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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: H2IB

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

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

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

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

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

6. DATE OF SURVEY December 3, 2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **84** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
84				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NEII 01/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/16/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/25/2013
(L33)

DETERMINATION APPROVAL

CCN# 24-5084

At the time of the standard survey completed September 13, 2013, the facility was not in substantial compliance. The most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

On November 7, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS). The FMS revealed that the facility continued to not be in substantial compliance. 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).

On November 19, 2013, CMS imposed the following enforcement remedy:

Mandatory denial of payment for new Medicare and Medicaid admissions effective December 13, 2013 (42 CFR 488.417(b))

On December 3, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the facility's plan of correction and on January 14, 2014 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 13, 2013 and an FMS completed on November 7, 2013. Based on the PCR findings, it was determined that the facility had corrected the deficiencies issued pursuant to the standard survey, completed on September 13, 2013 and FMS completed on November 7, 2013, effective December 13, 2013.

As a result of the PCR findings, CMS authorized this Department to notify the facility of the following:

Mandatory denial of payment for new Medicare and Medicaid admissions effective December 13, 2013 be rescinded. (42 CFR 488.417(b))

Correction of the LSC deficiencies with approved waivers cited at the time of the Federal Monitoring Survey (FMS) completed on November 7, 2013 have not yet been verified.

The facility has requested temporary waivers of the deficiencies cited under K17, K29, K18, K33 and K20 with a completion date of March 12, 2014. The facility has also requested a temporary waiver of the deficiency cited under K38 with a completion date of May 15, 2014.

The facility's request for a continuing waiver involving the deficiency cited under K17 at the time of the Federal Monitoring Survey completed on November 7, 2013, has been approved by CMS.

The facility's request for a continuing waiver involving the deficiency cited under K67 at the time of the standard survey completed on September 13, 2013, has been approved by CMS.

Correction of the Life Safety Code deficiency cited under K67 at the time of the standard survey completed on September 13, 2013, has been approved by CMS.

Please refer to the CMS 2567B. Effective December 13, 2013, the facility is certified for 84 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2014

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

RE: Project Number S5084023 and F5084023

Dear Ms. Murkowski:

On October 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 13, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In addition, on November 7, 2013, A surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference the FMS revealed that your facility continues to not be in substantial compliance. The most serious deficiencies in your facility 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.

On November 19, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 13, 2013 (42 CFR 488.417(b))

On December 3, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 14, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 13, 2013 and an FMS completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 13, 2013 and FMS completed on November 7, 2013, effective December 13, 2013.

As a result of the PCR findings, this Department recommended to the Region V Office of CMS the following actions related to the remedies in their letter of September 12, 2013. CMS concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 13, 2013 be rescinded. (42 CFR 488.417(b))

Correction of the Life Safety Code deficienciesies cited at the time of the Federal Monitoring Survey (FMS) completed on November 7, 2013 have not yet been verified. The following are the approved temporary waivers including their completion dates:

K17(Findings 2)	March 12, 2014	K18	March 12, 2014	K20	March 12, 2014
K25	March 12, 2014	K27	March 12, 2014	K29	March 12, 2014
K29	March 12, 2014	K33	March 12, 2014	K38	May 15, 2014
K18	January 24, 2014	K67	December 30, 2013		

Your request for a continuing waiver involving the deficiency cited under K17 (Finding 1) at the time of the Federal Monitoring Survey completed on November 7, 2013, has been approved by CMS.

Your request for a continuing waiver involving the deficiency cited under K67 (Finding 1) at the time of the standard survey completed on September 13, 2013, has been approved by CMS.

Correction of the Life Safety Code deficiency cited under K67 (Findings 2 and Findings3) at the time of the standard survey completed on September 13, 2013, has been approved by CMS.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure
cc: Licensing and Certification File 5084r13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245084	A. Building B. Wing	12/3/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**11/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**11/30/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**11/30/2013**
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	

Reviewed By State Agency	**Reviewed By** MM/GL	**Date:** 01/27/2014	**Signature of Surveyor:** 30951	**Date:** 12/03/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/13/2013		**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245084	A. Building B. Wing **01 - MAIN BUILDING 01**	1/14/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/01/2013**	ID Prefix	Correction Completed **11/30/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0020		LSC K0050		LSC K0052	
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/27/2014	28120	01/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
9/19/2013	

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
245084	A. Building B. Wing **01 - MAIN BUILDING 01**	1/14/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**
Reg. # **NFPA 101** LSC K0014		Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**
Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0064	
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**
Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0074		Reg. # **NFPA 101** LSC K0076	
ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**	ID Prefix	Correction Completed **12/13/2013**
Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147	

	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/27/2014	28120	01/14/2014
CMS RO				

Followup to Survey Completed on: 11/7/2013

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

FAX to: Number of Pages:

CCN: 245084 3 Month Date: 12/13/13

Name: Golden Living Center - Hillcrest of Wayzata 6 Month Date: 3/13/14

City, State: Wayzata, MN

FMS Survey Date: 11/7/13

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("W")	
E	K14	POC 12/13/13	Annotate 2567
E	K17	Finding 1 AW Finding 2 TW - 3/12/14	Waiver form
E	K18	TW 3/12/14	AEM: W, TW
E	K20	TW 3/12/14	ASPEN: IDR
E	K23	TW 3/12/14	ASPEN: Update citations
E	K27	TW 3/12/14	ASPEN: Enter POC dates
E	K29	TW 3/12/14	Print Revised 2567
E	K33	TW 3/12/14	Letter; in H; in AEM; lock
E	K38	TW 5/15/14	Tell facility POC is OK
E	K45	POC 12/13/13	Ask State to revisit
F	K48	TW 1/24/14	AEM note
F	K50	POC 12/13/13	
E	K51	POC 12/13/13	
F	K52	POC 12/13/13	E K143 POC 12/13/13
F	K54	POC 12/13/13	F K144 POC 12/13/13
E	K56	POC 12/13/13	D K147 POC 12/13/13
F	K62	POC 12/13/13	
B	K64	POC 12/13/13	
E	K67	TW 12/30/13	This is now a Annual Waiver
E	K69	POC 12/13/13	
E	K74	POC 12/13/13	
E	K76	POC 12/13/13	

Approved: (YES) NO By: S. Pelinski Date: 12/23/13

LIFE SAFETY CODE SURVEY REVIEW FORM

PART I: REQUEST FOR WAIVER

Facility: Golden Living Center – Hillcrest of Wayzata, Wayzata, MN
CCN: 245084
Survey Date: 11/7/2013
State Recommendation: NA

Part of Enforcement Case? X Yes No Due Date:

Case Submitted By: Facility

PART II: RO WAIVER DECISION INCLUDING BASIS FOR ANY DENIAL:

			Annual	Temporary	Exp Date
K-17	APPROVED X	DENIED	X		

BASIS FOR DECISION:
The waiver request demonstrated the corrective action would be an undue hardship and not practical due to configuration of building. The building is protected throughout by a complete sprinkler system.

REVIEWER: Stephen Pelinski **DATE: 12/23/2013**

DATE SENT TO STATE AGENCY: **BY:**

Entered on ATM: 12/23/13

golden living centers®

Enhancing lives through innovative healthcare™

Certified Mail # 7011 0110 0000 5007 8029

November 25th, 2013

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Ave, Suite 600
Chicago, Illinois 60601 - 5519

Dear Mr. Wexelberg;

Enclosed please find the plan of correction for the Federal survey completed November 7th, 2013 at Golden LivingCenter - Hillcrest of Wayzata. Also enclosed is an annual waiver request for item #1 of K017.

If you have any questions please contact me at (952) 473-5466, extension 399.

