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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: FEIG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

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

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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	IID
	55			
(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):

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5270 December 26, 2013

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

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 Leach

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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

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

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
245270	A. Building B. Wing	10/17/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WHITEWATER	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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/04/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/04/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/04/2013**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/04/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/04/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/04/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/04/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/04/2013**	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	Date:	Signature of Surveyor:	Date:
	GS/AK	11/19/2013	10160	10/17/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245270	01 - MAIN BUILDING 01	10/26/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WHITEWATER	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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	10/09/2013	ID Prefix Reg. # NFPA 101 LSC K0069	10/07/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	11/19/2013	25822	10/26/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

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

ID: FEIG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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)
(L4) **GOLDEN LIVINGCENTER - WHITEWATER 525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

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

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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	IID
	55			
(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 :
Kyla Einertson, HFE NE II 09/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/21/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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:

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

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

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

attained at the time of a revisit;

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	SEP 27 2013 MN Dept of Health Rochester A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

(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. H5270009 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 H520009 had not been substantiated during this survey.	F 000	Submission of the Response and Plan of correction is not a legal admission that a deficiency exists of that this Statement of Deficiency was correctly cited, and is also not to be construed as a admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set fort in the allegations. Accordingly, the 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.	
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 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	F 282	**F282:** 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	9/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dena Otto — TITLE: Executive Director — (X6) DATE: 9/27/13

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

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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	F 282	staff on a 1:1 basis as discovered • Nursing staff will be educated on following care plans and to notify the social worker when new hygiene products or equipment is needed • 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	10/4/13

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F 282	Continued From page 2 member to complete the task. ADON confirmed the care plan for assist of 1 for personal hygiene included shaving and had not been followed for R14.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident received grooming assistance as necessary related to facial hair removal for 1 of 1 resident (R14) reviewed in the sample for activities of daily living. Finding Include: R14 was assessed to be dependent on staff for completing activities of daily living and did not receive the assistance she needed to remove facial hair. 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 quarterly Minimum Data Set (MDS) and assessment dated 8/14/13; revealed R14 had required extensive assist of one staff to help	F 312	**F312:** Facial hair was removed via electric razor for resident R14. • All Residents have the potential to be effected 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 staff on a 1:1 basis as discovered. • Nursing staff will be educated on following care plans and to notify the social worker when new hygiene products or equipment is needed • 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	10/4/13

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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. 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 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 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	**F315:** A bladder assessment was completed for resident R52 to address indwelling catheter on	

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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	F 315	• All residents who have indwelling catheters have the potential to be affected by this practice. • Audits will be completed monthly by the ADNS or designee. ADNS will track all residents with indwelling catheters and ensure bladder assessments are accurate. • Licensed nursing staff will be educated on bladder re-assessment with foley catheter placement. • DNS/Designee will complete random audits to ensure all residents are receiving oral care per residents plan of care. • 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	10/4/13

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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 315		
F 325 SS=D	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	**F325:** 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.	

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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	F 325	• 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	10/4/13

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F 325	Continued From page 7	F 325		

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 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

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F 325	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.	F 325		
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 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	**F329:** 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	

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F 329	Continued From page 9 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to 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	F 329	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	10/4/13

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F 329	Continued From page 10	F 329		

antipsychotic drugs are at an increased risk of death compared to placebo. "
R54 was admitted 6/15/11, 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.

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F 329	Continued From page 11	F 329		

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 8/5/13, 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245270	A. BUILDING _____ B. WING _____	C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

(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 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 329		
F 371 SS=E	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 371	**F371:** • All Residents have the potential to be affected by this practice. • A beverage cart service will be initiated in the West dining room whereby cold beverages will be kept on ice and poured tableside. • Food and beverage temperature records will be audited weekly to ascertain proper food temps. • 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	10/4/13

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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 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	**F431:** • 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	

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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	F 431	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	10/4/13 sph

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F 431	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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F 431	Continued From page 16	F 431		

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

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,

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F 431	Continued From page 17 RPh. signature. 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 unrecognizable - 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 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 18 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	**F441:** • 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: 10/4/2012	10/4/2013 SPH

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F 441	Continued From page 19	F 441		

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 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 8/28/13, 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

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F 441	Continued From page 20	F 441		

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.

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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.

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F 441	Continued From page 22 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."	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Living Center Whitewater was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	Submission of the Response and Plan of correction is not a legal admission that a deficiency exists of that this Statement of Deficiency was correctly cited, and is also not to be construed as a admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set fort in the allegations. Accordingly, the 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. RECEIVED SEP 30 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok FS 10-23-13	

DC: 10-9-13

EXIT: 8-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dina Hill	Executive Director	9/27/13

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

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K 000	Continued From page 1 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 1967, with a partial basement and was determined to be of Type II(111) construction. In 1969, 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		

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

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on 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	K 050	**K050:** • The facility will hold quarterly fire drills for each shift scheduled routinely at varying times and placed on an annual calendar • The facility's Maintenance Director will document the completion of the fire drills monthly. Corrective action will be completed by: 10/9/~~2012~~ 2013 PB	

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
	245270	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

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K 050	Continued From page 3 discovery.	K 050		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 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 7-6.2.. 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* Gary Schroeder, Life Safety Code Spc.	K 069	**K69:** • Custom Alarm will connect the kitchen hood system into the building fire alarm system in coordination with Enviro Fire and Safety. Corrective action will be completed by: 10/7/~~2013~~ 2013	

Whitney, Marian (DPS)

From: Otto, Dena 36 [BH00869] [Dena.Otto@goldenliving.com]
Sent: Monday, September 30, 2013 12:49 PM
To: Nederhoff, Gary (MDH)
Cc: Whitney, Marian (DPS)
Subject: RE: CMS-2567 with POC request

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

From: Nederhoff, Gary (MDH) [Gary.Nederhoff@state.mn.us]
Sent: Monday, September 30, 2013 12:36 PM
To: Otto, Dena 36 [BH00869]
Cc: Whitney, Marian (DPS)
Subject: CMS-2567 with POC request

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