DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	H/V	VT	
Faci	lity I	D: 00	0934

							•	
MEDICARE/MEDICAID PROVIDE	R	3. NAME AND AI (L3) GOLDEN L			UZI INI	4. TYPE OF	ACTION: $\underline{7}^{(L8)}$	
NO.(L1) 245273		(L4) 900 3RD ST			KLIN	1. Initial	2. Recertification	
2. STATE VENDOR OR MEDICAID N	IO.	(L5) FRANKLIN		.1	(L6) 55333	3. Terminati 5. Validation		
(L2) 857948200			<u> </u>			7. On-Site V	*	
5. EFFECTIVE DATE CHANGE OF OV (L9) 04/01/2006	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Surve	ey After Complaint	
	/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			_
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR	ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	1	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:				_
From (a):		A. In Complia	ince With		And/Or Approved Waivers	Of The Following Rec	nuirements:	
To (b):		_	equirements e Based On:		2. Technical Person 3. 24 Hour RN		e of Services Limit	
10 T . 1 T . T . D . I	46 (7.10)	1. A	cceptable POC		4. 7-Day RN (Rural		nt Room Size	
12.Total Facility Beds	46 (L18)				5. Life Safety Code	9. Beds	/Room	
13.Total Certified Beds	46 (L17)	B. Not in Comp Requirements	liance with Progr and/or Applied V		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOW	'N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	: (L15)	
46								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION :	DATE):				
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGEN	CY APPROVAL	Date:	
Carrie Euerle, HFE NE	II	1	/31/2017	(L19)	Kamala Fiske-Downin	g, Enforcement	Specialist 1/31/2017	20)
PAR	Г II - ТО ВЕ	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE	E STATE AGENO	CY	
19. DETERMINATION OF ELIGIBILITY	ΓΥ		IPLIANCE WITI	H CIVIL	21. 1. Statement of F			
1. Facility is Eligible to Par	ticipate	RIGHTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTIO	ON:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	<u>VOLUNTARY</u>		<u>/OLUNTARY</u>	
03/01/1985					01-Merger, Closure		Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimb		Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termin	<u>011</u>	<u>HER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdraw	07-1	Provider Status Change	
(L27)	B. Dassind St	spension Date:	(L44)			00-2	Active	
	B. Reschid St	ispelision Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00454						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION AF	PPROVAT		



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

		POST-0	CERTIFICATIO	N REVISIT F	REPORT	
_	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building	NSTRUCTION			DATE OF REVISIT
245273	Υ	₁ B. Wing			Y2	12/16/2016 _{Y3}
NAME OF	F FACILITY			STREET ADDRESS, C	CITY, STATE, ZIP CODE	
GOLDE	N LIVINGCENTER - F	RANKLIN		900 3RD STREET SO	UTH	
FRANKLIN, MN 55333						
corrected	d and the date such o	corrective action	was accomplished. Each	deficiency should be fu	iencies and Plan of Correcully identified using either the codes shown to the left of the	ne regulation or LSC
ITE	М	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix	F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	483.65	Completed	Reg. #	Completed	Reg. #	Completed

LSC

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

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Correction

Completed

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Reg. #

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Reg. #

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12/16/2016

Correction

Completed

Correction

Completed

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ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC



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

Kumalu Fiske Downing

Golden Livingcenter - Franklin January 19, 2017 Page 2

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 FO	RM: RE	VISIT REPORT				
	ER / SUPPLIER CATION NUMBI		MULTIPLE CON A. Building B. Wing	ISTRUCTION				Y2	DATE OF 12/16/201	
	FACILITY N LIVINGCEN	ΓER - FF	RANKLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH FRANKLIN, MN 55333					
correctiv	e action was a	ccompli	shed. Each def	iciency should be	fully iden	reviously reported tha tified using either the refix codes shown to t	regulation o	r LSC provision	n number a	and the
ITE	M		DATE	ITEM		DATE	ITEM		ı	DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	21390 MN Rule 4658.	0800	Correction	ID Prefix		Correction	ID Prefix			orrection
Reg. #	Subp. 4 A-I		Completed	Reg. #		Completed	Reg. #		C	ompleted
LSC			12/16/2016	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		С	ompleted
LSC			=	LSC			LSC			
			_				_			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		C	ompleted
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		С	ompleted
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		С	ompleted
LSC			_	LSC			LSC			
			_				-			
REVIEWS		REVIE\	WED BY LS) GD/kfd	DATE 1/19/2017	SIGNATU	JRE OF SURVEYOR			DATE	
							31591		12/16/2	016
REVIEWS CMS RO	ED BY	REVIE\ (INITIA	WED BY LS)	DATE	TITLE				DATE	

Page 1 of 1 EVENT ID: H7WT13

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

10/6/2016

FOLLOWUP TO SURVEY COMPLETED ON

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	H/WT
Fac	ility ID: 00934

MEDICARE/MEDICAID PROVIDER NO.(L1)		3. NAME AND AI (L3) GOLDEN L (L4) 900 3RD ST (L5) FRANKLIN 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	IVINGCENTI REET SOUTH , MN	ER - FRAN H	(L6) 55333 02 (L7) 13 PTIP 22 CLIA 14 CORF	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey Aft FISCAL YEAR END 12/31	2. Recertification 4. CHOW 6. Complaint 9. Other
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	46 (L18) 46 (L17)	Compliance1. A B. Not in Comp	ance With equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code * Code: * Code:	6. Scope of S 7. Medical E	Services Limit Director om Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 46 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	ICF (L42) BLE SHOW LTC CA	(L43) ANCELLATION I	DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE Date : Amy Charais, HFE NE II 12/12/16			(L19)	/ LEG			
PART 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partic 2. Facility is not Eligible	-	20. COM	BY HCFA RE		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :		
OF PARTICIPATION 03/01/1985 (L24)	A. Suspension		4. LTC AGREEM ENDING DAY (L25) (L44) (L45)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	0 INVOLU 05-Fail to 06-Fail to on OTHER	Meet Health/Safety Meet Agreement der Status Change
28. TERMINATION DATE: 31. RO RECEIPT OF CMS-1539	(L28)	INTERMEDIARY/ 00454 DETERMINATION		(L31) .DATE (L33)	30. REMARKS DETERMINATION APP	ROVAL	



