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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H7WT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245273**

2. STATE VENDOR OR MEDICAID NO. (L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **12/16/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 1/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245273

January 26, 2017

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

Dear Mr. Fischgrabe:

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

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

Effective December 16, 2016 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.
.
You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 19, 2017

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5373027

Dear Mr. Fischgrabe:

On November 29, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 6, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 29, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on October 6, 2016. The most serious health deficiencies in your facility at the time of the standard survey were found 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.

On December 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, as of December 16, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 16, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 29, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 6, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 6, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 6, 2017, is to be rescinded.

In our letter of November 29, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 6, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 16, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245273 Y1	A. Building B. Wing Y2	12/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/16/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 1/19/2017	SIGNATURE OF SURVEYOR 31591	DATE 12/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

January 19, 2017

Ms. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5373027

Dear Mr. Fischgrabe:

On November 29, 2016, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility and imposed a daily fine in the amount of $300.00.

An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on December 16, 2016 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $64.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $364.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00934 Y1	A. Building B. Wing Y2	12/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 A-I LSC	Correction Completed 12/16/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 1/19/2017	SIGNATURE OF SURVEYOR 31591	DATE 12/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H7WT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245273**

2. STATE VENDOR OR MEDICAID NO. (L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **11/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 12/12/16 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/26/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

November 29, 2016

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5273027

Dear Mr. Fischgrabe:

On October 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. 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.

On November 21, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 17, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 6, 2016. The deficiency not corrected is as follows:

0441 Infection Control, Prevent Spread, Linens 483.65

The most serious deficiencies in your facility 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.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective December 4, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 6, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 6, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 6, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Franklin is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 6, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 remedy be imposed:

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

Failure to submit an acceptable ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 April 6, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. An onsite post certification revisit (PCR) was completed on 11/21/16. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	{F 441}		12/16/16

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

Electronically Signed | 12/7/2016

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
	245273	A. BUILDING _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 441}	Continued From page 1 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 441}	Preparation, submission and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 441}	Continued From page 2 review, the facility failed to ensure appropriate infection control techniques related to hand washing and perineal care for 2 of 2 residents (R34, R13) reviewed for infection control. Findings include: During a continuous observation on 11/21/16, at 1:07 p.m., nursing assistant (NA)-A was observed performing cares for R34. NA-A donned gloves and transferred R34 to her bed. NA-A removed R34's incontinent brief which was saturated with urine and placed the brief on the bed, partially on top of a plastic container of wipes before getting a garbage bag and putting the soiled product in the bag. She then wiped R34's perineal area and applied a barrier cream to her bottom. NA-A then removed her gloves, revealing a second pair of gloves underneath the outer pair. She then continued to apply a clean incontinent product to R34, transferred her back into her wheel chair and escorted her out into the hallway. At no time during the observation did NA-A wash her hands. At 1:22 p.m., NA-A entered R13's room. She applied gloves and transferred R13 into her wheel chair and assisted her into the bathroom. At this time surveyor intervened and requested NA-A wash her hands before proceeding to care for R13. During an interview on 11/21/16, at 1:37 p.m., NA-A stated she attended a recent handwashing education in-service. She stated she was supposed to wash her hands after caring for a resident and when "we clean them with spray." NA-A further stated she puts on two pairs of gloves so when she is done changing a resident she can remove the dirty ones and use the clean ones. NA-A stated she forgot to wash her hands	{F 441}	implementation of correction does not constitute and admission of or agreement with the facts and conclusions set forth on the survey report. our Plan of Correction is and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F441 It is the policy of Golden Living Center-Franklin that the facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of Correction for identified incident. All residents have to potential to be affected by not following protocol for hand hygiene and peri care. Staff have received re-education in regards to proper hand hygiene and peri care, to prevent the spread of infection. DNS/Designee to complete bi-weekly audits at random. Audits to be reviewed at monthly QAPI meetings. QAPI committee will provide direction and suggest change in auditing or practice when necessary based on the compliance noted, when reviewing audits. Audits needing direct follow up, will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

(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 441}	Continued From page 3 after caring for R13. During an interview on 11/21/16, at 1:42 p.m., the director of nursing (DON) stated the staff had recently received education regarding hand washing. The DON stated staff should wash their hands before and after caring for a resident. She further stated staff should not be wearing multiple sets of gloves. A facility policy titled Golden Living Handwashing/Hand Hygiene dated August 2014 indicated the facility considers hand hygiene the primary means to prevent the spread of infection. The policy directed staff to wash/sanitize hands before and after contact with a resident, after contact with bodily fluids and after removing gloves.	{F 441}	reviewed weekly at morning stand up.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245273 (Y1)	A. Building B. Wing (Y2)	11/21/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 11/17/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 11/17/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 12/12/2016	SIGNATURE OF SURVEYOR 35569	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on December 12, 2016

November 29, 2016

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

Re: Project # S5273027

Dear Mr. Fischgrabe:

On November 21, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 6, 2016 with orders received by you electronically on .

