QA Meeting for review and discussion.** **The date for completion is 4/8/12** POC page 49a	

F 428 SS=D

Resident # 28 and # 32 has had their medications reviewed for any drug irregularities by the consultant pharmacist and acted upon by the Director of Nursing.

All residents who receive medications in this facility have the potential to be affected by this same practice.

The Consultant Pharmacist and the Director of Nursing has been re-educated on their roles related to identifying and correcting any drug irregularities.

A monthly audit will be completed after the Consultant Pharmacist visits to assure compliance. Monthly pharmacy audits will be monitored and reviewed by DNS or designee. and the results will be brought to the QA Meeting for review and discussion.

The date for completion is April 8th. Executive Director is responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 428	Continued From page 49 mg liquid by mouth three times a day as needed for pain. On 12/30/11 R28 got a physician's order for MS 10 mg/5 ml solution by mouth give 5 mg every 2 hours as needed for pain and shortness of breath. On 1/18/12 R28 received a physician's order for MS 20 mg/ml give 5 mg sublingually every 2 hours as needed. Review of the Medication Administration Records (MAR's) for 12/11, 1/12 and 2/12 revealed no Tylenol or MS had been administered in 12/11 or 1/12. In 2/12 only MS had been administered and no Tylenol had been given. Between 2/1/12 and 2/28/12 18 doses of MS had been given for back, hip, breast and knee pain. There was no evidence of the level of pain R28 was having at the time of the MS administration. Although a location of pain was identified, the pain rating was blank. Review of the consulting pharmacist recommendations for 1/12 and 2/12 the irregularity with the pain medications not having parameters for use was not identified by the consulting pharmacist. There were no recommendations for either Tylenol or MS from the pharmacist. At 1:30 p.m. on 2/28/12 the DON stated she was uncertain why there were no parameters for use. At 3:00 p.m. the DON provided a copy of the faxed order from hospice to use the dementia pain scale and administer Tylenol for pain rated at 0-3 and MS for pain rated at 4-10. R32 was receiving an antipsychotic medication Abilify (aripiprazole) since 12/10 without adequate	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 428	Continued From page 50 indications for use and evidence it was at the lowest possible dose. R32 had multiple diagnoses including Alzheimer's dementia. The consulting pharmacist recommendation dated 2/20/12 identified the long term use of Abilify and requested the physician "evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose." On 2/22/12 the Geriatric Nurse Practitioner (GNP) identified no dose reduction in Abilify as the "condition is not well controlled/stable and a reduction is likely to impair the resident's function and/or cause psychiatric instability." Although the form completed by the GNP instructed the practitioner to "Please elaborate with patient specific information" the practitioner provided no additional information in her progress note or the consulting pharmacists form. The GNP order was noted by the Assistant Director of Nursing (ADON) on 2/22/12 and "No dose reduction" was neither identified nor clinical justification to continue the medication at its current dose which must include the risk vs. benefit of the medication.	F 428		

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

F5348020

PRINTED: 03/20/2012
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
	245348	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Golden Living Center-Rush City 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 TO: PATRICK SHEEHAN, SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000	RECEIVED MAR 30 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION **K 038 SS = F** **Combinations for the secured Memory Unit are posted by the two doors. One is posted by the door back into the interior of the building and the other code is posted by the door to the exterior of the building.** **All residents who reside in the facility have the potential to be affected by this.** **The Maintenance Director and Executive Director will be responsible for ensuring that the codes are posted at all times and changed if necessary to the secured Memory Unit.** **The date for Completion is April 8th, 2012** POC ok FS 4-2-12	

DC, 04.09.2012

EXIT: 02.28.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsey Callahan, LNHA

TITLE: EXECUTIVE DIRECTOR

(X6) DATE: 3/28/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 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.	K 000		
	Golden Living Center-Rush City is a 1-story building with a partial basement. The building was constructed in 1967. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation the exit doors in the	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 038	Continued From page 2 Memory Loss wing are secured electronically. The doors are equipped with a key pad to release the locks. However, the combination for the locks are not located on the doors as required by LSC(00) Section 19.2.2.2.5. This deficient practice could effect all patients, staff and visitors. Findings include: During the facility tour on 2-28-12 at 9:15 AM it was observed that the combination for key pad of the exits, two (2) is not posted on the door(s) ~~These doors are located in the Memory Loss unit.~~ One of these is back into the interior of the building and the other is to the exterior of the building. was not posted, on the door. These deficient practices were confirmed by the Director of Maintenance (JF) and the Administrator (KC) at the time of exit.	K 038		