DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicare/Medicaid Certification and Transmittal
Part I - To Be Completed by the State Survey Agency

Facility ID: 00942
ID: FEIG

Facility: GOLDEN LIVINGCENTER - WHITEWATER
525 BLUFF AVENUE
ST CHARLES, MN 55972

1. MEDICARE/MEDICAID PROVIDER NO.
245270
(L1)

2. STATE Vendor or MEDICAID NO.
823957600
(L2)

3. NAME AND ADDRESS OF FACILITY
GOLDEN LIVINGCENTER - WHITEWATER
525 BLUFF AVENUE
ST CHARLES, MN 55972
(L4) (L5)

4. TYPE OF ACTION:
7. Full Survey After Complaint
(L8)

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

6. DATE OF SURVEY
10/17/2013
(L34)

8. ACCREDITATION STATUS:
02 Accredited
(L10)

9. PROVIDER/SUPPLIER CATEGORY
02 SNF/NF/Dual
09 ESRD
13 PTIP
22 CLIA
(L7)

10. THE FACILITY IS CERTIFIED AS:
A. Not in Compliance with Program Requirements
And/or Approved Waivers Of The Following Requirements:
2. Technical Personnel
6. Scope of Services Limit
3. 12 Hour RN
7. Medical Director
4. 7-Day RN (Rural SNF)
8. Patient Room Size
5. Life Safety Code
9. Beds/Room

* Code: A*
(L12)

11. LTC PERIOD OF CERTIFICATION
From: 04/01/2006
To: 12/31/2013

12. Total Facility Beds
55
(L18)

13. Total Certified Beds
55
(L17)

14. LTC CERTIFIED BED BREAKDOWN
18 SNF
18/19 SNF
19 SNF
ICF
IID
55
(L37) (L38) (L39) (L42) (L43)

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

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

Post Certification Revisit by review of the facility’s plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and LSC. Effective October 9, 2013, the facility is certified for 55 skilled beds.

17. SURVEYOR SIGNATURE
Gary Nederhoff, Unit Supervisor 10/09/2013

18. STATE SURVEY AGENCY APPROVAL
Colleen B. Leach, Program Specialist 12/26/2013

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

21. TERMINATION ACTION:
00 VOLUNTARY
IN VOLUNTARY
01-Merger, Closure
05-Fail to Meet Health/Safety
02-Dissatisfaction W/ Reimbursement
06-Fail to Meet Agreement
03-Risk of Involuntary Termination
07-Provider Status Change
04-Other Reason for Withdrawal
00-Active

22. ORIGINAL DATE OF PARTICIPATION
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. REMARKS

27. ALTERNATIVE SANCTIONS

28. TERMINATION DATE:

29. INTERMEDIARY/CARRIER NO.
00454
(L28)

30. RO RECEIPT OF CMS-1539
11/21/2013
(L32)

31. DETERMINATION OF APPROVAL DATE

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)
Dear Ms. Otto:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 9, 2013, the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility’s Medicare approved area consists of all 55 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,

Colleen B. Leach
Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File
November 19, 2013

Ms. Dena Otto, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

RE: Project Number S5270022

Dear Ms. Otto:

On September 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 30, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 17, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 26, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 30, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 30, 2013, effective October 9, 2013 and therefore remedies outlined in our letter to you dated September 16, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File
## Post-Certification Revisit Report

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

### Name of Facility

**GOLDEN LIVINGCENTER - WHITEWATER**

### Street Address, City, State, Zip Code

525 BLUFF AVENUE
ST CHARLES, MN 55972

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).

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Reviewed By:  
State Agency: GS/AK  
Date: 11/19/2013  
Signature of Surveyor: 10160  
Date: 10/17/2013  

Followup to Survey Completed on: 8/30/2013  
Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES  NO
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).

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Reviewed By _______ Reviewed By PS/AK Date: 11/19/2013 Signature of Surveyor: 25822 Date: 10/26/2013

Followup to Survey Completed on: 8/28/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERs FOR MEdICARE & MEdICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FEIG
Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245270

2. STATE VENDOR OR MEDICAID NO. (L2) 823957600

3. NAME AND ADDRESS OF FACILITY
   (L3) GOLDEN LIVINGCENTER -
   (L4) WHITETWATER 525 BLUFF AVENUE
   (L5) ST CHARLES, MN
   (L6) 55972

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

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

6. DATE OF SURVEY (L34) 08/30/2013

7. PROVIDER/SUPPLIER CATEGORY (L7) 02

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

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

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

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

11. LTC CERTIFIED BED BREAKDOWN
    18 SNF
    18/19 SNF
    19 SNF
    ICF
    IID

    (L37)
    (L38)
    (L39)
    (L42)
    (L43)