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

Golden LivingCenter - Franklin November 29, 2016 Page 5 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

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

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245273	B. WING			R 11/21/2016	
	PROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 3RD STREET SOUTH RANKLIN, MN 55333	1 117	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated. Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. An onsite post certic completed on 11/21 were corrected can Also there are tag/sat the time of onsite the CMS2567. Because you are ensignature is not requipage of the CMS-2 submission of the Everification of compute that substate is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute that substates is not requipage of the CMS-2 submission of the Everification of compute the Everification o	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an arr facility may be conducted to antial compliance with the en attained in accordance with the fication revisit (PCR) was 1/16. The certification tags that be found on the CMS2567B. It is that were not found corrected at PCR which are located on the controlled in ePOC, your suired at the bottom of the first 1/567 form. Your electronic POC will be used as	{F 00	00}			
{F 441} SS=D	your verification. 483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	{F 44	41}			12/16/16
LABODATOR		DED/CLIDDLIED DEDDESENTATIVE'S SICK	LATURE		TITLE		(Y6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

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

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245273	B. WING			F	? 21/2016
	245273 AME OF PROVIDER OR SUPPLIER OLDEN LIVINGCENTER - FRANKLIN (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZII 900 3RD STREET SOUTH FRANKLIN, MN 55333	P CODE	11/2	21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
{F 441}	Infection Control Prisafe, sanitary and of to help prevent the of disease and infection Control The facility must estable Program under white (1) Investigates, coin the facility; (2) Decides what poshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreactions related to in (b) Preventing Spreactions related to in (c) When the Infect determines that a reprevent the spreadisolate the resident (2) The facility must communicable disefrom direct contact will true (3) The facility must hands after each do hand washing is incorposessional practice (c) Linens Personnel must hands	rogram designed to provide a comfortable environment and development and transmission oction. Of Program stablish an Infection Control ich it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections. Dead of Infection tion Control Program esident needs isolation to of infection, the facility must interpretable to prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	{F 44	41}			
	by:	NT is not met as evidenced tion, interview and document		Preparation, submission	and		

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

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245273	B. WING _			R 21/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		1/2010	
				900 3RD STREET SOUTH			
GOLDEN	I LIVINGCENTER - FF	RANKLIN		FRANKLIN, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 441}	Continued From pa	ge 2	F 44	1}			
	infection control tec washing and perine	ailed to ensure appropriate chniques related to hand eal care for 2 of 2 residents ed for infection control.	,	implementation of correction constitute and admission of with the facts and conclusion the survey report. our Plan cand executed as a means to improve the quality of care a	or agreement ns set forth on of Correction is o continuously and to comply		
	1:07 p.m., nursing a performing cares for and transferred R3-R34's incontinent burine and placed that top of a plastic configurbage bag and p	s observation on 11/21/16, at assistant (NA)-A was observed or R34. NA-A donned gloves 4 to her bed. NA-A removed rief which was saturated with e brief on the bed, partially on tainer of wipes before getting a utting the soiled product in the		with all applicable state and regulatory requirements. F441 It is the policy of Golden Livi Franklin that the facility mus and maintain an Infection Co Program designed to provide	ng Center- t establish ontrol e a safe,		
	applied a barrier cremoved her gloves gloves underneath continued to apply R34, transferred her and escorted her orduring the observat	ed R34's perineal area and eam to her bottom. NA-A then is, revealing a second pair of the outer pair. She then a clean incontinent product to er back into her wheel chair ut into the hallway. At no time tion did NA-A wash her hands.		sanitary and comfortable ento help prevent the development transmission of disease and Plan of Correction for identification. All residents have to potential affected by not following pro-	nent and infection. ied incident.		
	applied gloves and chair and assisted time surveyor interv	entered R13's room. She transferred R13 into her wheel her into the bathroom. At this vened and requested NA-A fore proceeding to care for		hygiene and peri care. Staff have received re-educa regards to proper hand hygicand peri care, to prevent the infection.	ene		
	NA-A stated she atteducation in-service supposed to wash resident and when NA-A further stated gloves so when she can remove the	on 11/21/16, at 1:37 p.m., tended a recent handwashing e. She stated she was her hands after caring for a "we clean them with spray." I she puts on two pairs of e is done changing a resident e dirty ones and use the clean she forgot to wash her hands		DNS/Designee to complete audits at random. Audits to be reviewed at more meetings. QAPI committee value direction and suggest chang or practice when necessary compliance noted, when revaludits needing direct follow	nthly QAPI will provide e in auditing based on the iewing audits.		

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

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245273	B. WING				R 21/2016
	PROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 3RD STREET SOUTH RANKLIN, MN 55333	11/2	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	director of nursing (recently received edwashing. The DON hands before and a further stated staff sets of gloves. A facility policy titled Handwashing/Handindicated the facility primary means to policy directed before and after control of the policy directed before and	on 11/21/16, at 1:42 p.m., the (DON) stated the staff had ducation regarding hand stated staff should wash their fter caring for a resident. She should not be wearing multiple	{F 4-	11}	reviewed weekly at morning stand	up.	