Sincerely,

Allison Murkowski

Allison Murkowski
Executive Director
Golden LivingCenter - Hillcrest of Wayzata

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 11/7/13 following a Minnesota Department of Health survey on 9/19/13. At this Comparative Federal Monitoring Survey, Golden Living Center Hillcrest of Wayzata was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Golden Living Center - Hillcrest of Wayzata is a two story building that was built at five different times. The original building was constructed in 1958. Additions were constructed in 1963, 1966, 1976 and 1991. The original building is of Type II (111) construction. The 1963, 1966 and 1991 additions were of Type II (000) construction. The 1976 addition is of Type II (222) construction. None of the buildings are separated by a two hour rated building separation so the building was surveyed as a single two story building of Type II (000) construction. The building is fully sprinklered, except as noted under tag K56. There are supervise smoke detectors located in the corridors and spaces open to the corridors. The facility has 84 certified beds. All 84 beds are certified for Medicare only. The census at the time of the survey was 55. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 014		

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

Allison Murkowski | Executive Director | 11/25/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 014		

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

Allison Muskowitz | Executive Director | 11/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 11/7/13 following a Minnesota Department of Health survey on 9/19/13. At this Comparative Federal Monitoring Survey, Golden Living Center Hillcrest of Wayzata was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Golden Living Center - Hillcrest of Wayzata is a two story building that was built at five different times. The original building was constructed in 1958. Additions were constructed in 1963, 1966, 1976 and 1991. The original building is of Type II (111) construction. The 1963, 1966 and 1991 additions were of Type II (000) construction. The 1976 addition is of Type II (222) construction. None of the buildings are separated by a two hour rated building separation so the building was surveyed as a single two story building of Type II (000) construction. The building is fully sprinklered, except as noted under tag K56. There are supervise smoke detectors located in the corridors and spaces open to the corridors. The facility has 84 certified beds. All 84 beds are certified for Medicare only. The census at the time of the survey was 55. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 014		

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

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K 014	Continued From page 1 Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide interior finish materials that meet the flame spread requirements of NFPA 101 - 2000 edition, Sections 19.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect approximately 30 of the 55 residents. Findings include: 1. On 11/7/13 at 12:40pm, observation revealed that there was wood paneling on the lower 32" of the corridor wall in the main lobby and the main corridor off of the main lobby. The facility had no information on the flame spread rating of the wood paneling. When asked if she knew what the flame spread rating of the wood paneling was the Executive Director replied, "I don't Know." 2. On 11/7/13 at 1:12pm, observation revealed that there was wood paneling on the walls of the Memory Care lounge. The facility had no information on the flame spread rating of the wood paneling. When asked if she knew what the flame spread rating of the wood paneling was the Executive Director replied, "I don't know."	K 014	**K 014** Item #1 Blueprints have been located for the wood paneling located in the main lobby and entrance corridor indicating a B label flame spread rating. This documentation has been placed in the LSC binder. Item #2 The wood shingles located on the memory unit were treated with Class A Fireproof Primer on 10/13/08. This product has a 15 year warranty. This documentation has been placed in the LSC binder. Date of compliance 12/13/13. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence.	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls	K 017		

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K 017	Continued From page 2 constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor wall separations in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.1, 19.3.6.2 and 19.3.6.4. This deficient practice could affect approximately 20 of the 55. Findings include: 1. On 11/7/13 at 11:15am, observation revealed that the Occupational Therapy area was open to the corridor. 2. On 11/7/13 at 3:35pm, observation revealed that there was a 10" by 25" vent in the corridor wall at the Maintenance Shop. The vent was protected by a fire damper but not by a smoke damper that was connected to the fire alarm	K 017	**K 017** Item #1 Annual waiver requested. (See CMS-2786R Form) Item #2 A smoke damper will be installed in the corridor wall vent above the maintenance shop entrance to comply with NFPA 101 - 2000 edition, section 19.3.6.2. The smoke damper will be connected to the fire alarm system. Additional correction time is requested to accommodate manufacturing, delivery and installation of this custom order. Date of compliance 3/12/14. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence.	

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K 017	Continued From page 3 system. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that meet the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.3, 19.3.6.3.1 and 19.3.6.3.2. This deficient practice could affect approximately 20 of the 55 residents.	K 018	**K 018** Item #1 An automatic positive latch will be installed on the pondsview lounge doors. Item #2 The bi-fold doors enclosing the Assisted Ling lobby closet will be replaced with doors that positively latch. Item #3 The latch of the Physical Therapy entrance doors has been repaired and the doors now positively latch. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to accommodate manufacturing and delivery of the custom door and hardware order.	

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K 018	Continued From page 4 Findings include: 1. On 11/7/13 at 2:25pm, observation revealed that the inactive leaf of the corridor double doors to the Pondview lounge was not automatically positive latching. The active leaf latches into the inactive leaf. If the inactive leaf was not automatically positive latched the entire door assembly would not be positively latched. 2. On 11/7/13 at 3:15pm, observation revealed that the corridor door to the closet at the lobby of the unseparated assisted living building were bi-fold doors. The doors did not positively latch and there was a 3/4" gap at the top of the doors. 3. On 11/7/13 at 3:45pm, observation revealed that the corridor door to the Physical Therapy room did not latch. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 018		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section	K 020		

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K 020	Continued From page 5 19.3.1, 19.3.1.1, 8.2.2.2, 8.2.3, 8.2.3.2.3 and 8.2.5. This deficient practice could affect approximately 35 of the 55 residents. Finding include: 1. On 11/7/13 at 2:15pm, observation revealed that there was a non fire rated door on the "Not an Exit" stair enclosure by room 266. In addition, the door did not positively latch. 2. On 11/7/13 at 2:50pm, observation revealed that there was a 10" by 30" duct penetration in the floor by room 286 that was not protected by a fire damper. 3. On 11/7/13 at 2:56pm, observation revealed that in the two story portion of the building none of the floor penetrations by the toilet exhaust ducts were protected by fire dampers. Observation of the lower level that was gutted revealed that there were no fire dampers where the toilet exhaust penetrated the floor above. The surveyor check three locations and the Maintenance Director checked several additional locations. The Maintenance Director stated that none of the other rooms he checked had fire dampers at the duct penetration of the floor. The Maintenance Director told the surveyor to " Assume all of the rooms are that way." These deficient practices were confirmed by the Maintenance Director at the time of discovery.	K 020	**K 020** Item #1 The door of the stair enclosure will be replaced with a 1 hour rated door and panic hardware with an automatic positive latch. Item #2 A fire damper will be installed in the vertical opening near room 286 and appropriately maintained according to code requirements. The damper will be connected to the fire alarm system. Item #3 All bathroom exhaust fans will have dampers to meet code requirements. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to allow for architect/engineering consultation and project coordination with a general contractor.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may	K 025		

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K 025	Continued From page 6 terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect approximately 30 of the 55 residents. Findings include: 1. On 11/7/13 at 12:45pm, observation revealed that above the ceiling at the smoke barrier between the lobby and the Memory Care unit there was a pipe and three conduits that were sealed with fiberglass insulation and were not properly firestopped. 2. On 11/7/13 at 1:02pm, observation revealed that the smoke barrier wall by room 223 does not continue above the ceiling through the attic space to the roof deck. 3. On 11/7/13 at 1:07pm, observation revealed that the smoke barrier wall by room 221 does not continue above the ceiling through the attic space to the roof deck.	K 025	**K 025** Item #1 Firestop calk will be applied to the Main Entrance/Memory Care smoke barrier penetrations above the ceiling. Item #2 The smoke barrier between the Memory Care lounge and rooms 223/218 will be extended beyond the ceiling to the roof to meet code requirements. Item #3 The corridor doors outside room 221/212 were mistakenly identified as a smoke barrier at the time of the survey. Smoke barriers and zones will be correctly identified and outlined on a diagram with the correction of K 048. Item #4 The corridor doors between the Memory Care unit and SA room 240 were mistakenly identified as a smoke barrier at the time of the survey. Smoke barriers and zones will be correctly identified and outlined on a diagram with the correction of K 048. Item #5 Firestop calk will be applied above the ceiling around the smoke barrier penetrations located in the corridor outside SA room 243.	