12. Total Facility Beds 55 (L18)

13. Total Certified Beds 55 (L17)

14. FACILITY MEETS
    1861(e)(1) or 1861(f)(1):

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

See Attached Remarks

16. SURVEYOR SIGNATURE
    Date: 09/30/2013
    Kyla Einertson, HFE NE II

17. STATE SURVEY AGENCY APPROVAL
    Date: 11/21/2013
    Kate JohnsTon, Enforcement Specialist

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

18. DETERMINATION OF ELIGIBILITY
    1. Facility is Eligible to Participate
    2. Facility is not Eligible

19. COMPLIANCE WITH CIVIL RIGHTS ACT:
    1. Statement of Financial Solvency (HCFA-2572)
    2. Ownership/Control Interests Disclosure Stmt (HCFA-1513)
    3. Both of the Above:

20. ORIGINALE DATE
    OF PARTICIPATION
    BEGINNING DATE
    ENDING DATE
    01/01/1985

21. ALTERNATIVE SANCTIONS
    A. Suspension of Admissions:
    B. Recind Suspension Date:

22. TERMINATION DATE:
    BEGINNING DATE
    ENDING DATE
    00

23. VOLUNTARY
    INVolUNTARY
    01-Merger, Closure
    05-Fail to Meet Health/Safety
    02-Dissatisfaction W/ Reimbursement
    06-Fail to Meet Agreement
    03-Risk of Involuntary Termination
    OTHER
    04-Other Reason for Withdrawal
    07-Provider Status Change
    00-Active

24. REASONS

25. DETERMINATION OF APPROVAL DATE
    11/21/2013

FORM CMS-1539 (7-84) (Destroy Prior Editions)
At the time of the standard survey completed August 30, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.
Certified Mail # 7011 2000 0002 5143 7067

September 16, 2013

Ms. Dena Otto, Administrator
Golden LivingCenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota  55972

RE: Project Number S5270022

Dear Ms. Otto:

On August 30, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 30, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5270009.

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

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

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

**Opportunity to Correct** - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

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

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

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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-271

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 9, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 9, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

**Original deficiencies not corrected**

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

**Original deficiencies not corrected and new deficiencies found during the revisit**

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

**Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by November 30, 2013 (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 March 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541
Feel free to contact me if you have questions.

Sincerely,

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

Enclosure (s)

cc: Licensing and Certification File
Department of Health and Human Services
Centers for Medicare & Medicaid Services

Statement of Deficiencies and Plan of Correction

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Name of Provider or Supplier

Golden LivingCenter - Whitewater

Street Address, City, State, Zip Code

525 Bluff Avenue

St. Charles, MN 55972

<table>
<thead>
<tr>
<th>(X4) Id Prefix</th>
<th>(X5) Completion Date</th>
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<thead>
<tr>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<tbody>
<tr>
<td>A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5270009 had not been substantiated during this survey.</td>
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<tr>
<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-referenced to the Appropriate Deficiency)</th>
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<tbody>
<tr>
<td>Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correct within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</td>
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F000: 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.

A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5270009 had not been substantiated during this survey.

F282: 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 written care plan was followed for personal hygiene for 1 of 1 resident (R14) reviewed for activities of daily living.

Findings include:

R14 was observed to have facial hair and had

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<th>Laboratory Director's or Provider/Supplier Representative's Signature</th>
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<td>(X9) Date</td>
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<tr>
<td>9/30/13</td>
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Facial hair was removed via electric razor for resident R14.

- All Residents have the potential to be affected by this practice.
- Audits will be completed by DNS or designee weekly to ensure staff are performing personal cares as stated on care plan.
- MDS coordinator will review audit results. Any discrepancies with the care plans found in the audits will be addressed to the

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.
### F 282

Continued From page 1

been assessed to need assistance of staff to maintain personal grooming which included the removal of facial hair per the comprehensive care plan.

R14 was admitted on 1/3/09 with diagnoses that included but were not limited to lumbago, edema, chronic airway obstruction, osteoporosis, anxiety, depressive disorder, and hypertension.

Review of the care plan dated 5-27-13, revealed R14 required assist of one staff with her personal hygiene care and instructed staff to remove any unwanted facial hair.

During an observation on 8-27-13 at 10:09 a.m., R14 was observed to have short hairs around her chin. On 8-28-13 at 3:34 p.m., R14 was observed to have short hairs around her chin. Again on 8-29-13 at 7:54 a.m., R14 was observed to have short hairs around her chin.

During interview on 8/29/13, at 10:44 a.m., nursing assistant (NA)-B indicated that facial hair removal was to be completed with morning cares. NA-A verified R14's morning cares were completed and verified shaving had not been completed for R14 today.

During an interview on 8/29/13 at 1:01 p.m., R14 stated she would like staff to shave her facial hair if needed.