	POST-C	CERTIFICATION	ON REVISIT F	REPORT			
PROVIDER / SUPPLIER / G		ISTRUCTION				DATE OF REV	/ISIT
IDENTIFICATION NUMBER 245273	A. Building B. Wing				Y2	11/21/2016	Y3
NAME OF FACILITY			STREET ADDRESS, (CITY, STATE, ZIP COD	DE		
GOLDEN LIVINGCENTE	GOLDEN LIVINGCENTER - FRANKLIN 900 3RD STREET SOUTH						
FRANKLIN, MN 55333							
program, to show those corrected and the date s	deficiencies previously uch corrective action v	y reported on the CMS- was accomplished. Eac	e, Medicaid and/or Clinica 2567, Statement of Defic ch deficiency should be fo on the CMS-2567 (prefix	iencies and Plan of our of our of our of the output of the	Correct either the	tion, that have ne regulation o	or LSC
ITEM	DATE	ITEM	DATE	ITEM		DAT	Έ
Y4	Y5	Y4	Y5	Y4		Y5	;
ID Profix Foods	Commontion	ID Brofiv Foods	Campatian	ID Brofiv		0.000	



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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

PRINTED: 02/07/2017 FORM APPROVED

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

	00304				11/21/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - FRANKLIN		STREET SOL		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED B' REGULATORY OR LSC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}		
	****ATTENTION*****				
	NH LICENSING CORRECTION OR	DER			
	In accordance with Minnesota Statute, 144A.10, this correction order has been pursuant to a survey. If, upon reinspect found that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in account a schedule of fines promulgated by the Minnesota Department of Health.	n issued tion, it is s cited n violation ordance			
	Determination of whether a violation had corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicated. When a rule contains several items, fair comply with any of the items will be corlack of compliance. Lack of compliance re-inspection with any item of multi-par result in the assessment of a fine even that was violated during the initial inspectorrected.	e tag d below. lure to nsidered e upon t rule will if the item			
	You may request a hearing on any asset that may result from non-compliance worders provided that a written request is the Department within 15 days of receipnotice of assessment for non-compliant	ith these s made to ot of a			
	INITIAL COMMENTS: An onsite follow-up visit was completed 11/21/16. During this onsite visit it was determined that the following correction # 4658.0800 subd. 4A-1 were NOT cor This uncorrected order/s will remain in will be reviewed at the next onsite visit. uncorrected order/s will be reviewed for	ns orders/s rected. effect and Also			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/07/16

STATE FORM 6899 If continuation sheet 1 of 4 H7WT12

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			P WING			R	
		00934	B. WING		11/2	21/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - FR	RANKI IN	D STREET SO LIN, MN 5533				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
{2 000}	Continued From pa	ige 1	{2 000}				
	penalty assessmen	t/s.					
21390	MN Rule 4658.0800	0 Subp. 4 A-I Infection Contro	ol 21390				
	control program muprocedures which pare A. surveillance collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and content and content for immunization prograte defined in part 465 procedures of reside the prevention and F. the development of the prevention and F. the development of the prevention and for the development of the products, including defined in part 4658. G. a system for the asystem for the products which affer disinfectants, antised incontinence product. In methods for the current standards of this MN Requirement.	ealth program including an am, a tuberculosis program a 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of lect infection control, such as eptics, gloves, and	as 1				
	by: Based on observati review, the facility fa	ion, interview and document ailed to ensure appropriate chniques related to hand					

Minnesota Department of Health

Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE		
			A. BUILDING:		R	
		00934	B. WING			1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - FR	ZANKI IN	STREET SOU N, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 2	21390			
		al care for 2 of 2 residents d for infection control.				
	Findings include:					
	1:07 p.m., nursing a performing cares for and transferred R34 R34's incontinent burine and placed that top of a plastic continger bag. She then wipe applied a barrier cremoved her gloves gloves underneath continued to apply a R34, transferred he and escorted her or during the observat At 1:22 p.m., NA-A applied gloves and chair and assisted time surveyor intervision.	s observation on 11/21/16, at assistant (NA)-A was observed or R34. NA-A donned gloves 4 to her bed. NA-A removed rief which was saturated with e brief on the bed, partially on ainer of wipes before getting a atting the soiled product in the ed R34's perineal area and earn to her bottom. NA-A then is, revealing a second pair of the outer pair. She then a clean incontinent product to back into her wheel chair at into the hallway. At no time it into the hallway. At no time it into the bathroom. She transferred R13's room. She transferred R13 into her wheel her into the bathroom. At this rened and requested NA-A fore proceeding to care for				
	NA-A stated she att education in-service supposed to wash it resident and when 'NA-A further stated gloves so when she she can remove the	on 11/21/16, at 1:37 p.m., ended a recent handwashing e. She stated she was her hands after caring for a "we clean them with spray." she puts on two pairs of e is done changing a resident e dirty ones and use the clean she forgot to wash her hands.				

Minnesota Department of Health

During an interview on 11/21/16, at 1:42 p.m., the

STATE FORM 6899 H7WT12 If continuation sheet 3 of 4

Minnesota Department of Health

			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00934				F 11/2	≀ 1/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	11/2	1/2010
GOLDEN	I LIVINGCENTER - FR	SANKI IN 900 3RD S	STREET SOL	JTH		
		FRANKLII	N, MN 5533		NI NI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 3	21390			
21390	director of nursing (recently received edwashing. The DON hands before and a further stated staff sets of gloves. A facility policy titled Handwashing/Handindicated the facility primary means to perform the policy directed before and after control of the policy directe	DON) stated the staff had ducation regarding hand stated staff should wash their fter caring for a resident. She should not be wearing multiple	21390			