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K 025	Continued From page 7 4. On 11/7/13 at 1:17pm, observation revealed that the smoke barrier wall by room 240 does not continue above the ceiling through the attic space to the roof deck. 5. On 11/7/13 at 1:26pm, observation revealed that above the ceiling at the smoke barrier by room 243 there was a 10" by 10" hole that was penetrated by a flexible duct that was not properly firestopped. 6. On 11/7/13 at 1:27pm, observation revealed that the smoke barrier wall by room 243 does not continue above the ceiling through the attic space to the roof deck. 7. On 11/7/13 at 2:10pm, observation revealed that in the attic at the smoke barrier by room 268 the wall consisted of drywall on one side of metal studs only. This wall construction does not provide the minimum 1/2-hour fire resistance rating required for an existing healthcare smoke barrier. In addition, there were a 12" by 20", a 20" by 24" and a 4" by 4" hole in the wall and penetrations by five pipes, six conduits and four cables that were not properly firestopped. 8. On 11/7/13 at 2:36pm, observation revealed that above the ceiling at the smoke barrier by the beauty shop there was a 24" by 24" hole in the wall that was not properly firestopped. 9. On 11/7/13 at 3:14pm, observation revealed that above the ceiling at the smoke barrier by room 217 there were penetrations by a duct and a conduit that were not properly properly firestopped. 10. On 11/7/13 at 3:36pm, observation revealed	K 025	Item #6 The corridor smoke barrier between SA rooms 243 and 244 will be extended beyond the ceiling to the roof to meet code requirements. Item #7 Drywall will be present on both sides of the metal studs in the attic space of smoke barrier wall outside of SA room 268. Firestop calk will be applied to all smoke barrier penetrations. Item #8 The smoke barrier wall outside of the beauty shop will be modified by replacing and securing missing blocks to meet code requirements. Item #9 Firestop calk will be applied above the ceiling to the smoke barrier penetrations located in the corridor outside of Reflections room 217. Item #10 The holes found above the ceiling in the smoke barrier wall outside of Reflections room 117 will be properly fire stopped. Item #11 The hole in the smoke barrier wall outside of Occupational Therapy will be properly firestopped.	

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K 025	Continued From page 8 that above the ceiling at the smoke barrier by room 117 there were two 3" by 4" holes and five conduit penetrations that were sealed with fiberglass and were not properly firestopped. 11. On 11/7/13 at 3:47pm, observation revealed that above the ceiling at the smoke barrier at the Occupational Therapy room there was a 2-1/4" hole in the wall that was not properly firestopped. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 025	Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to allow for architect/engineering consultation and project coordination with a general contractor.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain doors in smoke barrier walls as required by NFPA 101 - 2000 edition, section 19.3.7, 19.3.7.1, 19.3.7.6, 8.3 and 8.3.4. This deficient practice could affect approximately 20 of the 55 residents. Finding include:	K 027	**K 027** The corridor doors between the Memory Care unit and SA room 240 were mistakenly identified as a smoke barrier at the time of the survey. Smoke barriers and zones will be correctly identified and outlined on a diagram with the correction of K 048. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to allow for architect/engineering consultation and project coordination with a general contractor.	

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K 027	Continued From page 9 On 11/7/13 at 1:16pm, observation revealed that there was a 1/4" gap at the meeting edge of the cross-corridor smoke barrier doors by room 240. This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.3.2.1 and 8.4.1. This deficient practice could affect approximately 20 of the 55 residents. Findings include: 1. On 11/7/13 at 3:48pm, observation revealed that 13 rooms in the abandoned section of the lower level located by the Occupational Therapy	K 029	**K 029** Item #1 Door closers have been installed on the storage room doors located in the service hall beyond Occupational Therapy. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13. Item #2 1 hour rated automatic positive latching doors will be installed separating the lower level construction zone from the service hall. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to allow for architect/engineering consultation and project coordination with a general contractor.	

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K 029	Continued From page 10 area were used for storage of combustible items such as furniture, beds, equipment and the doors to the storage rooms were not self-closing. 2. On 11/7/13 at 3:50pm, observation revealed that the north portion of the lower level was gutted down to the bare walls. The gutted area was separated from the occupied portion of the facility by a smoke barrier with doors that were not positively latching. The gutted area of the building was not separated from the occupied area of the building by a minimum one hour fire rated barrier. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 029		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 19.2.1, 19.2.2.3, 7.1.3.2, 7.2.2.5, 8.2.3, 8.2.3.1.1, 8.2.3.1.2, 8.2.5 and 8.2.5.2, 8.2.5.3 and 8.2.5.4. This deficient practice could affect approximately 30 of the 55 residents.	K 033	**K 033** Item #1 A 1 hour rated door and panic hardware will be installed at the exit stair near room 242. The door will automatically positively latch. Item #2 An automatic positive latch will be installed on the exit stair door near room 279. Item #3 A 1 hour rated door and panic hardware will be installed at the exit stair near room 251. The door will automatically positively latch.	

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

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K 033	Continued From page 11 Findings include: 1. On 11/7/13 at 1:28pm, observation revealed that a door to the exit stair by room 242 did not have a fire resistance rating and the door was not positive latching. 2. On 11/7/13 at 2:16pm, observation revealed that the door to the exit stair by room 279 was not positive latching. 3. On 11/17/13 at 2:20pm, observation revealed that the door to the stair by room 251 was not positive latching and there was a 1/4" hole in the door adjacent to the door knob. 4. On 11/17/13 at 2:41pm, observation revealed that the door to the stair by the kitchen was not positive latching. 5. On 11/17/13 at 3:32pm, observation revealed that the door to the stair by room 102 was not positive latching. 6. On 11/17/13 at 3:42pm, observation revealed that the door to the stair by the boiler room did not have a fire resistance rating and the door was not positive latching. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 033	Item #4 An automatic positive latch will be installed on the exit stair door near the kitchen. Item #5 An automatic positive latch will be installed on the exit stair door near room 102. Item #6 The door leading to the boiler room will have a 1 hour fire rating and an automatic positive latch. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 3/12/14. Additional correction time is requested to accommodate manufacturing and delivery time of this custom order.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exit doors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 19.2.2, 19.2.2.2.4, 3.3.121, 7.1.6.1, 7.1.6.2, 7.1.10, 7.1.10.1, 7.2.1.3, 7.2.1.6, 7.7 and 7.7.1. This deficient practice could affect approximately 30 of the 55 residents. Findings include: 1. On 11/7/13 at 1:23pm, observation revealed that the exterior exit door by room 240 had a delayed egress device that did not unlock the door when tested by the surveyor. 2. On 11/7/13 at 1:36pm, observation revealed that the exterior exit door from the Memory Care lounge had a delayed egress device that did not unlock the door when tested by the surveyor. In addition, the delayed egress sign on the door stated that the door would open in 30 seconds however, the facility did not have any documentation that the authority having jurisdiction had approved an extension of time from 15 seconds to 30 seconds. When asked if the facility had any documentation approving the extension of time to 30 second the Executive Director replied, "No." 3. On 11/7/13 at 1:42pm, observation revealed that the exterior exit from the Memory Care lounge did not lead to the public way. The exit discharge sidewalk led to a gate in a fence. The	K 038	**K 038** Item #1 The delayed egress devise on the door near room 240 has been repaired. Date of compliance 12/13/13. Item #2 The delayed egress sign has been removed from the Memory Care emergency exit door. The door does not have a delayed egress. The mag lock releases with the activation of the fire monitoring system. All residents who reside on this unit have a clinical need for the secure environment for the prevention of elopement. Item #3 Revisions will be made to the North exterior exits of the Memory Care unit to comply with code requirements. Key pads will be installed on both sides of the secure fence gates (qty 2) that automatically release with the activation of the fire monitoring system. The access code will be displayed on the outside of the north patio gate allowing access to the egress path in all emergency situations. The North and South gate codes will be the same. Item #4 Modifications will be made to the walking surface outside of the Memory Care dining room exit door to meet code requirements.	