State licensing orders issued pursuant to the last survey completed on October 6, 2016 and found corrected at the time of this November 21, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on October 6, 2016, found not corrected at the time of this November 21, 2016 revisit and subject to penalty assessment are as follows:

21390 MN Rule 4658.0800 Subp. 4 A- 1 Infection Control $300.00

The details of the violations noted at the time of this revisit completed on November 21, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 11/21/16. During this onsite visit it was determined that the following corrections orders/s # 4658.0800 subd. 4A-1 were NOT corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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) COMPLETE DATE
{2 000}	Continued From page 1 penalty assessment/s.	{2 000}		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control techniques related to hand	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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21390	Continued From page 2 washing and perineal care for 2 of 2 residents (R34, R13) reviewed for infection control. Findings include: During a continuous observation on 11/21/16, at 1:07 p.m., nursing assistant (NA)-A was observed performing cares for R34. NA-A donned gloves and transferred R34 to her bed. NA-A removed R34's incontinent brief which was saturated with urine and placed the brief on the bed, partially on top of a plastic container of wipes before getting a garbage bag and putting the soiled product in the bag. She then wiped R34's perineal area and applied a barrier cream to her bottom. NA-A then removed her gloves, revealing a second pair of gloves underneath the outer pair. She then continued to apply a clean incontinent product to R34, transferred her back into her wheel chair and escorted her out into the hallway. At no time during the observation did NA-A wash her hands. At 1:22 p.m., NA-A entered R13's room. She applied gloves and transferred R13 into her wheel chair and assisted her into the bathroom. At this time surveyor intervened and requested NA-A wash her hands before proceeding to care for R13. During an interview on 11/21/16, at 1:37 p.m., NA-A stated she attended a recent handwashing education in-service. She stated she was supposed to wash her hands after caring for a resident and when "we clean them with spray." NA-A further stated she puts on two pairs of gloves so when she is done changing a resident she can remove the dirty ones and use the clean ones. NA-A stated she forgot to wash her hands after caring for R13. During an interview on 11/21/16, at 1:42 p.m., the	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	R 11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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21390	Continued From page 3 director of nursing (DON) stated the staff had recently received education regarding hand washing. The DON stated staff should wash their hands before and after caring for a resident. She further stated staff should not be wearing multiple sets of gloves. A facility policy titled Golden Living Handwashing/Hand Hygiene dated August 2014 indicated the facility considers hand hygiene the primary means to prevent the spread of infection. The policy directed staff to wash/sanitize hands before and after contact with a resident, after contact with bodily fluids and after removing gloves.	21390		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00934 Y1	A. Building B. Wing Y2	11/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 11/21/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 11/21/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 12/12/2016	SIGNATURE OF SURVEYOR 35569	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H7WT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245273**

2. STATE VENDOR OR MEDICAID NO. (L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **10/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR-Dietary Specialist 10/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 17, 2016

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5273027

Dear Mr. Fischgrabe:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute 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.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 January 6, 2017 (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 April 6, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		11/17/16

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

Electronically Signed | 10/27/2016

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

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise and implement the care plan for 1 of 4 residents (R34) reviewed for falls. Findings include: R34's care plan dated 3/7/16, indicated R34 was at risk for falls and included the following interventions: mattress moved to floor related to frequent falls from bed due to her impulsiveness; to prevent major injuries, mattress against wall d/t (due to) frequent falls, toilet schedule: staff assist q2h (every two hours) and prn (as needed) to promote skin integrity, manage incontinent product and perform peri cares after each incontinent episode as needed. The care plan did not include the use of a mechanical lift. R34's quarterly Minimum Data Set (MDS) assessment dated 8/24/16, indicated R34 received two person extensive assistance for bed mobility, transfers and toileting. R34's diagnoses included dementia, anxiety, kyphosis, muscle weakness and osteoporosis. R34's bowel and bladder care plan dated 9/9/16, indicated R34 could use walker and commode in room. R34's care plan further included R34 required extensive assistance with bed mobility, dressing, and transfers. The care plan did not include the use of a mechanical lift. R34's nursing assistant care sheet (undated) directed staff R34 transferred with assist of one staff member and a mechanical lift. The care	F 280	Preparation, submission and implementation 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. F280 R34's care plan and care sheets have been reviewed and updated to fall preventions and transfers accordingly. All residents have the potential to be affected if care plans are not updated to address current status. All fall reports will be reviewed by the IDT team, the IDT will come up with an intervention that will be implemented. The DNS/designee will update the care plan and care sheets accordingly and communicate the intervention to all nursing staff. Licensed staff will be re-educated on updating care plans, and updating care sheets on a weekly basis. Weekly care plan audits will be completed by the DNS/designee on random residents to assure care plans and care sheets reflect current care needs of the resident.	

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F 280	Continued From page 2 sheet included R34 to be a high fall risk and included R34's mattress was on the floor facing her head towards the closet when in bed. The care sheet directed staff R34 was assist of one for transfers every two hours and as needed. During the initial tour on 10/3/16, at 2:45 p.m. a mattress was observed on the floor of R34's room. On 10/4/16, at 9:04 a.m. nursing assistant (NA)-A stated R34 was assisted out of bed using a full mechanical lift, but in order to use the lift, R34 had to be sat up in bed so staff could lift up the mattress to put the legs of the lift under the mattress. NA-A stated that was the only way to hook R34 up to the lift as the legs did not fit around the mattress. On 10/4/16, at 2:06 p.m. R34 was observed asleep in her room on the mattress, covered up with a blanket and a body pillow on her left side. A floor mat was next to the mattress. -At 3:45 p.m. NA-B entered R34's room and stated "I'm going to get you up for supper, ok?" R34 replied "ok". NA-B then knelt on the floor mat next to R34's mattress. NA-B removed the body pillow from R34's left side and provided perineal (peri) care to R34. After NA-B finished pericare, NA-B brought R34's wheelchair next to the mattress and locked the brakes. NA-B then assisted R34 into a seated position on the mattress. NA-B then stood up and grabbed R34 by both hands and pulled R34 off of the mattress into a standing position. Once R34 was in a standing position, NA-B directed R34 to put her hands around NA-B's neck so she could steps toward the wheelchair and lowered R34 into wheelchair. NA-B then adjusted R34 in her	F 280	Audits will be reviewed by QAPI committee. Committee will provide direction and suggest change in auditing or practice when necessary based on compliance noted, when reviewing the audits. Executive Director or designee is responsible for compliance.	