Minnesota Department of Health

STATE FORM 6899 H7WT12 If continuation sheet 4 of 4

				STATI	E FOI	RM: RE\	/ISIT	REPORT				
	R / SUPPLIER		MULTIPLE CON	ISTRUCTIO	N						DATE (OF REVISIT
00934	CATION NOWB	EN Y1	A. Building B. Wing							Y2	11/21/2	2016 _{Y3}
NAME OF	FACILITY						STREE	T ADDRESS, C	ITY, STATE,	ZIP CODE		
GOLDEN	N LIVINGCEN	TER - FF	RANKLIN					D STREET SOU (LIN, MN 55333				
						<u></u>		<u> </u>				
correctiv	e action was a tion prefix cod	accomplis	tate surveyor to shed. Each def usly shown on t	iciency sho	uld be	fully ident	tified us	sing either the	regulation of	or LSC provisio	n numbe	er and the
ITE	М		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	20570		Correction	ID Prefix	20830			Correction	ID Prefix			Correction
Reg. #	MN Rule 4658. Subp. 4	0405	Completed	I D 4	MN Ru Subp. 1	le 4658.052 I	20	Completed	Reg. #			Completed
LSC			11/21/2016	LSC				11/21/2016	LSC			
ID D. f.			0 "	ID Destin				0 :	ID Dester			0 "
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg. #			Completed
LSC			=	LSC					LSC			
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg. #			Completed
LSC			_	LSC					LSC			
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg. #			Completed
LSC			-	LSC					LSC			
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Reg. #			Completed	Reg. #				Completed	Reg. #			Completed
LSC			- -	LSC					LSC			
REVIEWE	ED BY	REVIE\	WED BY	DATE		SIGNATU	RE OF	SURVEYOR			DATE	
STATE A		(INITIA		12/12/	2016		-	-	35569			1/21/2016
REVIEWE CMS RO	ED BY		WED BY	DATE	-	TITLE					DATE	

Page 1 of 1 EVENT ID: H7WT12

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

10/6/2016

FOLLOWUP TO SURVEY COMPLETED ON

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	H7	WT	
Faci	ility	ID:	00934

		10 22 00::11		1112 0 1111	ESCHVETHOENCH		raemty ib. cost.
1. MEDICARE/MEDICAID PRO NO.(L1) 245273	OVIDER	3. NAME AND AI (L3) GOLDEN L	IVINGCENT	ER - FRAN	NKLIN	4. TYPE OF ACT	ION: <u>2</u> (L8) 2. Recertification
2. STATE VENDOR OR MEDIC	(L4) 900 3RD STREET SOUTH			g o 55222	3. Termination	4. CHOW	
(L2) 857948200		(L5) FRANKLIN	l, MN		(L6) 55333	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE	OF OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey Af	ter Complaint
(L9) 04/01/2006	0.10.6.10.04.6.4.2.0	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA		· · · · · · · · · · · · · · · · · · ·
6. DATE OF SURVEY 1 8. ACCREDITATION STATUS:	0/06/2016 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF D 15 ASC	FISCAL YEAR ENI	DING DATE: (L35)
O Unaccredited 1 TJ	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE	12/31	
2 AOA 3 Ot							
11LTC PERIOD OF CERTIFICA	TION	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of		
To (b):		_	equirements e Based On:		2. Technical Personne		
		_	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural S)	7. Medical I NF) 8. Patient Ro	
12.Total Facility Beds	46 (L18)	1. A	ecceptable i OC		5. Life Safety Code	9. Beds/Roo	
13.Total Certified Beds	46 (L17)	X B. Not in Cor	-	-	5. Life Safety Code		111
-		Requirements	and/or Applied	Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREA					15. FACILITY MEETS	(1.15)	
18 SNF 18/19 S		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
46			(7.40)				
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY F	REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Kathy Sass, HPR-I	Dietary Speciali	st 1	10/31/2016	(L19)	Kamala Fiske-Downing	, Enforcement Spe	ecialist 11/18/2016 (L20)
	PART II - TO BE	COMPLETED 1	BY HCFA RI	EGIONAI	COFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIC			MPLIANCE WIT	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	ancial Solvency (HCFA-2 rol Interest Disclosure Str	
1. Facility is Eligible	-				3. Both of the Abov	re:	
2. Facility is not Eli	gible (L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION	I:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 0	<u>0</u> <u>INVOLU</u>	<u>UNTARY</u>
03/01/1985					01-Merger, Closure	05-Fail t	o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail t	o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER	:
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-F10V	ider Status Change
(L27)	D D . 10		(L44)			00-Activ	ve
()	B. Rescind S	uspension Date:	(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		00454					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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

Golden LivingCenter - Franklin October 17, 2016 Page 4

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.

Golden LivingCenter - Franklin October 17, 2016 Page 5

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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

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

PRINTED: 10/31/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING		10/	/06/2016
	PROVIDER OR SUPPLIER	ANKLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the otance. Because you are	F 0	00		
	at the bottom of the	rour signature is not required first page of the CMS-2567 nic submission of the POC will cion of compliance.				
F 280 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.20(d)(3), 483.1	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with 0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80		11/17/16
	incompetent or othe incapacitated under	r the laws of the State, to ng care and treatment or				
	within 7 days after to comprehensive assinterdisciplinary teat physician, a register for the resident, and disciplines as deter and, to the extent puther resident, the resident presentative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after				
ABORATOR	OIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IRE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

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

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245273		B. WING		10/06/2016		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 2000 3RD STREET SOUTH FRANKLIN, MN 55333	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280		ge 1 NT is not met as evidenced	F 280			
	review the facility fathe care plan for 1 for falls. Findings include: R34's care plan data trisk for falls and interventions: mattrequent falls from to prevent major injude to) frequent faq2h (every two hou promote skin integroduct and performing incontinent episode	tion, interview and document ailed to revise and implement of 4 residents (R34) reviewed ted 3/7/16, indicated R34 was included the following ress moved to floor related to be due to her impulsiveness; ruries, mattress against wall d/t lls, toilet schedule: staff assist rs) and prn (as needed) to rity, manage incontinent reperi cares after each as needed. The care plan did of a mechanical lift.		Preparation, submission and implementation of correction does constitute an admission of or agree with the facts and conclusions set the survey report. Our Plan of Corris prepared and executed as a meacontinuously improve the quality of and to comply with all applicable st federal regulatory requirements. F280 R34's care plan and care sheets have the preventions and transfers according residents have the potential to be a if care plans are not updated to adcurrent status.	ement forth on rection ans to care ate and ave gly. All affected	
	assessment dated received two perso mobility, transfers a included dementia, weakness and oster R34's bowel and blindicated R34 could room. R34's care prequired extensive dressing, and transinclude the use of a R34's nursing assist directed staff R34 transfers.	adder care plan dated 9/9/16, duse walker and commode in lan further included R34 assistance with bed mobility, fers. The care plan did not		All fall reports will be reviewed by t team, the IDT will come up with an intervention that will be implemented DNS/designee will update the care and care sheets accordingly and communicate the intervention to all nursing staff. Licensed staff will be re-educated of updating care plans, and updating sheets on a weekly basis. Weekly care plan audits will be core by the DNS/designee on random residents to assure care plans and sheets reflect current care needs of resident.	ed. The plan I on care mpleted care	