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K 038	Continued From page 13 gate was locked from the opposite side with a padlock and could not be unlocked from the side of egress. 4. On 11/7/13 at 1:51pm, observation revealed that the discharge from the Memory Care Dining room west exit did not discharge to a level walking surface. The walking surface outside of the door sloped 4" in a 24" distance. 5. On 11/7/13 at 1:53pm, observation revealed that the discharge from the Memory Care Dining room west exit discharged to a walking surface that was covered with wet leaves and was wet from water dripping on concrete path from the gutter above. This gutter arrangement would lead to a build up of ice during winter months. 6. On 11/7/13 at 1:54pm, observation revealed that the discharge from the Memory Care Dining room west exit discharged did not lead to the public way. The exit discharge sidewalk led to a gate in a fence. The gate was locked from the opposite side with a padlock and could not be unlocked from the side of egress. 7. On 11/7/13 at 1:56pm, observation revealed that the discharge from the Sub Acute Unit north lounge did not lead to the public way. The exit discharge sidewalk led to a gate in a fence. The gate was locked from the opposite side with a padlock and could not be unlocked from the side of egress. 8. On 11/7/13 at 3:25pm, observation revealed that the exit stair by room 201 discharged to a grassy area and did not have a hard path to the public way.	K 038	Item #5 The gutters have been cleared and re-sealed. Exit paths will be maintained. Item #6 Revisions will be made to the North exterior exits of the Memory Care unit to comply with code requirements. Key pads will be installed on both sides of the secure fence gates (qty 2) that automatically release with the activation of the fire monitoring system. The access code will be displayed on the outside of the north patio gate allowing access to the egress path in all emergency situations. The North and South gate codes will be the same. Item #7 Revisions will be made to the North SubAcute exterior egress path. Key pads will be installed on both sides of the secure fence that automatically release with the activation of the facilities fire monitoring system. Item #8 A hard surface exit path to the public way will be added to the exit stair near Reflections room 201. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 5/15/14. Additional correction time is requested due to seasonal temperatures of Winter/Spring and our inability to modify and create required exit paths.	

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K 038	Continued From page 14 These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 038		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide reliable lighting for all components of the means of egress as required by NFPA 101 - 2000 edition, Sections 19.2.8, 7.8.1.3 and 7.8.1.4. This deficient practice could affect approximately 20 of the 55 residents. Findings include: On 11/7/13 at 3:25pm, observation revealed that the exterior light fixture at the exit discharge by room 201 was a single fixture with a single bulb. This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 045	**K 045** The light fixture at the exit discharge by room 201 has been replaced with an XTOR5A LED wall pack. The fixture is connected to the emergency generator. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	K 048		

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K 048	Continued From page 15 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a written fire safety plan addressing all the items required by NFPA 101 - 2000 edition, Section 19.7.2.2. This deficient practice could affect all 55 residents. Findings include: On 11/7/13 at 9:25am, review of the undated document titled "Fire Plan" revealed that on page 14.11 evacuation of the smoke compartment is covered by the statement "Partial evacuation to next zone beyond fire/smoke door (see building Map)," however, no building map clearly showing the location of the smoke compartments was included in the fire plan. This deficient practice was confirmed by the Executive Director and Maintenance Director at the time of discovery.	K 048	**K 048** The facility will work with an architect and engineer to correctly identify smoke barriers and corresponding zones. An accurate facility map will be prepared and included with the facilities fire plan. All staff will be re-educated on the location of each smoke compartment and fire plan evacuation protocol. Allison Murkowski, Executive Director is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 1/24/14. Additional correction time is requested to allow for architect/engineering consultation and project coordination with a general contractor. Once the plan is developed the facility will need to re-educate staff on each shift.	
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:	K 050		

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K 050	Continued From page 16 Based on record review and interview, the facility failed to conduct fire drills in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.7.1.2. This deficient practice could affect all 55 residents. Findings included: 1. On 11/7/13 at 9:40am, review of the documents titled "Report of Monthly Fire Drill" for the last 12 months revealed that not all staff that participated in the fire drill documented their participation by signing the fire drill log sheet. 2. On 11/7/13 at 9:45am, review of the documents titled "Report of Monthly Fire Drill" for the last 12 months revealed that the nurse aids on the third shift during the third quarter of 2013 did not participate in a fire drill. The fire drill for the third shift was conducted on 9/26/13 at 6:30am. An interview with the executive director during the entrance conference revealed that the time for the nurse aid third shift was from 10:00pm to 6:00am. 3. On 11/7/13 at 9:50am, review of the documents titled "Report of Monthly Fire Drill" for the last 12 months revealed that not all of the fire drills included the transmission of the fire alarm signal. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 050	**K 050** Item #1 All staff that participate in the monthly fire drill will sign the fire drill documentation. Item #2 Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift. The facility has created a 12 month rolling fire drill matrix schedule in accordance with NFPA 101 LSC (00) Section 19.7.1.2. Any drills that deviate from the schedule will be held during the same conditions. Item #3 The fire alarm signal will be transmitted for all fire drills according to code requirements. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to	K 051		

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K 051	Continued From page 17 NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6, and NFPA 72 - 1999 edition, Sections 1-5.5.6.1 and 2-3.5.1. This deficient practice could affect approximately 20 of the 55 residents. Findings include: On 11/7/13 at 1:35pm, observation revealed the smoke detector located in the corridor by room 231 was located within the air flow of the adjacent	K 051	**K 051** The smoke detectors found to be within 36 inches of an HVAC deflector have been relocated in accordance with NFPA 70 (99) and 72 (99). 9.6.1.4. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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K 051	Continued From page 18 air supply outlet. This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 051		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3, 7-3.1, 7-3.2, 7-5.2.2 and Figure 7-5.2.2. This deficient practice could affect all 55 residents. Findings include: 1. On 11/7/13 at 9:55am, review of the document titled "IFS Integrated Fire & Security" dated 4/1/13 revealed that the fire alarm test and inspection form did not include all of the required information. There was no list of the test results	K 052	**K 052** Item #1 Fire alarm test and inspection results containing the required information have been obtained. Item #2 An accurate report has been obtained from IFS indicating the location of manual pull stations. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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K 052	Continued From page 19 for the individual devices that were tested. 2. On 11/7/13 at 9:56am. review of the document titled "IFS Integrated Fire & Security" dated 4/1/13 revealed that not all of the initiating devices were listed in the device summary section of the report. The report indicates that there were no manual pull stations located in the facility. When asked at 9:56am, how many manual pull stations were located in the building the Maintenance Director replied, " Fourteen." These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview, the facility failed to properly document sensitivity testing of the fire alarm system smoke detectors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Section 7-3.2.1. This deficient practice could affect all 55 residents. Findings include: On 11/7/13 at 10:03am, an interview with the Maintenance Director revealed that the facility did not have any documentation that the smoke	K 054	**K 054** The facilities fire monitoring system includes addressable smoke detectors. The sensitivity report has been printed from the alarm panel. All smoke detectors are within acceptable sensitivity range. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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K 054	Continued From page 20 detectors were tested for sensitivity within the last two years.	K 054		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Sections 5-1.1 and 5-6.5.2.3. This deficient practice could affect approximately 20 of the 55 residents. Findings include: 1. On 11/7/13 at 1:57pm, observation revealed that in the north sub acute shower room the sprinkler was obstructed by the solid shower curtain. 2, On 11/7/13 at 2:17pm, observation revealed	K 056	**K 056** Item #1 & #2 New top mesh shower curtains have been purchased and installed. Mesh material is the top 19" of the curtain. Fabric meeting NFPA 701 standards begins 22" down from the ceiling. Item #3 A sprinkler head will be installed in the TR closet of the Pondsview lounge. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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K 056	Continued From page 21 that the shower room by room 264 the sprinkler was obstructed by the solid shower curtain. 3. On 11/7/13 at 2:30pm, observation revealed that in the Therapeutic Recreation storage closet was not sprinklered. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2-2, 2.2.1.1 and 2-4.1.4. This deficient practice could affect all 55 residents. Findings include: 1. On 11/7/13 at 4:00pm, observation revealed that the sprinkler in the converter room was showing signs of corrosion. 2. On 11/5/13 at 2:50pm, observation revealed that there were not two spare sprinklers for each type used in the facility kept on site.	K 062	**K 062** Item #1 The sprinkler head in the converter room will be replaced. Item #2 2 types of each sprinkler head used throughout the building will be obtained and properly stored. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 22 These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 062		
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install fire extinguishers in accordance with NFPA 101 - 2000 edition, Sections 19.3.5.6 and 9.7.4.1 as well as NFPA 10 - 1998 edition, Sections 1-6.10 and 4-3.1. This deficient practice could affect approximately 20 of the 55 residents. Findings include: 1. On 11/7/13 at 10:21am, observation revealed that the fire extinguisher located in the main entrance vestibule was sitting on the floor and was not mounted on the wall. 2. On 11/7/13 at 10:22am, observation of the inspection tag on the fire extinguisher located in the main entrance vestibule revealed that the extinguisher was not visually inspected in the month of October 2013. These deficient practices were confirmed by the Executive Director at the time of discovery.	K 064	**K 064** Item #1 & 2 The fire extinguished has been properly inspected and is now mounted on the wall. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 23 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the heating air conditioning and ventilation system in accordance with NFPA 101 - 2000 edition, Section 19.5.2.1 and 9.2.1; as well as, NFPA 90A - 1999 edition section 3-4.7. This deficient practice could affect approximately 20 of the 55 residents. Finding include: 1. On 11/7/13 at 3:10pm, observation revealed that there was a 4" by 15" opening in the floor adjacent to room 219 that was protected by a fire damper. An interview with the Maintenance Director at the time of discovery revealed that the fire damper had not been exercised within the last four years and the facility did not have a maintenance program to exercise fire dampers every four years. 2. On 11/7/13 at 3:30pm, observation revealed that there was a fire damper located in the floor by room 201. The fire damper was covered by an approximate 1" build up of dust and dirt. An interview with the Maintenance Director at the time of discovery revealed that the fire damper had not been exercised within the last four years and the facility did not have a maintenance program to exercise fire dampers every four	K 067	**K 067** Item #1 & 2 Fire damper maintenance was performed on 12/12/13. Damper testing is scheduled for 12/20/13. Fire dampers will be added to the facilities preventative maintenance software program where tasks are recorded and alerts sent with tasks coming due. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/31/13. Additional correction time is requested to complete the damper testing and completion of test documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 24 years.	K 067		
K 069 SS=E	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 observation and interview, the facility failed to install the kitchen range hood fire extinguishing system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96 - 1998 edition, Section 7-5.1. This deficient practice could affect approximately 30 of the 55 residents. Findings include: On 11/7/13 at 3:05pm, observation revealed that the manual activation pull station for the kitchen range hood system was located 69" behind the cooking equipment and not in the means of egress from the kitchen. This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 069	**K 069** The kitchen range hood manual activation pull station has been relocated to the means of egress. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within	K 074		