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F 280	Continued From page 3	F 280		

wheelchair and wheeled her out of the room.
-NA-B was interviewed and stated that it was hard on her knees to help R34, but it was better now that there was a floor mat next to the mattress. NA-B stated R34's body pillow was put on her left side so that "she can't crawl out of bed, she can't get over the pillow."

On 10/5/16, at 9:20 a.m. NA-D and NA-E were interviewed and stated R34 was to be transferred using two staff and a gait belt. The two staff were to have R34 stand up and grab on to her walker to stand up from her wheelchair and then the two staff would lower R34 on to the mattress and staff would need to be on the floor on their knees to provide additional care assistance. NA-D and NA-E indicated that R34 used to have a higher bed but after continuous falls from bed was removed.

On 10/5/16, at 1:07 p.m. NA-D was observed assisting R34 to the bathroom. NA-D applied a gait belt around R34's waist and directed R34 to put her hands on the grab bar on the wall and directed R34 to stand up. NA-D assisted R34 to stand and pivot turn as NA-D pulled R34's pants down and assisted her to sit on the toilet. NA-D provided peri care to R34 when she was finished on the toilet and assisted R34 to stand using the grab bar and turn to sit in her wheelchair.

Registered nurse (RN)-A was interviewed on 10/5/16, at 9:25 a.m. who stated R34 did not have a bed due to her having four falls from bed. RN-A went on to say that due to multiple falls from bed the decision was made to take away R34's bed frame and put a mattress on the floor. RN-A stated R34 was to be transferred using a full mechanical lift. RN-A went on to say staff

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F 280	Continued From page 4	F 280		

were to use a sheet to transfer R34 from the mattress to the floor mat and then use the lift to assist R34 off of the floor. RN-A was not aware of R34 being transferred without the use of the lift. RN-A confirmed staff should not be transferring R34 by pulling her off of the mattress by her hands. RN-A was questioned on the care plan only including "extensive assist" verses the nursing assistant care plan that directed staff to use the lift. RN-A confirmed the care plan was inconsistent. RN-A went through incident reports and fall interdisciplinary team (IDT) notes and confirmed the intervention put into place after R34's 5/21/16, fall was not implemented. RN-A confirmed that should have been completed and confirmed R34 had another fall from bed on 5/27/16.

The director of nursing (DON) was interviewed on 10/5/16, at 10:07 a.m. who stated R34 had multiple falls out of bed and when she ran out of interventions she was told by nurse consultants to try putting R34's mattress on the floor. The DON stated R34 transferred with a mechanical lift and staff were to assist R34 to the floor mat and use the lift to assist R34 off of the floor. The DON confirmed it was not appropriate to lift up R34's mattress to put the lift legs underneath. The DON was questioned about the different assistance staff was providing during transfers. The DON stated "we can't be doing that" and staff was to use the full lift for transfers. The DON was also questioned about staff using a body pillow on R34's left side when she was in bed so she was unable to roll out. The DON stated "we can't be doing that, they are restraining her then and we can't be doing that." The DON went on to say staff should use body pillows for positioning only.

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F 323	Continued From page 5	F 323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions, follow the care plan and safely transfer 1 of 4 residents (R34) reviewed for falls. Findings include: During the initial tour on 10/3/16, at 2:45 p.m. a mattress was observed on the floor of R34's room. On 10/4/16, at 9:04 a.m. registered nurse (RN)-A and nursing assistant (NA)-A pushed R34 into her room. A mattress was observed on the floor of R34's room. RN-A indicated she was completing an assessment on R34 to see if she could work with therapy and use the commode in her room. RN-A and NA-A applied a gait belt around R34's waist and directed R34 to put her hands on her walker and assisted R34 to a standing position. RN-A and NA- then assisted R34 to turn and sit down on the commode after assisting her with pulling down her pants and incontinent pad. RN-A stated R34 did well with this transfer and she was going to tell therapy to start working with her on	F 323	F323 R34's bed was removed off of the floor and placed on a bed frame. R34 was provided a wider bed and a sensor alarm to alert staff and positioning pillow removed. All residents and staff have the potential for injury, when caring for a resident whose mattress is on the floor. Re-education provided to all staff on safe handling of residents, proper bed positioning and use of positioning pillows. Weekly audits of resident care including transfers and bed positioning will be completed on random residents to monitor for ongoing compliance. Audits will be reviewed by QAPI Committee. Committee will provide direction and suggest change in auditing or practice when necessary based on the compliance noted, when reviewing the audits.	11/17/16

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F 323	Continued From page 6 transfers. On 10/4/16, at 9:12 a.m. NA-A was interviewed and stated that R34's bed was removed and a mattress was placed on the floor after R34 was determined a high fall risk and had multiple falls out of bed. NA-A stated R34 was assisted out of bed using a full mechanical lift, but in order to use the lift, R34 had to be sat up in bed so staff could lift up the mattress to put the legs of the lift under the mattress. NA-A stated that was the only way to hook R34 up to the lift as the legs did not fit around the mattress. NA-A stated that was "ridiculous" and staff had to be on their hands and knees to assist R34 as the bed was not adjustable and R34 was unable to be toileted. Staff was directed to check and change R34's incontinent product every two hours. On 10/4/16, at 2:06 p.m. R34 was observed asleep in her room on the mattress, covered up with a blanket and a body pillow on her left side. A floor mat was next to the mattress. At 3:45 p.m. NA-B entered R34's room and stated "I'm going to get you up for supper, ok?" R34 replied "ok." NA-B then knelt on the floor mat next to R34's mattress. NA-B removed the body pillow from R34's left side and provided perineal (peri) care to R34. After NA-B finished pericare, NA-B brought R34's wheelchair next to the mattress and locked the brakes. NA-B then assisted R34 into a seated position on the mattress. NA-B then stood up and grabbed R34 by both hands and pulled R34 off of the mattress into a standing position. Once R34 was in a standing position, NA-B directed R34 to put her hands around NA-B's neck so she could steps toward the wheelchair and lowered R34 into wheelchair. NA-B then adjusted R34 in her wheelchair and wheeled her out of the room.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

NA-B was interviewed and stated that it was hard on her knees to help R34, but it was better now that there was a floor mat next to the mattress. NA-B stated R34's body pillow was put on her left side so that "she can't crawl out of bed, she can't get over the pillow."