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

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F 280	sheet included R34 included R34's mather head towards the care sheet directed for transfers every included R34's mather head towards the care sheet directed for transfers every included R34's a full mechanical life R34 had to be sate the mattress. NA-A stathook R34 up to the around the mattress. NA-A stathook R34 up to the around the mattress. On 10/4/16, at 2:06 asleep in her room with a blanket and afloor mat was nextated "I'm going to R34 replied "ok". Now next to R34's mattress and locked assisted R34 into a mattress. NA-B the by both hands and into a standing position, Now hands around NA-E toward the wheelch included R34's mattress. NA-B the by both hands and into a standing position, Now hands around NA-E toward the wheelch included R34's mattress.	to be a high fall risk and tress was on the floor facing he closet when in bed. The staff R34 was assist of one two hours and as needed. The staff R34 was assist of one two hours and as needed. The staff R34 was assist of one two hours and as needed. The staff R34 was assist of one two hours and as needed. The staff R34 was assist of one two hours and as needed. The staff R34 was assist ant was assisted out of bed using the legs of the lift under the ted that was the only way to lift as the legs did not fit staff as the legs did not fi	F 28	Audits will be reviewed by committee. Committee will direction and suggest cha or practice when necessa compliance noted, when raudits. Executive Director or desi responsible for compliance	I provide nge in auditing ry based on eviewing the gnee is		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 280	wheelchair and whe-NA-B was interview on her knees to he that there was a flo NA-B stated R34's side so that "she car get over the pillow." On 10/5/16, at 9:20 interviewed and statusing two staff and to have R34 stand to stand up from he staff would lower R would need to be oprovide additional on NA-E indicated that bed but after conting removed. On 10/5/16, at 1:07 assisting R34 to the gait belt around R3 put her hands on the directed R34 to state stand and pivot turn down and assisted provided peri care on the toilet and as grab bar and turn to Registered nurse (10/5/16, at 9:25 a.r. have a bed due to RN-A went on to safrom bed the decisi R34's bed frame at RN-A stated R34 went on R34 went R3	beeled her out of the room. Wed and stated that it was hard Ip R34, but it was better now or mat next to the mattress. body pillow was put on her left an't crawl out of bed, she can't	F 28			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 280	mattress to the floor assist R34 off of the R34 being transferr RN-A confirmed state R34 by pulling her of hands. RN-A was goonly including "extenursing assistant cause the lift. RN-A confirmed the interest R34's 5/21/16, fall of confirmed that shour confirmed that shour confirmed R34 had 5/27/16. The director of nurse 10/5/16, at 10:07 and multiple falls out of interventions she were try putting R34's mastated R34 transfer staff were to assist the lift to assist R34 confirmed it was not mattress to put the was questioned about staff was providing stated "we can't be use the full lift for try questioned about s R34's left side when unable to roll out. To doing that, they are can't be doing that.	to transfer R34 from the r mat and then use the lift to e floor. RN-A was not aware of red without the use of the lift. If should not be transferring off of the mattress by her uestioned on the care plan nsive assist" verses the are plan that directed staff to onfirmed the care plan was went through incident reports nary team (IDT) notes and vention put into place after was not implemented. RN-A ald have been completed and another fall from bed on m. who stated R34 had bed and when she ran out of as told by nurse consultants to attress on the floor. The DON red with a mechanical lift and R34 to the floor mat and use off of the floor. The DON of appropriate to lift up R34's lift legs underneath. The DON out the different assistance during transfers. The DON doing that" and staff was to ansfers. The DON was also taff using a body pillow on a she was in bed so she was he DON stated "we can't be restraining her then and we "The DON went on to say dy pillows for positioning only.	F 28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 323 F 323 SS=D	483.25(h) FREE O HAZARDS/SUPEF The facility must el environment remai as is possible; and	F ACCIDENT	F 32 F 32			11/17/16
	by: Based on observareview, the facility interventions, follow transfer 1 of 4 resident Findings include: During the initial to mattress was observatives. On 10/4/16, at 9:04 and nursing assistaroom. A mattress was and nursing assistaroom. A mattress was room. RN-A an assessment on with therapy and use RN-A and NA-A apwaist and directed walker and assiste RN-A and NA- ther down on the commoulling down her pastated R34 did wellow.	tion, interview and document failed to implement fall with eare plan and safely dents (R34) reviewed for falls. The care plan and safely dents (R34) reviewed for falls. The care plan and safely dents (R34) reviewed for falls. The care plan and safely dents (R34) reviewed for falls. The care plan and safely dents (R34) reviewed for falls. The care plan and safely dents (R34) and the floor of R34's and to see if she could work are the commode in her room. The care plied a gait belt around R34's R34 to put her hands on her day and the care assisted R34 to turn and site and incontinent pad. RN-A with this transfer and she was to start working with her on		R34's bed was removed off of the and placed on a bed frame. R34 w provided a wider bed and a senso to alert staff and positioning pillow removed. All residents and staff hapotential for injury, when caring for resident whose mattress is on the Re-education provided to all staff handling of residents, proper bed positioning and use of positioning Weekly audits of resident care inc transfers and bed positioning will be completed on random residents to monitor for ongoing compliance. Audits will be reviewed by QAPI Committee. Committee will provided irection and suggest change in all or practice when necessary based compliance noted, when reviewing audits.	vas r alarm ave the r a floor. on safe pillows. luding be o e uditing I on the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTI			TE SURVEY MPLETED
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F 323	transfers. On 10/4/16, at 9:12 and stated that R34 mattress was placed determined a high fout of bed. NA-A st bed using a full me the lift, R34 had to lift up the mattress the mattress. NA-A to hook R34 up to the around the mattres "ridiculous" and stakes to assist R34 adjustable and R34 Staff was directed the incontinent product on 10/4/16, at 2:06 asleep in her room with a blanket and a floor mat was next NA-B entered R34's to get you up for su NA-B then knelt on mattress. NA-B ren R34's left side and R34. After NA-B fin R34's wheelchair in the brakes. NA-B the position on the mat grabbed R34 by bothe mattress into a was in a standing put her hands arou steps toward the will wheelchair. NA-B the will be the state of the stat	a.m. NA-A was interviewed a.m. NA-A was interviewed and a ad on the floor after R34 was fall risk and had multiple falls ated R34 was assisted out of chanical lift, but in order to use be sat up in bed so staff could to put the legs of the lift under stated that was the only way he lift as the legs did not fit s. NA-A stated that was ff had to be on their hands and as the bed was not was unable to be toileted. o check and change R34's	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY IPLETED
		245273	B. WING			10/	06/2016
	PROVIDER OR SUPPLIER			900	EET ADDRESS, CITY, STATE, ZIP CODE 3RD STREET SOUTH ANKLIN, MN 55333	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	NA-B was interview on her knees to he that there was a flot NA-B stated R34's side so that "she care get over the pillow. On 10/5/16, at 1:07 assisting R34 to the gait belt around R3 put her hands on the directed R34 to state stand and pivot turned down and assisted provided peri care on the toilet and as grab bar and turn to R34's care plan data risk for falls and interventions: mattifrequent falls from to prevent major in (due to) frequent falls from to prevent wo how promote skin integer product and perfor incontinent episode R34's quarterly Mirassessment dated	wed and stated that it was hard lp R34, but it was better now for mat next to the mattress. body pillow was put on her left an't crawl out of bed, she can't " 7 p.m. NA-D was observed be bathroom. NA-D applied a 34's waist and directed R34 to the grab bar on the wall and and up. NA-D pulled R34's pants her to sit on the toilet. NA-D to R34 when she was finished asisted R34 to stand using the o sit in her wheelchair. Ited 3/7/16, indicated R34 was included the following ress moved to floor related to bed due to her impulsiveness; juries, mattress against wall d/t alls, toilet schedule: staff assist urs) and prn (as needed) to rity, manage incontinent m peri cares after each as needed.	F3	23			