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	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 25 health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide drapery materials meeting the requirements of NFPA 101 - 2000 edition, Sections 19.7.5.1 and 10.3.1. This deficient practice could affect approximately 20 of the 55 residents. Findings include: 1. On 11/7/13 at 12:50pm, observation revealed that the curtains in room 204 did not have a label indicating if they were fire retardant and the facility had no documentation on the fire retardant nature of the material. When asked if she knew what the fire retardant nature of the drapery material was the Executive Director replied, "No." 2. On 11/7/13 at 1:55pm, observation revealed that there were fabric draperies located in the Memory Care dining room. There were no fire retardant labels on the drapes and the facility had no documentation on the fire retardant nature of the drapery materials. When asked if she knew what the fire retardant nature of the drapery	K 074	**K 074** Item #1 & 2 The drapes found it resident room #204 have been removed. Fire Block Fire Retardant treatment has been applied to all other curtains without the appropriate fire ratings labels. When Fire Block Fire Retardant is applied to fabric the manufacturer recommends that it be reapplied after the third washing. If curtains become soiled maintenance coordinates cleaning with the housekeeping department and will track when curtains with the fire retardant treatment are washed and/or requiring reapplication. Documentation will be kept in the LSC survey binder. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

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K 074	Continued From page 26 material was the Executive Director replied, "No."	K 074		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store oxygen in accordance with NFPA 101 - 1999 edition, Sections 19.3.2. and 19.3.2.4; as well as NFPA 99 - 1999 edition, Section 8-3.1.11.2. This deficient practice could affect approximately 20 of the 55 residents. Findings include: 1. On 11/7/13 at 1:29pm, observation revealed that in the oxygen storage room nine oxygen cylinders were not secured. 2. On 11/7/13 at 1:30pm, observation revealed that in the oxygen storage room combustibles were stored within 5' of oxygen cylinders. There were five cardboard boxes with plastic parts located 2" from two oxygen cylinders.	K 076	**K 076** Item #1 An oxygen cylinder rack has been purchased and placed in the oxygen storage room, individually securing each cylinder. Item #2 The oxygen storage room will be free of combustible materials. A weekly audit will be completed by the Assistant Director of Nursing to verify compliance. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

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K 076	Continued From page 27 These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 076		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to transfer liquid oxygen in a room that was in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.3.2.4, as well as, NFPA 99 - 1999 edition, Section 8-6.2.5.2. This deficient practice could affect approximately 20 of the 55 residents. Findings include:	K 143	**K 143** The oxygen storage and transfer room will be free of combustible materials. A weekly audit will be completed by the Assistant Director of Nursing to verify compliance. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13	

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

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K 143	Continued From page 28 On 11/7/13 at 1:31pm, observation revealed that the liquid oxygen transferring room was used for storage of combustible items. The room contained six plastic bins filled with plastic parts, 12 cardboard boxes filled with plastic tubes and hoses, a plastic garbage can and a plastic laundry bin. This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 143		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conduct monthly load tests of the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.5.1 and 9.1.3; NFPA 99 - 1999 edition, sections 3-4.1.1.2, 3-4.1.1.3 and 5-3.1; as well as NFPA 110 - 1999 edition, section 6-4.2. This deficient practice could affect all 55 residents. Findings include:	K 144	**K 144** Item #1 The reliable fuel source confirmation letter has been obtained from the facilities natural gas provider and placed in the LSC survey binder. Item #2 An emergency battery powered light has been placed near the generator. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

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K 144	Continued From page 29 1. On 11/7/13 at 10:50am, an interview with the Maintenance Director revealed that the fuel source for the emergency generator was natural gas and the facility did not have a letter from the provider indicating that it was a reliable supply. 2. On 11/7/13 at 4:07pm, observation revealed that the emergency generator was located outside in an enclosed area and there was no battery powered emergency light in the area. These deficient practices were confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly install electrical wiring in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.5.1 and 9.1.2, as well as, NFPA 70 - 1999 edition. This deficient practice could affect approximately 1 of the 55 residents residents. Findings include: On 11/7/13 at 3:20pm, observation revealed that in room 207 a bed sensor was plugged into an electrical powerstip and not into an electrical outlet installed in accordance with NFPA 70.	K 147	**K 147** The bed sensor has been plugged directly into the wall outlet. Power strips will not be used to provide power supply to patient care equipment. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. Date of compliance 12/13/13.	

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	245084	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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

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K 147	Continued From page 30 This deficient practice was confirmed by the Executive Director and the Maintenance Director at the time of discovery.	K 147		

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

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K017 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5, because the Occupational Therapy gym is open to the corridor.	An annual/continuing waiver is being requested for K 017 item #1. Compliance with this provision will cause an unreasonable hardship because: 1. Construction of walls would separate the Occupational Therapy gym into 2 separate areas and would not allow direct supervision by the therapists. 2. Walls would limit the room layout options and impact the maneuvering/mobility of wheelchairs within the space. 3. Relocation of the Occupational Therapy Gym cannot be accommodated in any other area of the building without severely impacting coordination of care between Occupational Therapy, Speech Therapy and Physical Therapy and would create a significant inconvenience to residents and transportation staff. There will be no adverse effect on the building occupant's safety in accordance with because: 1. The space is not used for patient sleeping rooms and is not a hazardous area. 2. The corridors onto which the space connects to is in the same smoke compartment and is protected by an automatic smoke detection system with quick-response sprinklers. 3. The space does not obstruct access to required exits. 4. Therapists provide supervision whenever the space is in use. 5. The closest fire department is 2 miles away and has an average response time of less than 6 minutes.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FAX to:

Number of Pages:

CCN: 245084

3 Month Date:

Name: Golden Living Center - Wayzata

6 Month Date:

City, State: Wayzata, MN

FMS Survey Date: 11/7/13

Fed Surveyor: 2/10/12

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("W")	
	K17	TW 4/11/14	Annotate 2567
	K20	TW 4/11/14	Waiver form
	K25	TW 4/30/14	AEM: W, TW
	K29	TW 4/30/14	ASPEN: IDR
	K38	TW 6/30/14	ASPEN: Update citations
			ASPEN: Enter POC dates
			Print Revised 2567

TW extension request granted for 5 tags. — Letter; in H; in AEM; lock

Tell facility POC is OK

Ask State to revisit

AEM note

Approved: YES NO

By: S. Pelinski

Date: 3/7/14

Pelinski, Stephen (CMS/CQISCO)

From: Murkowski, Allison 3 [LC02332] <Allison.Murkowski@goldenliving.com>
Sent: Tuesday, March 04, 2014 9:41 AM
To: Pelinski, Stephen (CMS/CQISCO)
Subject: FMS POC

Greetings Steven,

We have run into a few set-backs as it relates to correction of a few of our outstanding FMS tags and need to request extended completion dates.