On 10/5/16, at 1:07 p.m. NA-D was observed assisting R34 to the bathroom. NA-D applied a gait belt around R34's waist and directed R34 to put her hands on the grab bar on the wall and directed R34 to stand up. NA-D assisted R34 to stand and pivot turn as NA-D pulled R34's pants down and assisted her to sit on the toilet. NA-D provided peri care to R34 when she was finished on the toilet and assisted R34 to stand using the grab bar and turn to sit in her wheelchair.

R34's care plan dated 3/7/16, indicated R34 was at risk for falls and included the following interventions: mattress moved to floor related to frequent falls from bed due to her impulsiveness; to prevent major injuries, mattress against wall d/t (due to) frequent falls, toilet schedule: staff assist q2h (every two hours) and prn (as needed) to promote skin integrity, manage incontinent product and perform peri cares after each incontinent episode as needed.

R34's quarterly Minimum Data Set (MDS) assessment dated 8/24/16, indicated R34 received two person extensive assistance for bed mobility, transfers and toileting. R34 had diagnoses that included dementia, anxiety, kyphosis, muscle weakness and osteoporosis.

R34's bowel and bladder care plan dated 9/9/16, indicated R34 could use walker and commode in room. R34's care plan further included R34

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	245273	A. BUILDING _____ B. WING _____	10/06/2016

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required extensive assistance with bed mobility, dressing, and transfers.

R34's nursing assistant care sheet (undated) directed staff R34 transferred with assist of one staff member and a mechanical lift. The care sheet included R34 to be a high fall risk and included R34's mattress was on the floor facing her head towards the closet when in bed. The care sheet directed staff R34 was assist of one for transfers every two hours and as needed.

On 10/5/16, at 9:20 a.m. NA-D and NA-E were interviewed and stated R34 was to be transferred using two staff and a gait belt. The two staff were to have R34 stand up and grab on to her walker to stand up from her wheelchair and then the two staff would lower R34 on to the mattress and staff would need to be on the floor on their knees to provide additional care assistance. NA-D and NA-E indicated R34 used to have a higher bed but after continuous falls from bed was removed.

RN-A was interviewed on 10/5/16, at 9:25 a.m. who stated R34 did not have a bed due to her having four falls from bed. RN-A went on to say that due to multiple falls from bed the decision was made to take away R34's bed frame and put a mattress on the floor. RN-A stated R34 was to be transferred using a full mechanical lift. RN-A went on to say staff were to use a sheet to transfer R34 from the mattress to the floor mat and then use the lift to assist R34 off of the floor. RN-A was not aware of R34 being transferred without the use of the lift. RN-A confirmed staff should not be transferring R34 by pulling her off of the mattress by her hands. RN-A was questioned on the care plan only including "extensive assist" verses the nursing assistant

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F 323	Continued From page 9 care plan that directed staff to use the lift. RN-A confirmed the care plan was inconsistent. RN-A went through incident reports and fall interdisciplinary team (IDT) notes and confirmed the intervention put into place after R34's 5/21/16, fall was not implemented. RN-A confirmed that should have been completed and confirmed R34 had another fall from bed on 5/27/16. The director of nursing (DON) was interviewed on 10/5/16, at 10:07 a.m. who stated R34 had multiple falls out of bed and when she ran out of interventions she was told by nurse consultants to try putting R34's mattress on the floor. The DON stated R34 transferred with a mechanical lift and staff were to assist R34 to the floor mat and use the lift to assist R34 off of the floor. The DON confirmed it was not appropriate to lift up R34's mattress to put the lift legs underneath. The DON was questioned about the different assistance staff was providing during transfers. The DON stated "we can't be doing that" and staff was to use the full lift for transfers. The DON was also questioned about staff using a body pillow on R34's left side when she was in bed so she was unable to roll out. The DON stated "we can't be doing that, they are restraining her then and we can't be doing that." The DON went on to say staff should use body pillows for positioning only.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		11/17/16

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F 441	Continued From page 10 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection prevention measures related to hand washing and perineal care for 3 of 3 residents (R24, R13, R34) reviewed during the survey.	F 441	It is the policy of Golden Living Center Franklin that the facility must establish and maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	