	mobility, transfers a diagnoses that incl kyphosis, muscle v	on extensive assistance for bed and toileting. R34 had uded dementia, anxiety, veakness and osteoporosis. ladder care plan dated 9/9/16, d use walker and commode in plan further included R34					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245273	B. WING _		10	/06/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	R34's nursing assidirected staff R34 staff member and sheet included R34 included R34's mather head towards to care sheet directed for transfers every. On 10/5/16, at 9:20 interviewed and stausing two staff and to have R34 stand to stand up from his staff would lower F would need to be oprovide additional on NA-E indicated R3 but after continuous. RN-A was interview who stated R34 did having four falls from the towards and the stand to take a mattress on the file transferred using went on to say staff transfer R34 from and then use the lift RN-A was not away without the use of should not be transformed on the should not have the lift RN-A was not away without the use of should not be transformed on the should not have the lift RN-A was not away without the use of should not be transformed on the should on the staff should not be transformed on the should on the staff should not be transformed on the should not be transformed not should not should not should not should not should not sh	assistance with bed mobility,	F 3	23		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245273	B. WING _		10/	06/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - FF	RANKLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH FRANKLIN, MN 55333	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 441 SS=D	care plan that direct confirmed the care went through incided interdisciplinary teathe intervention put fall was not implemed should have been of had another fall from the director of nurs 10/5/16, at 10:07 at multiple falls out of interventions she with try putting R34's mastated R34 transfer staff were to assist the lift to assist R34 confirmed it was not mattress to put the was questioned about staff was providing stated "we can't be use the full lift for triple questioned about s R34's left side when unable to roll out. The doing that, they are can't be doing that. Staff should use bo 483.65 INFECTION SPREAD, LINENS The facility must estinged in the control of the con	ted staff to use the lift. RN-A plan was inconsistent. RN-A ent reports and fall m (IDT) notes and confirmed into place after R34's 5/21/16, ented. RN-A confirmed that completed and confirmed R34 m bed on 5/27/16. Sing (DON) was interviewed on m. who stated R34 had bed and when she ran out of as told by nurse consultants to attress on the floor. The DON red with a mechanical lift and R34 to the floor mat and use off of the floor. The DON out appropriate to lift up R34's lift legs underneath. The DON out the different assistance during transfers. The DON doing that" and staff was to ansfers. The DON was also taff using a body pillow on a she was in bed so she was he DON stated "we can't be restraining her then and we" The DON went on to say dy pillows for positioning only. I CONTROL, PREVENT	F 32			11/17/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245273	B. WING _		10/	06/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied (3) Maintains a recactions related to i (b) Preventing Spr (1) When the Infed determines that a prevent the spread isolate the residen (2) The facility must communicable disfrom direct contact will t (3) The facility must hands after each of hand washing is in professional practic (c) Linens Personnel must ha	ol Program stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of Infection ction Control Program resident needs isolation to if of infection, the facility must t. ist prohibit employees with a ease or infected skin lesions it with residents or their food, if ransmit the disease. It require staff to wash their lirect resident contact for which dicated by accepted	F 44	11		
	by: Based on observareview, the facility prevention measure	intrology in the survey.		It is the policy of Golden Livin Franklin that the facility must and maintain and Infection Corogram designed to provide sanitary and comfortable envito help prevent the development	establish Introl a safe, ronment and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245273	B. WING		10/	06/2016
_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 900 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	RN-B entered R24 change to her right tote into R24's rook RN-B put on a padressing from R24 name tag, irrigated powder to the outs grabbed a pair of sbasket. After meashisg the wound, RI returned the scissor garbage and left this gloves or wash during the dressing. During an interview RN-B stated he shafter removing his wash between the During an interveiw RN-C stated she ewhen entering a rowash of sanitize haprior to applying a leaving the room. So not be touching other and after die to before and after die to change of the praminary meaninfections. The polibefore and after die to change of the	tion on 10/5/16, at 10:13 a.m., 's room to complete a dressing thip. RN-B carried a plastic om, set it down on a side table. ir of gloves and removed the 's hip. RN-B then touched his the wound and applied ide of the open wound. He then cissirs and a q-tip out of the surinhe should have washed N-B covered the wound, ors to the basket, grabbed the re room. Rn-B did not change /sanitize his hands at any time g change. If on 10/5/16, at 10:23 a.m., ould have washed his hands gloves. He stated, "I didn't clean and the dirty." If on 10/6/16, at 9:12 a.m., expected staff to wash hands om and to change gloves and ands after removing a dressing new treatment and before the further stated staff should ner items with gloves on.	F 4	transmission of disease Plan of correction for ide All residents have the positive affected by not following hygiene. Staff will receive educate the infection control policimportance of proper haprevent the spread of into DNS/Designee will comprandom audits to monitor of infection control policimportance. Audits will be reviewed to Committee. Committee direction and suggest of or practice when necess compliance noted, when DNS/designee is response compliance.	entified incidents: otential to be protocol for hand ion in regards to cy and the nd hygiene to fection. olete weekly or for compliance y. by QAPI will provide nange in auditing sary based on the n reviewing audits.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245273	B. WING		10/	06/2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 900 3RD STREET SOUTH FRANKLIN, MN 55333		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	R13's room to assi wheelchair. Prior to NA-B and NA-C do to roll side to side to incontinent product toward NA-C, NA-B incontinent product underneath perineal care after incontinent product gloves before placify product under R13 R13 with pulling upfrom the bed to the mechanical lift. At a interviewed and standard gloves before placify underneath R13. Note to complete perineating product change but to complete R13's incontinent product the sincontinent product R34: On 10/4/16, at 3:45 room to assit R34 wheelchair. NA-B with each air. NA-B with each and R34'S floor mat. Naset them on the incontinent pad and R34'S floor mat. Naset them on the incontinent pad area, then had R34 area, then had R34.	p.m. NA-B and NA-C entered st her out of bed and into her o assisting R13 out of bed, anned gloves and directed R13 o assist R13 with an a change. As R13 was turned a removed R13's soiled and placed a new incontinent in R13. NA-B did not perform removing the soiled and did not remove her dirtying the clean incontinent. NA-B and NA-C then assisted ther pants and assited her wheelchair using a assisted she did not remove her ing a clean incontient product IA-B stated that she usually I care with every incontinent at did not have wipes near her pericare. NA-B stated R13's	F 44			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245273	B. WING		10	/06/2016
	PROVIDER OR SUPPLIER	ANKLIN		STREET ADDRESS, CITY, STATE, ZIP COI 900 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	to front) and then w towards her buttock on the floor on the i her gloves. NA-B th underneath R34 an and assisted her ou NA-B then stated sl bag to throw away t interviewed at 3:50 had a bag next to h completed peri-care "forgot and missed" The director of nurse 10/6/16 at 12:48 p.r providing pericare w change and should "front to back." The should be changing soiled linen or soiled should be using har changes. The DON disposing of inconti	oward her perineal area (back iped R34 from perineal are as. NA-B then threw the wipes nontinent pad and removed en put a clean incontinent pad d assisted R34 with dressing at of bed into her wheelchair. He was going to get a garbage the soiled items. NA-B was p.m. and stated she usually er but she forgot and usually er from front to back but she that this time." Sing (DON) was interviewed on m. and stated NA-B should be with every incontinent pad be providing perineal care DON went on to say NA-B a her gloves after handling d incontient products and and sanitizer between glove also stated NA-B should be ment products and used the garbage and not throw	F 4	41		