During an interview on 8/29/13 at 3:24 p.m., the assistant director of nursing (ADON) stated she expected the nursing assistant to see if residents needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, I would expect the staff

<table>
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<th>F 282</th>
<th>staff on a 1:1 basis as discovered</th>
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<td></td>
<td>Nursing staff will be educated on following care plans and to notify the social worker when new hygiene products or equipment is needed</td>
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<td>Results of audits will be compiled for discussion and review at QA meetings for IDT to discuss compliance and any further actions needed for 3 months</td>
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Corrective Action will be completed by: 10/4/2013
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<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
F 312: Continued From page 3
with personal hygiene.

Review of the care plan dated 5/27/13, revealed R14 required assist of one staff with her personal hygiene care and instructed staff to remove any unwanted facial hair.

During an observation on 8/27/13 at 10:09 a.m., R14 was observed to have short hairs around her chin. On 8/28/13 at 3:34 p.m., R14 was observed to have short hairs around her chin. Again on 8/29/13 at 7:54 a.m., R14 was observed to have short hairs around her chin.

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During an interview on 8/29/13 at 1:01 p.m., R14 stated she would like staff to shave her facial hair as needed.

During an interview on 8/29/13 at 3:24 p.m., the assistant director of nursing (ADON) stated she expected the nursing assistant to see if residents needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, I would expect the staff member to complete the task. ADON verified a care plan that indicated staff assist of one with personal hygiene would include shaving facial hair.

F 315: 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315: A bladder assessment was completed for resident R52 to address indwelling catheter on
**F 315**  Continued From page 4

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

- Based on observation, interview and document review, the facility failed to reassess bladder function after initiation of an indwelling Foley catheter for 1 of 3 residents (R52) reviewed for urinary catheter use.

Findings include:

- R52 was readmitted from the hospital on 8/5/13, with diagnoses that included severe sepsis and urine retention. The 14 day Minimum Data Set (MDS) a comprehensive assessment dated 8/17/13. identified R52 was alert and oriented with no cognitive deficit and required extensive assist with toileting needs. During review of nursing progress note dated 8/21/13, noted a call was placed to primary physician to update on R52's urinary status. R52 had been having frequency in urine every 15-30 minutes of approximately 50 cc of urine. R52 had a physician order for indwelling Foley catheter to be inserted on 8/21/13.

- During observation on 8/28/13, at 8:36 p.m. noted R52 had a catheter leg bag on left leg. This was

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<td>F 315</td>
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<td>• All residents who have indwelling catheters have the potential to be affected by this practice.</td>
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<td>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</td>
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<td>• Audits will be completed monthly by the ADNS or designee. ADNS will track all residents with indwelling catheters and ensure bladder assessments are accurate.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>• Licensed nursing staff will be educated on bladder re-assessment with foley catheter placement.</td>
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<td>Based on observation, interview and document review, the facility failed to reassess bladder function after initiation of an indwelling Foley catheter for 1 of 3 residents (R52) reviewed for urinary catheter use.</td>
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<td>• DNS/Designee will complete random audits to ensure all residents are receiving oral care per residents plan of care.</td>
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<td>Findings include:</td>
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<td>R52 was readmitted from the hospital on 8/5/13, with diagnoses that included severe sepsis and urine retention. The 14 day Minimum Data Set (MDS) a comprehensive assessment dated 8/17/13. identified R52 was alert and oriented with no cognitive deficit and required extensive assist with toileting needs. During review of nursing progress note dated 8/21/13, noted a call was placed to primary physician to update on R52's urinary status. R52 had been having frequency in urine every 15-30 minutes of approximately 50 cc of urine. R52 had a physician order for indwelling Foley catheter to be inserted on 8/21/13.</td>
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<td>Corrective Action will be completed by:</td>
<td>10/4/2013</td>
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F 315 Continued From page 5 connected to a Foley catheter.

During review of R52’s bladder assessment on 8/18/13, identified R52 was able to recognize need for toileting and would let staff know when needed to use the urinal or bathroom. No assessment was completed when catheter was initiated.

During review of care plan date revised 8/22/13, indicated R52 had alteration in elimination status due to urinary retention and identified indwelling Foley catheter.

During interview on 8/20/13, at 10:19 a.m. the assistant director of nursing (ADON) verified the bladder status assessment should had been updated to show the current use of an indwelling Foley catheter.

During review of Incontinence Management/Bladder Function Guideline dated 2013, directed staff in the use of indwelling catheter justification/decision diagram to assist with evaluation of indwelling catheters. The policy identified an evaluation of causal factors determines program initiated and incontinent residents are assessed per the guideline.