1. K017 & K020, required dampers are anticipated to arrive this week. Per the vendor they will need approx. 3 weeks for installation and testing. to be safe I am requesting and extension date of 4/11/14. Under advisement of our Mechanical Engineer the bathroom exhaust ducts leading up from the closed lover level bathrooms were capped and fire stopped because installation of dampers was not achievable. The bathroom fixtures will be removed. Do we need to submit some sort of addendum to the POC to reflect this change for K020?
2. K025 & K029, Work was delayed due to asbestos testing of material in the various work areas. We are also waiting on delivery of a few doors that were placed on backorder. An extended date of 4/30/14 is requested.
3. K038, Due to the extended winter season and temperatures continuing to be below zero we do not anticipate having K038 completed by the POC date of 5/15/14. An extended date of 6/30/14 is requested at this time.

Other outstanding items:
Federal approval of annual waiver for K017, Item #1
Federal approval of annual waiver for K067, Item #1
Federal approval of time extension requested on 1/10/14 for K067, Item #2 for 8/31/14

Thank you,
Allison Murkowski, Executive Director
Golden Living Center - Hillcrest of Wayzata
Phone: (952)473 - 5466 X 399
Direct: (952)404-7399
Pager: (612)534-6248
Fax: (952)473-6842

FAX to: Number of Pages:

CCN: 245084 3 Month Date:

Name: Golden Living Center - Wayzata 6 Month Date:

City, State: Wayzata, MN

FMS Survey Date: 11/7/13

Fed Surveyor: 2/10/12

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("W")		
	K17	TW	4/11/14	This is now an Annual Wavier see page 2
	K20	TW	4/11/14	
	K25	TW	4/30/14	
	K29	TW	4/30/14	
	K38	TW	6/30/14	

Annotate 2567

Waiver form

AEM: W, TW

ASPEN: IDR

ASPEN: Update citations

ASPEN: Enter POC dates

Print Revised 2567

TW extension request granted for 5 tags.

Letter; in H; in AEM; lock

Tell facility POC is OK

Ask State to revisit

AEM note

Approved: YES NO By: S. Pelinski Date: 3/7/14

H:\Formlet\LSC POC Review Sheet.xls

Pelinski, Stephen (CMS/CQISCO)

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Sent: Tuesday, March 04, 2014 9:41 AM
To: Pelinski, Stephen (CMS/CQISCO)
Subject: FMS POC

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Other outstanding items:
Federal approval of annual waiver for K017, Item #1
Federal approval of annual waiver for K067, Item #1
Federal approval of time extension requested on 1/10/14 for K067, item #2 for 8/31/14

Thank you,
Allison Murkowski, Executive Director
Golden Living Center - Hillcrest of Wayzata
Phone: (952)473 - 5466 X 399
Direct: (952)404-7399
Pager: (612)534-6248
Fax: (952)473-6842

Larson, Monica (MDH)

From: Whitney, Marian (DPS)
Sent: Thursday, March 20, 2014 9:24 AM
To: Larson, Monica (MDH)
Subject: FW: Golden Living Ctr - Wayzata, #245084
Attachments: Scanned_document_11-03-2014_11-16-23.pdf

Marian Whitney
Healthcare Section
651-201-7213
fax 651-215-0525

From: Sheehan, Pat (DPS)
Sent: Wednesday, March 12, 2014 9:34 AM
To: Rexeisen, Robert (DPS); Whitney, Marian (DPS)
Subject: FW: Golden Living Ctr - Wayzata, #245084

FYI

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

From: Suzuki, Jan M. (CMS/CQISCO) [mailto:Jan.Suzuki@cms.hhs.gov]
Sent: Tuesday, March 11, 2014 11:15 AM
To: Zwart, Benjamin (MDH); Dehler, Robert (MDH); Sheehan, Pat (DPS)
Subject: Golden Living Ctr - Wayzata, #245084

Please see attached for TW extensions granted for LSC FMS deficiencies.

Thanks,

Jan Suzuki
Principal Program Representative
Centers for Medicare & Medicaid Services
RO V, Chicago
Midwest Division of Survey and Certification
LTC Certification and Enforcement Branch
(P) 312-886-5209
(F) 443-380-6602

jan.suzuki@cms.hhs.gov

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H2IB

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

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

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

4. TYPE OF ACTION: **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 **09/13/2013** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **84** (L18)
13.Total Certified Beds **84** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
84				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 11/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Enforcement Specialist — 11/25/2013 (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
01/16/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/25/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN# 245084

At the time of the standard survey completed September 13, 2013, the facility was not in substantial compliance. The most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required. 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 6558

October 30, 2013

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

RE: Project Number S5084023

Dear Ms. Murkowski:

On September 13, 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 September 13, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5084070. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 13, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5084070 that was found to be unsubstantiated.

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;

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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7365
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 23, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 December 13, 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 13, 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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING _____ B. WING _____	09/13/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation of H5084070 was also conducted during the recertification survey and was unsubstantiated.	F 000	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	**F 279** 1. R 43's bowel medications have been reviewed by the resident's physician. All bowl medications have been discontinued. 2. The Registered Dietician has reviewed R43's diet. R43 is receiving a regular diet that includes foods with bran, fruits, nuts, whole grain breads and cereals. Extra fluids are encouraged and prune juice is being offered at each meal. 3. R43's care plan has been revised to include non-pharmacological interventions for constipation. 4. Other residents at risk for constipation will be identified on admission, re-admission, change in condition and quarterly. Residents at risk will have care plans developed that include non-pharmacological interventions.	

POC accepted 11/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allison Muskovka | TITLE: Executive Director | (X6) DATE: 11/12/13

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING _____ B. WING _____	09/13/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for constipation and hypertension for 1 of 5 residents (R43) reviewed for unnecessary medication use. Findings include: R43 had physician orders for bowel medications for constipation however non- pharmacological interventions were not identified on the resident's care plan. In addition, R43 was prescribed multiple hypertensive medications and a care plan was not developed with non-pharmacological interventions to address R43 hypertension. R43 was admitted to facility in 6/11 with diagnoses including vascular dementia, depression, insomnia, and hypertension. The resident was readmitted to the facility on 8/30/13, following a hip fracture. Review of the admission orders dated 8/30/13, revealed the following medications for constipation; Colace 100 mg twice daily for constipation, Senna Tablet 8.6 mg everyday for constipation, Bisacodyl suppository insert 10 mg rectally as needed for constipation, Fleet enema insert one application rectally as needed (used for constipation), as well as Dilaudid (narcotic pain medication with common side effect of constipation) 2 mg every 3 hours as needed for pain. The care plan dated 6/15/11, did not address R43's potential for constipation and	F 279	5. Nursing and Dietary staff responsible for the completion of care plans have been educated on the development of care plans for those at identified at risk for constipation. 6. The Director of Nursing is responsible for monitoring compliance. 7. R43's care plan has been revised to include management of her hypertension and non-pharmacological interventions. 8. Other residents with a diagnosis of hypertension will be identified on admission, re-admission, change in condition and quarterly. The care plans for residents with hypertension will include non-pharmacological interventions for hypertension. 9. Nursing staff responsible for the completion of care plans have been educated on the development of care plans for those with hypertension and to include the use of non-pharmacological interventions. 10. The Director of Nursing is responsible for monitoring compliance. 11. Comprehensive Care plan audits will be completed weekly. 12. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 13. Date of Compliance 11/30/13.	