F5273025

Printed: 10/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245273

B. WING

10/05/2016

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - FRANKLIN

STREET ADDRESS, CITY, STATE, ZIP CODE

900 3RD STREET SOUTH FRANKLIN. MN 55333

	F	FRANKLIN, MN 5	5333	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)	ATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	Fire Safety			
	A Life Safety Code Survey was conducted by Minnesota Department of Public Safety, Stat Fire Marshal Division, on October 05,2016. the time of this survey, Golden Living Center Franklin was found to be in substantial compliance with the requirements for particip in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 200 edition of National Fire Protection Associatio (NFPA) 101 Life Safety Code (LSC), Chapte Existing Health Care Occupancies.	pation		
	Golden Living Center Franklin was construct follows: The original building was constructed 1962, one-story, has a partial basement, is fully fire sprinkler protected and was determined to be 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 Type II(111) construction; The 2nd Addition was constructed in 1994, if one-story, has no basement, is fully fire spring protected and was determined to be of Type II(111) construction.	is e pe of s e pe of s nkler		
	The building has a complete fire alarm syste with smoke detection in the corridors and spopen to the corridors which is monitored for automatic fire department notification. The f	paces	l <u>e</u>	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

		AND HUMAN SERV & MEDICAID SERV				FORM	10/12/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		R/CLIA	(-,,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE		
		245273		B. WING		10/05	5/2016
	ROVIDER OR SUPPLIER N LIVINGCENTER -	FRANKLIN	900 3R	RESS, CITY, S D STREET (LIN, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII F BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	has a capacity of 4 at time of the surve	6 beds and had a ce		K 000			



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 <u>only a suggestion</u> 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