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

Based on a resident’s comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible; and

F 325:
The RD completed a nutritional assessment for R52. MD was aware of weight loss and added an addendum to her dictation showing weight loss was expected secondary to treatment of CHF with diuretic.
F 325 Continued From page 6
   (2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
   Based on interview and document review, the facility failed to implement interventions after completing an assessment for significant weight loss for 1 of 3 residents (R52) reviewed for nutrition.

Findings include:
R52 had not maintained acceptable parameters of nutritional status related to a significant weight loss that had not been addressed by the facility.

R52 was admitted on 7/26/13, and readmitted from the hospital on 8/5/13, with diagnoses that included but not limited to severe sepsis and anemia. R52's 14 day Minimum Data Set (MDS) dated 8/17/13, indicated R52 had a weight gain of 5% or more in the last month with a weight of 189. According to hospital admission noted dated August 1, 2013, R52's appetite had been poor since last hospitalization and attributes it to being asked to "watch what he eats and also restrict fluids."

A nutritional assessment note dated 8/21/13, completed by dietary services manager (DSM) identified R52 had an admission weight of 204 pounds (lbs.) and current weight was 189 indicated a 5% or 15 pound weight loss. The assessment revealed R52 had not been on a physician prescribed weight loss program. R52's

- All Residents using have the potential to be affected by this practice.
- Residents' last weights will be put on CNA worksheet for them to compare current weight to see if there is a change and a re-weigh is needed.
- DSM and DNS/ADNS will meet weekly and review all residents documented weights for significant changes. They will also ensure that the RD and MD are notified with concerns related to weight loss or weight gain and make sure that assessments, interventions and documentation is in place.
- The RD will perform an audit monthly on entire resident population for significant weight loss.
- Nursing Staff will be educated to verify and report significant weight changes to the DSM and educated on the re-weigh guideline.
- Results of audits will be compiled for discussion and review at QA meetings for IDT to discuss compliance and any further actions needed for 3 months.

Corrective Action will be completed by: 10/4/2012
F 325 Continued From page 7

average meal intake was 63%.

R52's documented weights since admission:
Weight at admission (07/26/2013) was 204 lbs.
Weight on 08/10/2013 was 192 pounds which was a 5.9% or 12 pound weight loss in fourteen days.
Weight on 08/27/2013 was 188 pounds which was a 7.8% or 16 lbs. weight loss from admission on 07/26/13.

During review of R52's care plan dated 8/21/13, identified to be at nutritional risk due to therapeutic diet, weight may fluctuate due to diuretic (is any substance that promotes the production of urine.) use and fluid restriction. Goal was to follow diet and fluid restriction. Interventions included monitor weight per physician orders.

During interview on 8/29/13, at 1:28 p.m. the DSM verified R52 was assessed to be at risk for weight loss as identified on the nutrition assessment instead of weight gain according to the 14 day MDS. The DSM verified R52 was not on any type of supplement or any other nutritional interventions at this time. The DSM indicated that the department managers talk daily about weight loss in stand-up (meeting with department heads to discuss resident concerns) and would also send note to primary physician if weight loss was identified to see what interventions would be needed. The DSM indicated they would also send an update to the registered dietician. The DSM indicated they would first start with adding sandwich at bedtime or ice cream. The DSM figured admission weight at 204 lbs. and most current weight was 188 lbs. which identified a 9% weight loss form admission. The DSM confirmed
Continued From page 8

they had not realized R52 had a significant weight loss and verified had not recently checked R52's weight. The DSM indicated the licensed nurses could update me the DSM if a weight loss was noted when documenting weights. The DSM indicated had not been notified of a weight loss from nursing staff concerning R52. During interview on 8/29/13, at 2:33 p.m. the registered dietician (RD) indicated R52 was on routine diuretic for diuresis but verified the physician should had documented in the chart to indicate weight loss expected due to diuretic therapy. The RD indicated the DSM does typically notify the RD when weight loss was present. The RD confirmed had not been aware of R52's weight loss.

During review of weight monitoring policy dated 2011, indicated all weights would be reviewed by the DSM and the RD would be notified of any significant weight changes or trends through the referral process.

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not

F 329: Physician justification was added to the medical record to the prescribed Haldol with specific symptoms/parameters for usage or resident R54. A sleep assessment was completed for resident R52.

- All residents using antipsychotics and hypnotics
F 329 Continued From page 9

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<td>F 329</td>
<td>Continued From page 9</td>
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<td>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.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to have a physician's justification for use of an antipsychotic (Haldol) medication for anxiety vs. a psychotic diagnosis with symptoms that warrants the use of Haldol for 1 of 5 residents (R54) who received Haldol for anxiety and the facility failed to complete a sleep assessment which includes the sleep pattern prior to the initiation of a hypnotic (Trazodone) medication for 1 of 5 residents (R52) who had been reviewed for unnecessary medications.