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

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F 279	Continued From page 2 non-pharmacological interventions to prevent constipation prior to and/or in conjunction with bowel medication. When interviewed on 9/11/13, at 11:09 a.m. LPN-A stated R43 was able to walk independently prior recent hip fracture, but recently had a need for assistance with transferring and mobility. When interviewed on 9/12/13, at 3:18 p.m. LPN-A and RN-A stated medications for constipation were new orders for R43, since readmission from the hospital on 8/30/13, due to risk for constipation related to narcotic pain medication and decreased mobility. Staff were unable to provide documentation that non-pharmacological interventions had been used prior to or in conjunction with the medication use. LPN-A and RN-A also reported on 9/13/13, at 11:25 a.m. that the medical director stated a regular diet was a common intervention. Physician orders dated 8/30/13, revealed anti-hypertensive medication as follows: Cozaar 100 mg daily, metorprolol taratrate 100 mg twice daily, Norvasc 5 mg daily, as well as Lasix 60 mg twice daily for edema (increased on 9/1/13). The care plan dated 6/15/11, did not address R43's hypertension and non-pharmacological interventions to maintain blood pressure such as diet, fluid needs, and range of acceptable blood pressure. When interviewed on 9/13/13, at 11:25 a.m. LPN-A and RN-A confirmed the care plan did not include the resident's hypertension and appropriate interventions.	F 279		

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F 279	Continued From page 3 A facility policy for development of comprehensive care plans was requested, but not provided.	F 279		
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 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document attempts at dose reduction of anti-depressant medication and to	F 329	**F 329** 1. The drug regime for R43 has been reviewed. The routine Trazadone and other bowl medications have been discontinued. 2. The facility has reviewed all residents who have been on an antidepressant for greater than one year to determine if continued use is supported with appropriate documentation. 3. The drug regime of all residents will be reviewed by the DNS or designee during the facilities completion of their quarterly MDS to ensure they are free from unnecessary drugs. 4. The Executive Director will complete a monthly audit to ensure the drug regime of each resident is reviewed with the completion of their quarterly MDS. 5. The Executive Director or designee is responsible for monitoring and compliance. 6. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 7. Date of Compliance 11/30/13.	

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

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F 329	Continued From page 4 utilize non-pharmacological interventions for constipation prior to initiating and/or in conjunction with bowel medications for 1 of 5 residents (R43) reviewed for unnecessary medication use. Findings include: R43 was admitted to the facility in 6/11, and then was hospitalized with a hip fracture and was re-admitted to the facility on 8/30/13. The resident continued to receive Trazodone (antidepressant medication commonly used for insomnia) 75 milligrams (mg) at bedtime and 50 mg as needed prior to and after returning from the hospital. According to the resident's medical record, the last dose reduction attempt for the Trazodone occurred more than 18 months prior, on 3/2/12. The as needed dose had not been administered in 9/13, however, had been administered once in 7/13 and once in 8/13. Documentation was lacking to support the use of non-pharmacological interventions attempted to promote sleep. In addition, attempts at reducing or discontinuation the medication had not been tried. The care plan dated 6/15/11, identified R43 as being at risk for sleep pattern disturbance, has past diagnoses of sleep disturbance, has orders for sleep medication, complains of insomnia or not being able to sleep. The goal of the care plan identified no sleep related behavioral symptoms, such as, restlessness, irritability, lethargy or disorientation and R43 expresses feelings of being well rested. The interventions directed staff to administer sleep medication as ordered by physician, assess for pain and offer pain medications and other interventions if needed,	F 329		

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	245084	A. BUILDING _____ B. WING _____	09/13/2013

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F 329	Continued From page 5	F 329		

assess usual pattern of sleep, discourage resident form consuming caffeine two hours before bedtime, family to bring in personal items and tell staff what may be causing and contributing to problems, maintain environment conductive to sleep (quiet, comfortable temperature, dimmed lights), Offer food, fluids, milk (warm), review medications that resident is receiving for interference with sleep.

When interviewed on 9/13/13, at 10:29 a.m. licensed practical nurse (LPN)- B who worked evening and day shift, stated that R43 laid down in bed, went to sleep, and did not have problems sleeping. LPN-B stated R43 took medication to help her sleep.

On 9/13/13, at 10:45 a.m. a registered nurse (RN)-A and LPN-A stated most of the interventions on the care plan were used every night to promote sleep for residents residing on the memory care unit. R43 had a history of insomnia, but the staff acknowledged R43 had not had a dosage reduction since 3/2/12, or documentation to indicate the efficacy of the non-pharmacological interventions.

Physician orders included the following medications for constipation for R43: Colace 100 mg twice daily, Senna tablet 8.6 mg everyday, as well as Bisacodyl suppository 10 mg rectally as needed and Fleet enema application as necessary. The was prescribed a regular diet, weight bearing as tolerated, and Dilaudid 2 mg every three hours as needed, a narcotic pain medication known to contribute to constipation.

Since the resident's return from the hospital the dietitian had not assessed the resident's change

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F 329	Continued From page 6 in status or whether a extra fluids, a high fiber diet, etc. would have been warranted. The care plan dated 6/15/11, did not address R43's potential for constipation and non-pharmacological interventions to prevent constipation before using medication. When interviewed on 9/11/13, at 11:09 a.m. LPN-A stated R43 was able to walk independently prior recent hip fracture, but recently had a need for assistance with transferring and mobility. When interviewed on 9/12/13, at 3:18 p.m. LPN-A and RN-A stated medications for constipation were new orders for R43, since readmission from the hospital on 8/30/13, due to risk for constipation related to narcotic pain medication and decreased mobility. Staff were unable to provide documentation that non-pharmacological interventions had been used prior to or in conjunction with the medication use. LPN-A and RN-A also reported on 9/13/13, at 11:25 a.m. that the medical director stated a regular diet was a common intervention.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to identify drug regimen irregularities for 1 of 5 residents (R43) reviewed for unnecessary medications. Findings include: R43 was prescribed Trazodone, an antidepressant medication commonly used to promote sleep, and a rationale for the continued use of the medication was not documented. R43 was admitted to the facility in 6/11, and then was hospitalized with a hip fracture and was re-admitted to the facility on 8/30/13. The resident continued to receive Trazodone (antidepressant medication commonly used for insomnia) 75 milligrams (mg) at bedtime and 50 mg as needed prior to and after returning from the hospital. According to the resident's medical record, the last dose reduction attempt for the Trazodone occurred more than 18 months prior, on 3/2/12. The as needed dose had been administered twice from 7/13 to 9/13. Documentation was lacking to support the use of non-pharmacological interventions attempted to promote sleep. In addition, attempts at reducing or discontinuation the medication had not been tried. When interviewed on 9/13/13, at 10:29 a.m. licensed practical nurse (LPN)- B who worked evening and day shift, stated that R43 laid down in bed, went to sleep, and did not have problems sleeping. LPN-B stated R43 took medication to	F 428	**F 428** 1. All resident's drug regimes are reviewed monthly by a licensed pharmacist to identify drug regime irregularities. 2. The pharmacist completes the "Clinical Pharmacist letter to Physician Services" to report any irregularities and recommendation found during their monthly review. 3. The DNS reviews the "Clinical Pharmacist letter to Physician Services" and routes them to the appropriate physician. 4. The drug regime for R43 has been reviewed. The routine Trazadone and Colace have been discontinued and the resident is being offered prune juice daily. 5. The facility has reviewed all residents who have been on an antidepressant for greater than one year to determine if continued use is supported with appropriate documentation. 6. The DNS will complete a monthly audit to ensure the licensed pharmacist has reviewed the drug regime of all residents. 7. The Director of Nursing or designee is responsible for monitoring and compliance 8. The QA Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. 9. Date of Compliance 11/30/13.	