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F 441	Continued From page 11 Findings include; R24: During on observation on 10/5/16, at 10:13 a.m., RN-B entered R24's room to complete a dressing change to her right hip. RN-B carried a plastic tote into R24's rooom, set it down on a side table. RN-B put on a pair of gloves and removed the dressing from R24's hip. RN-B then touched his name tag, irrigated the wound and applied powder to the outside of the open wound. He then grabbed a pair of scissirs and a q-tip out of the basket. After measurinhe should have washed hisg the wound, RN-B covered the wound, returned the scissors to the basket, grabbed the garbage and left the room. Rn-B did not change his gloves or wash/sanitize his hands at any time during the dressing change. During an interview on 10/5/16, at 10:23 a.m., RN-B stated he should have washed his hands after removing his gloves. He stated, "I didn't wash between the clean and the dirty." During an interveiw on 10/6/16, at 9:12 a.m., RN-C stated she expected staff to wash hands when entering a room and to change gloves and wash of sanitize hands after removing a dressing prior to applying a new treatment and before leaving the room. She further stated staff should not be touching other items with gloves on. A facility policy titled Golden Living, Handwashing/Hand Hygeine, dated August 2014 indicated the facility considers hand hygeine to be the praminary means to prevent the spread of infections. The policy directed staff to wash hands before and after direct contact with residents, before and after handling clean or soiled	F 441	transmission of disease and infection. Plan of correction for identified incidents: All residents have the potential to be affected by not following protocol for hand hygiene. Staff will receive education in regards to the infection control policy and the importance of proper hand hygiene to prevent the spread of infection. DNS/Designee will complete weekly random audits to monitor for compliance of infection control policy. Audits will be reviewed by QAPI Committee. Committee will provide direction and suggest change in auditing or practice when necessary based on the compliance noted, when reviewing audits. DNS/designee is responsible for compliance.	

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dressings, and after removing gloves.
R13:
On 10/4/16 at 3:27 p.m. NA-B and NA-C entered R13's room to assist her out of bed and into her wheelchair. Prior to assisting R13 out of bed, NA-B and NA-C donned gloves and directed R13 to roll side to side to assist R13 with an incontinent product change. As R13 was turned toward NA-C, NA-B removed R13's soiled incontinent product and placed a new incontinent product underneath R13. NA-B did not perform perineal care after removing the soiled incontinent product and did not remove her dirty gloves before placing the clean incontinent product under R13. NA-B and NA-C then assisted R13 with pulling up her pants and assited her from the bed to the wheelchair using a mechanical lift. At 3:34 p.m. NA-B was interviewed and stated she did not remove her gloves before placing a clean incontient product underneath R13. NA-B stated that she usually completed perineal care with every incontinent product change but did not have wipes near her to complete R13's pericare. NA-B stated R13's incontinent product was wet.

R34:
On 10/4/16, at 3:45 p.m.NA-B went into R34's room to assit R34 out of bed and into her wheelchair. NA-B was observed to change R34's incontinent product and performed perineal care. NA-B donned gloves and removed R34's soiled incontinent pad and set it on the floor on top of R34'S floor mat. NA-B then removed her gloves, set them on the incontinent pad on the floor and donned new gloves. NA-B then assisted R34 with perineal care. NA-B cleansed R34's perineal area, then had R34 turn to her right and continued to provide perineal care wiping R34

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F 441	Continued From page 13 from her buttocks toward her perineal area (back to front) and then wiped R34 from perineal are towards her buttocks. NA-B then threw the wipes on the floor on the incontinent pad and removed her gloves. NA-B then put a clean incontinent pad underneath R34 and assisted R34 with dressing and assisted her out of bed into her wheelchair. NA-B then stated she was going to get a garbage bag to throw away the soiled items. NA-B was interviewed at 3:50 p.m. and stated she usually had a bag next to her but she forgot and usually completed peri-care from front to back but she "forgot and missed that this time." The director of nursing (DON) was interviewed on 10/6/16 at 12:48 p.m. and stated NA-B should be providing pericare with every incontinent pad change and should be providing perineal care "front to back." The DON went on to say NA-B should be changing her gloves after handling soiled linen or soiled incontient products and should be using hand sanitizer between glove changes. The DON also stated NA-B should be disposing of incontinent products and used gloves directly into the garbage and not throw them onto the floor.	F 441		

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

F5273025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

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GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

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K 000	INITIAL COMMENTS Fire Safety A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 05,2016. At the time of this survey, Golden Living Center Franklin was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Golden Living Center Franklin was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The building has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility	K 000		

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 has a capacity of 46 beds and had a census of 41 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
October 17, 2016

Mr. Dru Fischgrabe, Administrator
Golden LivingCenter - Franklin
900 3rd Street South
Franklin, MN 55333

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5273027

Dear Mr. Fischgrabe:

The above facility was surveyed on October 3, 2016 through October 6, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	10/06/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/3/16 through 10/6/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise and implement the care plan for 1 of 4 residents (R34) reviewed for falls. Findings include: R34's care plan dated 3/7/16, indicated R34 was at risk for falls and included the following interventions: mattress moved to floor related to frequent falls from bed due to her impulsiveness; to prevent major injuries, mattress against wall d/t (due to) frequent falls, toilet schedule: staff assist q2h (every two hours) and prn (as needed) to promote skin integrity, manage incontinent	2 570	Preparation, submission and implementation 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. F280 R34's care plan and care sheets have been reviewed and updated to fall preventions and transfers accordingly. All	11/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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2 570	Continued From page 3 product and perform peri cares after each incontinent episode as needed. The care plan did not include the use of a mechanical lift. R34's quarterly Minimum Data Set (MDS) assessment dated 8/24/16, indicated R34 received two person extensive assistance for bed mobility, transfers and toileting. R34's diagnoses included dementia, anxiety, kyphosis, muscle weakness and osteoporosis. R34's bowel and bladder care plan dated 9/9/16, indicated R34 could use walker and commode in room. R34's care plan further included R34 required extensive assistance with bed mobility, dressing, and transfers. The care plan did not include the use of a mechanical lift. R34's nursing assistant care sheet (undated) directed staff R34 transferred with assist of one staff member and a mechanical lift. The care sheet included R34 to be a high fall risk and included R34's mattress was on the floor facing her head towards the closet when in bed. The care sheet directed staff R34 was assist of one for transfers every two hours and as needed. During the initial tour on 10/3/16, at 2:45 p.m. a mattress was observed on the floor of R34's room. On 10/4/16, at 9:04 a.m. nursing assistant (NA)-A stated R34 was assisted out of bed using a full mechanical lift, but in order to use the lift, R34 had to be sat up in bed so staff could lift up the mattress to put the legs of the lift under the mattress. NA-A stated that was the only way to hook R34 up to the lift as the legs did not fit around the mattress.	2 570	residents have the potential to be affected if care plans are not updated to address current status. All fall reports will be reviewed by the IDT team, the IDT will come up with an intervention that will be implemented. The DNS/designee will update the care plan and care sheets accordingly and communicate the intervention to all nursing staff. Licensed staff will be re-educated on updating care plans, and updating care sheets on a weekly basis. Weekly care plan audits will be completed by the DNS/designee on random residents to assure care plans and care sheets reflect current care needs of the resident. Audits will be reviewed by QAPI committee. Committee will provide direction and suggest change in auditing or practice when necessary based on compliance noted, when reviewing the audits. Executive Director or designee is responsible for compliance.	