Findings include:

R54 received as needed Haldol, an antipsychotic medication, without specific indications for use and a clear justification to use this antipsychotic medication out of class for treating anxiety. There is a warning with use of Haldol as found in the Drug Information Handbook for Nursing 11th Edition 2011 it read: "WARNING Increased Mortality in Elderly Patients with Dementia-Related Psychosis. Elderly patients with dementia-related psychosis treated with

have the potential to be affected by this practice.
- The social worker will audit three residents per week to ensure proper documentation related to diagnosis and specific parameters are in place for any ordered antipsychotics.
- DNS or designee will audit residents using hypnotics for sleep to ensure sleep assessment are completed on a monthly basis.
- Nursing Staff will be educated on ensuring a diagnosis is in place for antipsychotics and that sleep assessments are in place for place for hypnotics used for sleep.
- Results of audits will be compiled for discussion and review at QA meetings for IDT to discuss compliance and any further actions needed for 3 months.

Corrective Action will be completed by: 10/4/2012
F 329 Continued From page 10
antipsychotic drugs are at an increased risk of
death compared to placebo.  "
R54 was admitted 5/15/11, with diagnosis that
included anxiety, Alzheimer’s disease and
dementia.

The facility identified R54 on the quarterly
Minimum Data Set (MDS), an assessment dated
5/14/13, to have short and long term memory
problem, severely impaired decision making, no
moods, no behaviors, and received
anti-depression medications.

Document review of physician orders dated
8/20/13, revealed orders for Haldol 0.5 milligrams
every eight hours as needed for anxiety, with a
start date of 8/20/13.

During observations on 8/30/13, at 11:20 a.m.,
R54 sat in the lobby watching other residents play
bingo.

Document review of the resident care plan dated
6/24/11, read R54 felt sad and restless and
interventions included offer food, fluids, and
administer medications.

Document review of facility daily behavior
observation log, revealed behavior monitoring for
Haldol began on 8/27/13, and seven days after as
needed Haldol was initiated. Behavior monitoring
revealed target behaviors of delusional thinking
and anxious. Behavior monitoring revealed no
behaviors on 8/27/13, no behaviors on 8/28/13,
and on 8/29/13, had behavior of anxious (the
specific behaviors exhibited to indicate anxiety
were not identified) with intervention of redirection
and quiet, with behavior improved.
F 329\* Continued From page 11
During interview 8/30/13, at 10:48 a.m.,
registered nurse (RN)-A, verified lack of specific
resident symptoms for use of as needed Haldol.
RN-A verified R54's order for Haldol as needed
for anxiety, dated 8/20/13. RN-A verified R54
received the following 3 doses of as needed
Haldol, 8/20/13, 8/22/13, and 8/25/13.
R52 was not comprehensively assessed for
insomnia prior to the use of the hypnotic
(Trazodone) a medication used to induce sleep.

R52 was readmitted to the facility on 8/6/13, with
diagnoses including insomnia. Current physician
orders were reviewed. It noted a physician order
for Trazodone 25 milligrams at bedtime related to
insomnia with a start date of 8/21/13.

Further review of the medical record, revealed
Trazodone was started with no evidence of a
sleep assessment to identify actual or potential
causes of a sleep problem, or evaluate
non-pharmacological intervention to promote
sleep. Also there was no evidence of ongoing
monitoring of sleep quality or hours of sleep to
determine if the medication was effective. The 14
day Minimum Data Set dated 8/17/13, indicated
R52 had no trouble falling or staying asleep or
sleeping too much.

During interview on 8/29/13, at 10:49 a.m. the
assistant director of nursing (ADON) confirmed
would like licensed nursing staff to use the sleep
monitoring tool to track and trend sleep patterns
and verified the form was not used on everybody.
The ADON indicated the form should be used on
residents on hypnotics or sedatives. The ADON
indicated if R52 was having problems sleeping
the sleep monitoring tool should had been
initiated to have the documentation prior to the
continued from page 12

medication being started. The ADON indicated the sleep hygiene assessment should have been redone within the first 7 days prior to initiation of the Trazodone.

Sleep assessment policy was requested and had not been provided.

F 371:

483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must:
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review, the facility failed to ensure milk was held at or below 41 degrees Fahrenheit before serving to the residents. This was not done in the dining room and had the potential to affect all residents who drank milk for the meal. There are 52 residents in the facility but not all requested milk or drank the milk once received.

Findings include:

Milk being served to the residence had a temperature of between 58.5 degrees and 63.4 degrees Fahrenheit.

Observations during the kitchen tour on 8/29/13,

F 329
F 371 Continued From page 13
at 11:21 a.m., revealed glasses filled with milk on a tray sitting on the counter for lunch tray line set up. The milk temperature at that time was 40 degrees Fahrenheit.

Observations of milk temperature on the test tray at 12:20 p.m., after the last tray was served from the cart, revealed milk was 58.5 degrees Fahrenheit. A glass of milk was removed from the dining table and was tested at 63.4 degrees Fahrenheit.