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F 428	Continued From page 8 help her sleep. On 9/13/13, at 10:45 a.m. a registered nurse (RN)-A and LPN-A stated most of the interventions on the care plan were used every night to promote sleep for residents residing on the memory care unit. R43 had a history of insomnia, but the staff acknowledged R43 had not had a dosage reduction since 3/2/12, or documentation to indicate the efficacy of the non-pharmacological interventions. Monthly consultant pharmacist reviews over the previous 12 months, revealed no recommendations related to the lack of use of non-pharmacological interventions to promote sleep or Trazodone dose reduction. A pharmacist note on 3/7/13, asked staff to assess the Trazodone after Celexa (antidepressant) response. No further documentation regarding the Trazodone was noted. The last dose reduction of Celexa was on 9/4/11. When interviewed on 9/20/13, at 8:50 a.m. the consultant pharmacist stated R43 resided in a dementia care unit and as part of the evening care routine staff should have provided a quiet, comfortable, calm environment to promote sleep. The pharmacist acknowledged a dose reduction for the Trazodone has not occurred for over 18 months, but stated the facility had instead been working to reduce R43's antipsychotic medication (last reduction on 6/13), and attempted to work on one medication at a time.	F 428		

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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. A complaint investigation of H5084070 was also conducted during the recertification survey and was unsubstantiated.	F 000		

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

Allison Muskowski | Executive Director | 11/12/13

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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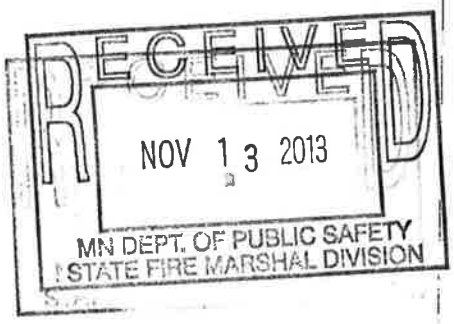
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 19, 2013. At the time of this survey, Golden Livingcenter Hillcrest of Wayzata was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok W/ AW for K67 #1 W/ TW for K67 #2 + 3 FS 11-14-13	

DC: 10-23-13
9-13-13
EXIT.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allison Muskewitz
TITLE: Executive Director
(X6) DATE: 11/12/13

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 By E-Mail 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 Livingcenter Hillcrest Wayzata is a 2-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1958, is 1-story, without a basement and was determined to be Type II (222) construction. In 1960 a two-story addition was constructed to the southwest of the original building down the hill and determined to be of Type II (111) construction. Another addition was constructed in 1973 to the east of the 1960 addition and determined to be Type II (222). In 1992 an in-fill addition was constructed to the east of the existing building, connecting an 2-story assisted living center which is a conforming construction and was determined to be of Type II (111) construction. The building is divided into 8 smoke zones by 1/2 hour fire barriers. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 54 at the time of the survey. Because the original building and the additions are of the conforming construction types the facility was surveyed as 1 building Type II (111). The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect 54 residents. Findings include: On facility tour between 9:30 AM and 2:00 PM on 9/19/2013, observation revealed that the 1963 building west side stairwell exit is not separated at the bottom of the stairs with a 2 hour fire separation from from construction.	K 020	**K 020** 1. A 2 hours fire separation will be added between the bottom of the 1963 building's northwestern stairwell and the lower level construction zone. 2. The 2 hour separation will be completed by 12/13/13. 3. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	Continued From page 3 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 review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 54 residents, visitors and staff. Findings include: On facility tour between 9:30 AM and 2:00 PM on 9/19/2013, a review of the available fire drill reports revealed that the facility's Day-shift fire drills in 2012 and 2013 were conducted between the hours of 10:20 AM, 7:00 AM, 2:00 PM, 2:30 PM, and the Evening-shift fire drills between 5:00 PM, 7:00 PM, 4:30 PM, 4:00 PM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050	**K 050** 1. Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift. 2. The facility has created a 12 month rolling fire drill matrix schedule in accordance with NFPA 101 LSC (00) Section 19.7.1.2. 3. Any drills that deviate from the schedule will be held during the same conditions. 4. The Executive Director is responsible for monitoring and compliance. 5. Date of compliance 12/1/13.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052	Continued From page 4 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation smoke detectors were located within 36 inches of HVAC deflectors. This deficient practice could effect 54 building occupants in the event of a fire emergency and cause delay of the fire alarm activation in accordance with NFPA 70(99) and NFPA 72(99) edition. 9.6.1.4. Findings include: On facility tour between 9:30 PM and 2:00 PM on 9/19/2013, it was observed that 4 smoke detectors located in the 1958 building corridor were located within 36 inches of the HVAC deflectors supply not in accordance with NFPA 72 (99) edition. This deficient practice was confirmed by the facility Administrator and Maintenance Supervisor.	K 052	**K 052** 1. The smoke detectors found to be within 36 inches of an HVAC deflector have been relocated in accordance with NFPA 70 (99) and 72 (99). 9.6.1.4. 2. An audit of the entire building will be completed to ensure no other smoke detectors are within 36 inches of an HVAC deflector. 3. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. 4. Date of compliance 11/30/13.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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

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K 067	Continued From page 5 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and interviews, it was observed that the facility's general heating, ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect the residents. Findings include: During the facility tour between 9:30 AM and 2:00 PM on 9/19/2013, 1.Observation revealed that the ventilation system for the 1958 building is utilizing the egress corridor as the supply air plenum for the resident rooms. There is no ducted return system with the only return appearing to be through the resident room bathroom fans. The HVAC system shuts down on fire alarm but the resident room bathroom fans continuously exhaust. 2. The two main boiler concrete slabs which the boilers are mounted are cracked and in disrepair. 3. In the boiler room the second level concrete walk way to the generator is cracked and in disrepair.	K 067	**K 067** # 1 - Annual waiver requested (See CMS-2786R Form) # 2 - Time extension requested (See CMS-2786R Form) 1. The concrete slabs supporting the boilers will be replaced. 2. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. 3. Date of compliance 3/12/14. # 3 - Time extension requested (See CMS-2786R Form) 1. The concrete cracks in mezzanine of the main boiler room will be repaired. 2. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. 3. Date of compliance 3/12/14.	

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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245084	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 6 This deficient practice was verified by the Administrator and Maintenance Supervisor at the time of the inspection.	K 067		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 9:30 AM and 2:00 PM on 9/19/13, observations revealed in the boiler room next to the sump pump on the wall were rusted and corroded wiring inside conduits and a junction box. This deficient practice was verified by the Administrator and Maintenance Supervisor.	K 147	**K 147** 1. The electrical wiring, conduit and junction box located on the eastern wall of the main boiler room will be replaced. 2. Adam Larson, Director of Maintenance is responsible for correction and monitoring to prevent reoccurrence. 3. Date of compliance 12/13/13.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, November 14, 2013 8:44 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: 'Murkowski, Allison 3 [LC02332]'; Rexeisen, Robert (DPS); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Loveland, Jim (MDH); Meath, Mark (MDH)
Subject: Golden Living Center - Hillcrest of Wayzata (245084) K67 Annual Waiver - Previously Approved - No Changes

This is to inform you that GLC Hillcrest of Wayzata is requesting an annual waiver for K67, corridors as a plenum. The exit date was 9-13-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, November 14, 2013 8:56 AM
To: 'jan.suzuki@cms.hhs.gov'
Cc: 'Murkowski, Allison 3 [LC02332]'; Rexeisen, Robert (DPS); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Loveland, Jim (MDH); Meath, Mark (MDH)
Subject: Golden Living Center - Hillcrest of Wayzata (245084) K67 Temporary Waiver for Items 2 & 3

This is to notify you that I am accepting GLC Hillcrest of Wayzata's request for a temporary waiver until 3-12-14 for items 2 & 3 of K67, to repair a cracked concrete floor in the boiler room that will occur with the replacement of the boiler. The exit date was 9-13-13.

Patrick Sheehan, Fire Safety Supervisor
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Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
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Name of Facility
Golden Living Center - Hillcrest of Wayzata

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K067	Items #2 and #3 A temporary waiver is being requested for K-067 for items #2 and #3 Additional time is being requested to correct items #2 and #3 of K067 as written on the 2567 dated 9/19/13 due to the scope of the repairs, time needed to evaluate the best solution for replacement of the boiler/associated costs and the time necessary to complete to job while maintaining the temperature in the building through the winter months. The proposed compliance date for completion of the repairs is March 12th, 2014.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 11-14-13

Form CMS-2786R (03/04) Previous Versions Obsolete

Name of Facility
Golden Living Center - Hillcrest of Wayzata

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

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

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 11-14-13

Form CMS-2786R (03/04) Previous Versions Obsolete