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2 570	Continued From page 4 On 10/4/16, at 2:06 p.m. R34 was observed asleep in her room on the mattress, covered up with a blanket and a body pillow on her left side. A floor mat was next to the mattress. -At 3:45 p.m. NA-B entered R34's room and stated "I'm going to get you up for supper, ok?" R34 replied "ok." NA-B then knelt on the floor mat next to R34's mattress. NA-B removed the body pillow from R34's left side and provided perineal (peri) care to R34. After NA-B finished pericare, NA-B brought R34's wheelchair next to the mattress and locked the brakes. NA-B then assisted R34 into a seated position on the mattress. NA-B then stood up and grabbed R34 by both hands and pulled R34 off of the mattress into a standing position. Once R34 was in a standing position, NA-B directed R34 to put her hands around NA-B's neck so she could steps toward the wheelchair and lowered R34 into wheelchair. NA-B then adjusted R34 in her wheelchair and wheeled her out of the room. -NA-B was interviewed and stated that it was hard on her knees to help R34, but it was better now that there was a floor mat next to the mattress. NA-B stated R34's body pillow was put on her left side so that "she can't crawl out of bed, she can't get over the pillow." On 10/5/16, at 9:20 a.m. NA-D and NA-E were interviewed and stated R34 was to be transferred using two staff and a gait belt. The two staff were to have R34 stand up and grab on to her walker to stand up from her wheelchair and then the two staff would lower R34 on to the mattress and staff would need to be on the floor on their knees to provide additional care assistance. NA-D and NA-E indicated that R34 used to have a higher bed but after continuous falls from bed was removed.	2 570		

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2 570	Continued From page 5 On 10/5/16, at 1:07 p.m. NA-D was observed assisting R34 to the bathroom. NA-D applied a gait belt around R34's waist and directed R34 to put her hands on the grab bar on the wall and directed R34 to stand up. NA-D assisted R34 to stand and pivot turn as NA-D pulled R34's pants down and assisted her to sit on the toilet. NA-D provided peri care to R34 when she was finished on the toilet and assisted R34 to stand using the grab bar and turn to sit in her wheelchair. Registered nurse (RN)-A was interviewed on 10/5/16, at 9:25 a.m. who stated R34 did not have a bed due to her having four falls from bed. RN-A went on to say that due to multiple falls from bed the decision was made to take away R34's bed frame and put a mattress on the floor. RN-A stated R34 was to be transferred using a full mechanical lift. RN-A went on to say staff were to use a sheet to transfer R34 from the mattress to the floor mat and then use the lift to assist R34 off of the floor. RN-A was not aware of R34 being transferred without the use of the lift. RN-A confirmed staff should not be transferring R34 by pulling her off of the mattress by her hands. RN-A was questioned on the care plan only including "extensive assist" verses the nursing assistant care plan that directed staff to use the lift. RN-A confirmed the care plan was inconsistent. RN-A went through incident reports and fall interdisciplinary team (IDT) notes and confirmed the intervention put into place after R34's 5/21/16, fall was not implemented. RN-A confirmed that should have been completed and confirmed R34 had another fall from bed on 5/27/16. The director of nursing (DON) was interviewed on 10/5/16, at 10:07 a.m. who stated R34 had multiple falls out of bed and when she ran out of	2 570		

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2 570	Continued From page 6 interventions she was told by nurse consultants to try putting R34's mattress on the floor. The DON stated R34 transferred with a mechanical lift and staff were to assist R34 to the floor mat and use the lift to assist R34 off of the floor. The DON confirmed it was not appropriate to lift up R34's mattress to put the lift legs underneath. The DON was questioned about the different assistance staff was providing during transfers. The DON stated "we can't be doing that" and staff was to use the full lift for transfers. The DON was also questioned about staff using a body pillow on R34's left side when she was in bed so she was unable to roll out. The DON stated "we can't be doing that, they are restraining her then and we can't be doing that." The DON went on to say staff should use body pillows for positioning only. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		11/17/16