During interview on 8/29/13, at 12:35 p.m., dietary manager stated she expected milk to be served at 38-42 degrees.

Document review of facility policy Preparation, not dated, identified milk as potentially hazardous food. Facility policy Holding and Serving, undated, directed to hold potentially hazardous cold foods at a continuous temperature of 41 degrees Fahrenheit or below.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary

F 431:
- All Residents using narcotics may have the potential to be effected by this practice.
- DNS or designee will audit weekly the narcotic disposal documentation to ensure the method of disposal is being documented by two licensed nurses.
- All licensed nursing staff will be educated on disposal and documentation of narcotics.
- Results of audits will be compiled for discussion and
F 431 Continued From page 14

Instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and documentation review, the facility failed to document destruction of fentanyl patches (a narcotic used for moderate to severe pain) and a controlled substance and the facility did not follow the current recommendations for disposal of medication vs. use of sewer system for destruction. This practice could encourage diversion of pain medications by staff, residents and/or visitors.

Findings Include: The facility had not documented actual disposition of used fentanyl patches and they were flushed down the sewer system.

On 8/30/13, at 9:04 a.m., assistant director of...
Continued From page 15

F 431

nursing and licensed practical nurse (LPN)-B informed surveyor when a used fentanyl patch had been removed from a resident the used fentanyl patch had been placed into a facial tissue and then two nurses had flushed the used fentanyl patch down the toilet.

During interview on 8/30/13, at 9:04 a.m., licensed practical nurse-B (LPN-B) stated two nurses had signed the narcotic book when a new fentanyl patch is removed from the medication cart and had shown surveyor at the time signatures of two nurses signing for count of fentanyl patches remaining from the east medication cart narcotic book. LPN-B stated the signature for the count of fentanyl patches remaining had also been for the destruction of the used fentanyl patch, at the time surveyor observed the east medication cart narcotic book and there had been no documentation of destruction of used fentanyl patches. LPN-B stated we do not write flushed old fentanyl patch for destruction. LPN-B verified there was no log of destruction for used fentanyl patches.

During interview on 8/30/13, at 9:04 a.m., assistant director of nursing verified the east medication cart narcotic book had no documentation of destruction of used fentanyl patches. The assistant director of nursing stated we do not have a log for destruction of used fentanyl patches.

During interview on 8/30/13, at 12:37 p.m., facility pharmacist stated she recommends flushing the used patches with two nurses and documenting destruction.

Documentation of facility policy Disposal of
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<th>F 431</th>
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<tbody>
<tr>
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<td>medications and medication-Related supplies</td>
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<td>Controlled Substance Disposal dated revised</td>
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<td>November 2011, read &quot;Policy Medications</td>
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<td>included in the Drug Enforcement Administration</td>
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<td>(DEA) classification as controlled substances are</td>
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<td>subject to special handling, storage, disposal, and</td>
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<td>recordkeeping in the facility in accordance with</td>
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<td>federal and state laws and regulations.</td>
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<td>Procedures A. The director of nursing, in</td>
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<tr>
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<td>collaboration with the consultant pharmacist, is</td>
</tr>
<tr>
<td></td>
<td>responsible for the facility's compliance with</td>
</tr>
<tr>
<td></td>
<td>federal and state laws and regulations in the</td>
</tr>
<tr>
<td></td>
<td>handling of controlled medications. Only</td>
</tr>
<tr>
<td></td>
<td>authorized licensed nursing and pharmacy</td>
</tr>
<tr>
<td></td>
<td>personnel have access to controlled medications.</td>
</tr>
<tr>
<td></td>
<td>B. When a dose of a controlled medication is</td>
</tr>
<tr>
<td></td>
<td>removed from the container for administration but</td>
</tr>
<tr>
<td></td>
<td>refused by the resident or not given for any</td>
</tr>
<tr>
<td></td>
<td>reason, it is not placed back in the container. It is</td>
</tr>
<tr>
<td></td>
<td>destroyed in the presence of [two licensed</td>
</tr>
<tr>
<td></td>
<td>nurses], and the disposal is documented on the</td>
</tr>
<tr>
<td></td>
<td>accountability record/book on the line</td>
</tr>
<tr>
<td></td>
<td>representing that dose. The same process</td>
</tr>
<tr>
<td></td>
<td>applies to the disposal of unused partial tablets</td>
</tr>
<tr>
<td></td>
<td>and unused portions of single dose ampules and</td>
</tr>
<tr>
<td></td>
<td>doses of controlled substances wasted for any</td>
</tr>
<tr>
<td></td>
<td>reason. D. Disposition is documented on the</td>
</tr>
<tr>
<td></td>
<td>[individual controlled substance accountability</td>
</tr>
<tr>
<td></td>
<td>record/book] (See 10.11: CONTROLLED DRUG</td>
</tr>
<tr>
<td></td>
<td>RECORD). For emergency kit controlled</td>
</tr>
<tr>
<td></td>
<td>substances disposal, the bottom portion of the</td>
</tr>
<tr>
<td></td>
<td>accountability record is completed (see 10.11:</td>
</tr>
<tr>
<td></td>
<td>CONTROLLED DRUG RECORD).&quot;</td>
</tr>
</tbody>
</table>