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2 830	Continued From page 7 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions, follow the care plan and safely transfer 1 of 4 residents (R34) reviewed for falls. Findings include: During the initial tour on 10/3/16, at 2:45 p.m. a mattress was observed on the floor of R34's room. On 10/4/16, at 9:04 a.m. registered nurse (RN)-A and nursing assistant (NA)-A pushed R34 into her room. A mattress was observed on the floor of R34's room. RN-A indicated she was completing an assessment on R34 to see if she could work with therapy and use the commode in her room. RN-A and NA-A applied a gait belt around R34's waist and directed R34 to put her hands on her walker and assisted R34 to a standing position. RN-A and NA- then assisted R34 to turn and sit down on the commode after assisting her with pulling down her pants and incontinent pad. RN-A stated R34 did well with this transfer and she was going to tell therapy to start working with her on transfers. On 10/4/16, at 9:12 a.m. NA-A was interviewed and stated that R34's bed was removed and a mattress was placed on the floor after R34 was determined a high fall risk and had multiple falls out of bed. NA-A stated R34 was assisted out of bed using a full mechanical lift, but in order to use	2 830	F323 R34's bed was removed off of the floor and placed on a bed frame. R34 was provided a wider bed and a sensor alarm to alert staff and positioning pillow removed. All residents and staff have the potential for injury, when caring for a resident whose mattress is on the floor. Re-education provided to all staff on safe handling of residents, proper bed positioning and use of positioning pillows. Weekly audits of resident care including transfers and bed positioning will be completed on random residents to monitor for ongoing compliance. Audits will be reviewed by QAPI Committee. Committee will provide direction and suggest change in auditing or practice when necessary based on the compliance noted, when reviewing the audits.	

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2 830	Continued From page 8 the lift, R34 had to be sat up in bed so staff could lift up the mattress to put the legs of the lift under the mattress. NA-A stated that was the only way to hook R34 up to the lift as the legs did not fit around the mattress. NA-A stated that was "ridiculous" and staff had to be on their hands and knees to assist R34 as the bed was not adjustable and R34 was unable to be toileted. Staff was directed to check and change R34's incontinent product every two hours. On 10/4/16, at 2:06 p.m. R34 was observed asleep in her room on the mattress, covered up with a blanket and a body pillow on her left side. A floor mat was next to the mattress. At 3:45 p.m. NA-B entered R34's room and stated "I'm going to get you up for supper, ok?" R34 replied "ok." NA-B then knelt on the floor mat next to R34's mattress. NA-B removed the body pillow from R34's left side and provided perineal (peri) care to R34. After NA-B finished pericare, NA-B brought R34's wheelchair next to the mattress and locked the brakes. NA-B then assisted R34 into a seated position on the mattress. NA-B then stood up and grabbed R34 by both hands and pulled R34 off of the mattress into a standing position. Once R34 was in a standing position, NA-B directed R34 to put her hands around NA-B's neck so she could steps toward the wheelchair and lowered R34 into wheelchair. NA-B then adjusted R34 in her wheelchair and wheeled her out of the room. NA-B was interviewed and stated that it was hard on her knees to help R34, but it was better now that there was a floor mat next to the mattress. NA-B stated R34's body pillow was put on her left side so that "she can't crawl out of bed, she can't get over the pillow." On 10/5/16, at 1:07 p.m. NA-D was observed assisting R34 to the bathroom. NA-D applied a	2 830		

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2 830	Continued From page 9 gait belt around R34's waist and directed R34 to put her hands on the grab bar on the wall and directed R34 to stand up. NA-D assisted R34 to stand and pivot turn as NA-D pulled R34's pants down and assisted her to sit on the toilet. NA-D provided peri care to R34 when she was finished on the toilet and assisted R34 to stand using the grab bar and turn to sit in her wheelchair. R34's care plan dated 3/7/16, indicated R34 was at risk for falls and included the following interventions: mattress moved to floor related to frequent falls from bed due to her impulsiveness; to prevent major injuries, mattress against wall d/t (due to) frequent falls, toilet schedule: staff assist q2h (every two hours) and prn (as needed) to promote skin integrity, manage incontinent product and perform peri cares after each incontinent episode as needed. R34's quarterly Minimum Data Set (MDS) assessment dated 8/24/16, indicated R34 received two person extensive assistance for bed mobility, transfers and toileting. R34 had diagnoses that included dementia, anxiety, kyphosis, muscle weakness and osteoporosis. R34's bowel and bladder care plan dated 9/9/16, indicated R34 could use walker and commode in room. R34's care plan further included R34 required extensive assistance with bed mobility, dressing, and transfers. R34's nursing assistant care sheet (undated) directed staff R34 transferred with assist of one staff member and a mechanical lift. The care sheet included R34 to be a high fall risk and included R34's mattress was on the floor facing her head towards the closet when in bed. The care sheet directed staff R34 was assist of one	2 830		

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2 830	Continued From page 10 for transfers every two hours and as needed. On 10/5/16, at 9:20 a.m. NA-D and NA-E were interviewed and stated R34 was to be transferred using two staff and a gait belt. The two staff were to have R34 stand up and grab on to her walker to stand up from her wheelchair and then the two staff would lower R34 on to the mattress and staff would need to be on the floor on their knees to provide additional care assistance. NA-D and NA-E indicated R34 used to have a higher bed but after continuous falls from bed was removed. RN-A was interviewed on 10/5/16, at 9:25 a.m. who stated R34 did not have a bed due to her having four falls from bed. RN-A went on to say that due to multiple falls from bed the decision was made to take away R34's bed frame and put a mattress on the floor. RN-A stated R34 was to be transferred using a full mechanical lift. RN-A went on to say staff were to use a sheet to transfer R34 from the mattress to the floor mat and then use the lift to assist R34 off of the floor. RN-A was not aware of R34 being transferred without the use of the lift. RN-A confirmed staff should not be transferring R34 by pulling her off of the mattress by her hands. RN-A was questioned on the care plan only including "extensive assist" verses the nursing assistant care plan that directed staff to use the lift. RN-A confirmed the care plan was inconsistent. RN-A went through incident reports and fall interdisciplinary team (IDT) notes and confirmed the intervention put into place after R34's 5/21/16, fall was not implemented. RN-A confirmed that should have been completed and confirmed R34 had another fall from bed on 5/27/16. The director of nursing (DON) was interviewed on 10/5/16, at 10:07 a.m. who stated R34 had	2 830		

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2 830	Continued From page 11 multiple falls out of bed and when she ran out of interventions she was told by nurse consultants to try putting R34's mattress on the floor. The DON stated R34 transferred with a mechanical lift and staff were to assist R34 to the floor mat and use the lift to assist R34 off of the floor. The DON confirmed it was not appropriate to lift up R34's mattress to put the lift legs underneath. The DON was questioned about the different assistance staff was providing during transfers. The DON stated "we can't be doing that" and staff was to use the full lift for transfers. The DON was also questioned about staff using a body pillow on R34's left side when she was in bed so she was unable to roll out. The DON stated "we can't be doing that, they are restraining her then and we can't be doing that." The DON went on to say staff should use body pillows for positioning only. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring safe transfers. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. Time period for correction: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;	21390		11/17/16

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21390	Continued From page 12 B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection prevention measures related to hand washing and perineal care for 3 of 3 residents (R24, R13, R34) reviewed during the survey. Findings include: R24: During on observation on 10/5/16, at 10:13 a.m., RN-B entered R24's room to complete a dressing change to her right hip. RN-B carried a plastic tote into R24's rooom, set it down on a side table. RN-B put on a pair of gloves and removed the	21390	It is the policy of Golden Living Center Franklin that the facility must establish and maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction for identified incidents: All residents have the potential to be affected by not following protocol for hand hygiene.	

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21390	Continued From page 13 dressing from R24's hip. RN-B then touched his name tag, irrigated the wound and applied powder to the outside of the open wound. He then grabbed a pair of scissirs and a q-tip out of the basket. After measurinhe should have washed hisg the wound, RN-B covered the wound, returned the scissors to the basket, grabbed the garbage and left the room. RN-B did not change his gloves or wash/sanitize his hands at any time during the dressing change. During an interview on 10/5/16, at 10:23 a.m., RN-B stated he should have washed his hands after removing his gloves. He stated, "I didn't wash between the clean and the dirty." During an interveiw on 10/6/16, at 9:12 a.m., RN-C stated she expected staff to wash hands when entering a room and to change gloves and wash of sanitize hands after removing a dressing prior to applying a new treatment and before leaving the room. She further stated staff should not be touching other items with gloves on. A facility policy titled Golden Living, Handwashing/Hand Hygeine, dated August 2014 indicated the facility considers hand hygeine to be the praminary means to prevent the spread of infections. The policy directed staff to wash hands before and after direct contact with residents, before and after handling clean or soiled dressings, and after removing gloves. Euerle, Carrie R13: On 10/4/16 at 3:27 p.m. NA-B and NA-C entered R13's room to assist her out of bed and into her wheelchair. Prior to assisting R13 out of bed, NA-B and NA-C donned gloves and directed R13	21390	Staff will receive education in regards to the infection control policy and the importance of proper hand hygiene to prevent the spread of infection. DNS/Designee will complete weekly random audits to monitor for compliance of infection control policy. Audits will be reviewed by QAPI Committee. Committee will provide direction and suggest change in auditing or practice when necessary based on the compliance noted, when reviewing audits. DNS/designee is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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21390	Continued From page 14 to roll side to side to assist R13 with an incontinent product change. As R13 was turned toward NA-C, NA-B removed R13's soiled incontinent product and placed a new incontinent product underneath R13. NA-B did not perform perineal care after removing the soiled incontinent product and did not remove her dirty gloves before placing the clean incontinent product under R13. NA-B and NA-C then assisted R13 with pulling up her pants and assited her from the bed to the wheelchair using a mechanical lift. At 3:34 p.m. NA-B was interviewed and stated she did not remove her gloves before placing a clean incontient product underneath R13. NA-B stated that she usually completed perineal care with every incontinent product change but did not have wipes near her to complete R13's pericare. NA-B stated R13's incontinent product was wet. R34: On 10/4/16, at 3:45 p.m.NA-B went into R34's room to assit R34 out of bed and into her wheelchair. NA-B was observed to change R34's incontinent product and performed perineal care. NA-B donned gloves and removed R34's soiled incontinent pad and set it on the floor on top of R34'S floor mat. NA-B then removed her gloves, set them on the incontinent pad on the floor and donned new gloves. NA-B then assisted R34 with perineal care. NA-B cleansed R34's perineal area, then had R34 turn to her right and continued to provide perineal care wiping R34 from her buttocks toward her perineal area (back to front) and then wiped R34 from perineal are towards her buttocks. NA-B then threw the wipes on the floor on the incontinent pad and removed her gloves. NA-B then put a clean incontinent pad underneath R34 and assisted R34 with dressing and assisted her out of bed into her wheelchair.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	Continued From page 15 NA-B then stated she was going to get a garbage bag to throw away the soiled items. NA-B was interviewed at 3:50 p.m. and stated she usually had a bag next to her but she forgot and usually completed peri-care from front to back but she "forgot and missed that this time." The director of nursing (DON) was interviewed on 10/6/16 at 12:48 p.m. and stated NA-B should be providing pericare with every incontinent pad change and should be providing perineal care "front to back." The DON went on to say NA-B should be changing her gloves after handling soiled linen or soiled incontient products and should be using hand sanitizer between glove changes. The DON also stated NA-B should be disposing of incontinent products and used gloves directly into the garbage and not throw them onto the floor. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's infection control program. The administrator or designee could provide education to all facility staff on infection control. The administrator or designee could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		