Documentation review of facility Example Forms |
Controlled Drug Record Section 10.11 dated |
revised November 2011, identified disposition of |
remaining doses, doses transferred to a medical |
waste container with quantity, date, RN signature,
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 17</td>
<td>RPh. signature.</td>
<td>F 431</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is the current Food and Drug Administration (FDA) updated April 14, 2011. Guidelines for Drug Disposal

FDA worked with the White House Office of National Drug Control Policy (ONDCP) to develop the first consumer guidance for proper disposal of prescription drugs. Issued by ONDCP in February 2007 and updated in October 2009, the federal guidelines are summarized here:

- Follow any specific disposal instructions on the drug label or patient information that accompanies the medication. Do not flush prescription drugs down the toilet unless this information specifically instructs you to do so.
- Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government's household trash and recycling service (see blue pages in phone book) to see if a take-back program is available in your community. The Drug Enforcement Administration, working with state and local law enforcement agencies, is sponsoring National Prescription Drug Take Back Days throughout the United States.
- If no instructions are given on the drug label and no take-back program is available in your area, take them out of their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter - to make the medication less appealing and recognizable - then put them in a sealable bag, empty can, or other container to prevent the medication from leaking or breaking out of a garbage bag.

F 441 483.65 INFECTION CONTROL, PREVENT  F 441
F 441: Continued From page 18

SS=D | SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 441:

- All Residents receiving injections or using breathing treatments have the potential to be affected by this practice.
- DNS or designee will observe practice of nebulizer treatments and insulin administration on a weekly basis.
- All licensed nursing staff will be educated on proper guidelines on nebulizer treatments and injection administration.
- Results of audits will be compiled for discussion and review at QA meetings for IDT to discuss compliance and any further actions needed for 3 months.

Corrective Action will be completed by: 10/4/2013
F 441 - Continued From page 19

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to promote practices to
prevent spread of infection for 1 of 2 residents (R64) observed for nebulizer administration who's
equipment was not cleaned and air dried after use and 1 of 1 residents (R53) observed for
insulin administration who's skin was not prepped with a clean alcohol wipe.

Findings Include:

R64's nebulizer equipment was observed to not be cleaned and air dried after administration of
medication.

R64 had diagnosis that included acute respiratory
type failure.

Document review of care plan dated 7/26/13,
identified R64 had alteration in respiratory status
due to asthma, due to pneumonia, risk for fatigue
due to shortness of breath. Interventions for
administering medications as ordered.

Document review of physician orders dated
8/13/13, revealed orders for sodium chloride 0.9
percent nebulization solution one vial by
inhalation four times a day.

Document review of the facility medication
administration record dated 8/01/13 to 9/28/13,
revealed R64 received nebulizer medication as
ordered.

Observations on 8/28/13, at 4:22 p.m., licensed
practical nurse-A (LPN-A) placed medication in
F 441  Continued From page 20

nebulizer cup and attached the cup to the face mask. LPN-A then placed the face mask on R64 and started the nebulizer machine. Observation at 5:01 p.m., nebulizer machine and equipment laid on R64’s bed, nebulizer cup and mask remained connected with droplets in the cup. Observation at 5:54 p.m., revealed the same with droplets in the cup.

During interview on 8/28/13, at 5:54 p.m., LPN-A verified the nebulizer equipment had not yet been cleaned and stated sometimes I forget.

During interview on 8/28/13, at 6:18 p.m., assistant director of nursing stated she expected staff to rinse nebulizer equipment right after treatment and place the equipment on a paper towel to air dry.

Policy for cleaning nebulizer equipment was requested on 8/29/13 from the assistant director of nursing, documentation provided was Medication Administration Competency Checklist Nebulizers dated 2010, read "Action 10. When finished turn off compressor. Disconnect the nebulizer reservoir and clean. (rinse with warm water and left to air dry.)"

R53’s skin had been wiped with a used alcohol pad prior to insulin administration.

R53 had diagnoses that included diabetes, end stage renal disease and dialysis.

Document review of care plan dated 5/20/13, identified R53 had alteration in blood glucose due to insulin dependent diabetes mellitus. Interventions for administering medications as ordered.
F 441: Continued From page 21

Document review of physician orders dated 7/23/13, revealed orders for novolog 100 units per milliliters (insulin aspart) solution 12 units subcutaneous three times a day with meals, may also get sliding scale at the same time. Novolog 100 units per milliliters (insulin aspart) solution sliding scale subcutaneous three times a day with meals.

Document review of the facility medication administration record dated 8/01/13 to 8/28/13, revealed R53 received insulin medication as ordered.

Observations on 8/28/13, at 5:14 p.m., licensed practical nurse-A (LPN-A) put on gloves, wiped rubber top of insulin vial off with alcohol wipe, obtained syringe and injected air into insulin vial and then had drawn up 18 units of insulin. LPN-A had placed the same alcohol wipe that had been used to wipe off the top of the rubber insulin vial into gloved hand, entered residents room and wiped area on R53’s right upper arm with used alcohol pad, administered insulin by injection, disposed of insulin syringe in sharps container, removed gloves and washed hands.

During interview on 8/28/13, at 5:26 p.m., LPN-A verified the alcohol pad she had used to clean the rubber top of the insulin vial off had been used to clean R53’s skin. She stated I’m sorry, I just get so nervous.

During interview on 8/28/13, at 6:18 p.m., assistant director of nursing stated she would expect staff to use a different alcohol wipe to clean resident’s skin.
Policy for insulin administration was requested on 8/29/13 from the assistant director of nursing, documentation provided was Insulin Administration Competency copy undated, read "Action 5. Prepares medication as follows: b. Swabs rubber cap with alcohol wipe. 8. Obtains alcohol wipe for skin preparation."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
GOLDEN LIVINGCENTER - WHITELAND

**ADDRESS**
525 BLUFF AVENUE
ST CHARLES, MN 55972

**DATE SURVEY COMPLETED**
08/28/2013

---

**ID NUMBER**
245270

**SUMMARY STATEMENT OF DEFICIENCIES**

**ID**

**PREFIX**

**TAG**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

<table>
<thead>
<tr>
<th>K 000</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRE SAFETY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE VISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

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 discloseable 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 discloseable 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.
**K 000** Continued From page 1
St Paul, MN 55101-5145, or

By email to:
Barbara.Lundberg@state.mn.us and
Marian.Whitney@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

Golden Living Center Whitewater is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1987, with a partial basement and was determined to be of Type II(111) construction. In 1989, an addition was constructed to the West Wing that was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 50 at the time of the survey.
K 000  Continued From page 2

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:
NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.
The staff is familiar with procedures and is aware that drills are part of established routine.
Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2.
This deficient practice could affect all 50 residents.

Findings include:

On facility tour between 8:00 AM and 10:30 AM on 08/28/2013, the review of the fire drills reports for August 2012 to July 2013 and the 2012 - 4th quarter - Evening shift was missed.

This deficient practice was confirmed by the Director of Maintenance (RC) at the time of
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K050</td>
<td>Continued From page 3 discovery.</td>
<td>K050</td>
<td></td>
</tr>
<tr>
<td>K069</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong></td>
<td>K069</td>
<td>- Custom Alarm will connect the kitchen hood system into the building fire alarm system in coordination with Enviro Fire and Safety.</td>
</tr>
</tbody>
</table>

Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 98. This STANDARD is not met as evidenced by:

Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not installed in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 7-5.2. This deficient practice could affect all 50 residents.

Findings include:

- On facility tour between 8:00 AM and 10:30 AM on 08/28/2013, the review of the kitchen hood system inspection documentation from Enviro dated 3/28/2013, indicated that the kitchen hood suppression system is not connect to the building fire alarm system.

This deficient practice was confirmed by the Director of Maintenance (RC) at the time of discovery.

**TEAM COMPOSITION**
Hi Gary and Marian,

I am so sorry! I was trying so hard to make sure I didn't do that. I was working off the prior year template, as you may have guessed.

You most DEFINITELY have my permission to cross out the date and make it 2013. In fact, I really appreciate that! And thank you for accepting our POC and making this change so easy. Jeepers... I was trying to be careful.

Thanks again,

Dena Otto
Executive Director
Golden Living Center - Whitewater
525 Bluff Avenue
St. Charles, MN 55972
(507) 932-3283 (507) 932-4756 fax

Hi Dena, I have accepted the plan of correction but some of the dates you give are 2012 year. You can either provide a corrected copy of these dates, or you can give me permission to put a line through the dates you gave and then hand write the correct date of 10/04/2013 and put my signature. Please respond to this e-mail and include Marian as she is from the fire marshal office and has the same concern with the date of 2012. Thanks.

Gary Nederhoff, Unit Supervisor
L&C division-MDH
18 Wood Lake Drive SE
Rochester, MN 55904

Telephone: 507-206-2731
Fax: 507-206-2711
gary.nederhoff@state.mn.us