Golden LivingCenter - Franklin October 17, 2016 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

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

Golden LivingCenter - Franklin October 17, 2016 Page 3 Golden LivingCenter - Franklin October 17, 2016 Page 4

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
00934		B. WING		10/0	6/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - FR	ANKLIN		STREET SOU N, MN 5533:	_		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION	ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of whose the minute of the Minnesota Department of the Minnesota Depa	ction order has y. If, upon reins iency or deficience or deficience assessed in ines promulgate artment of Health	been issued spection, it is notices cited each violation accordance ed by rule of th.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	compliance with rule provided a rule provided a rule number indicate several items the items will be Lack of complete ment of a fine e	a all at the tag cated below. s, failure to e considered iance upon -part rule will even if the item				
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliand t a written requi nin 15 days of re	ce with these est is made to eceipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.infobul.htm The St delineated on the a	participate in the nsure orders continued artment of Healtin 14-01, availa state.mn.us/divate licensing orders	onsistent with th ble at s/fpc/profinfo/in ders are				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/27/16

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) PR

	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
A. BOILDING.	A. BOILDING.	
00934 B. WING		10/06/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
GOLDEN LIVINGCENTER - FRANKLIN 900 3RD STREET SOUTH FRANKLIN, MN 55333	1	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
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.		

Minnesota Department of Health

STATE FORM 6899 H7WT11 If continuation sheet 2 of 16

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00934		B. WING		10/0	6/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOLDEN	I LIVINGCENTER - FF	RANKI IN	STREET SOU N, MN 5533:				
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			11/17/16	
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required					
	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			Preparation, submission and implementation of correction does constitute an admission of or agre with the facts and conclusions set the survey report. Our Plan of Corris prepared and executed as a me continuously improve the quality or and to comply with all applicable s federal regulatory requirements. F280 R34's care plan and care sheets he been reviewed and updated to fall preventions and transfers according	ement forth on rection ans to f care tate and		

Minnesota Department of Health

STATE FORM 6899 H7WT11 If continuation sheet 3 of 16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00004	B. WING		10/05/0015
NAME OF DOO	VIDED OD CLIDDLIED	00934		CTATE ZID CODE	10/06/2016
	VIDER OR SUPPLIER	900 3RD 9	STREET SOL	STATE, ZIP CODE JTH	
GOLDEN LIV	VINGCENTER - FR	ANKLIN FRANKLII	N, MN 5533	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 570 Cd	ontinued From pag	ge 3	2 570		
inc	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.			residents have the potential to be if care plans are not updated to accurrent status.	
as red mo ind				All fall reports will be reviewed by team, the IDT will come up with ar intervention that will be implement DNS/designee will update the care and care sheets accordingly and communicate the intervention to a nursing staff	n red. The e plan
inc roc dro inc R3 dir sta sh inc he ca for Or (N a f	dicated R34 could om. R34's care pl quired extensive a essing, and transficude the use of a R34's nursing assistented staff R34 traff member and a neet included R34's matter head towards that esheet directed ar transfers every truring the initial tou attress was obserom. In 10/4/16, at 9:04 IA)-A stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil mechanical lift R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress to put it is stated R34 vertuil R34 had to be sat use mattress vertuil R34 vertuil R34 had to be sat use mattress vertuil R34	adder care plan dated 9/9/16, I use walker and commode in an further included R34 assistance with bed mobility, fers. The care plan did not mechanical lift. Itant care sheet (undated) ansferred with assist of one mechanical lift. The care to be a high fall risk and tress was on the floor facing the closet when in bed. The staff R34 was assist of one wo hours and as needed. It on 10/3/16, at 2:45 p.m. a rived on the floor of R34's Is a.m. nursing assistant was assisted out of bed using the bed so staff could lift up the legs of the lift under the legs of the lift under the led that was the only way to		Licensed staff will be re-educated updating care plans, and updating sheets on a weekly basis. Weekly care plan audits will be coby the DNS/designee on random reassure care plans and care she reflect current care needs of the readults will be reviewed by QAPI committee. Committee will provide direction and suggest change in a or practice when necessary based compliance noted, when reviewing audits. Executive Director or designee is responsible for compliance.	mpleted residents ests esident.

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMPI	
		A. BOILBING.			
	00934	B. WING		10/0	6/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN LIVINGCENTER - FF	ZANKI IN	STREET SOL N, MN 55333			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
asleep in her room with a blanket and a floor mat was next -At 3:45 p.m. NA-B stated "I'm going to R34 replied "ok." N next to R34's mattrepillow from R34's let (peri) care to R34. ANA-B brought R34's mattress and locke assisted R34 into a mattress. NA-B the by both hands and into a standing posistanding position, N hands around NA-E toward the wheelch wheelchair. NA-B the wheelchair and wheelchair and wheelchair and wheelchair and wheelchair was a flo NA-B stated R34's side so that "she car get over the pillow." On 10/5/16, at 9:20 interviewed and stausing two staff and to have R34 stand to stand up from he staff would lower R would need to be o provide additional on NA-E indicated that	p.m. R34 was observed on the mattress, covered up a body pillow on her left side. A to the mattress. entered R34's room and get you up for supper, ok?" A-B then knelt on the floor mat ess. NA-B removed the body ift side and provided perineal After NA-B finished pericare, is wheelchair next to the d the brakes. NA-B then seated position on the en stood up and grabbed R34 pulled R34 off of the mattress tion. Once R34 was in a IA-B directed R34 to put her B's neck so she could steps air and lowered R34 into nen adjusted R34 in her eleled her out of the room. Wed and stated that it was hard p R34, but it was better now or mat next to the mattress. body pillow was put on her left in't crawl out of bed, she can't				

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Minnesota Department of Health

	SURVEY	
A. BOILDING.		
00934 B. WING 10/0	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) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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 that should have been completed and confirmed the intervention put into place after R34's 5/21/16, fall was not implemented. RN-A 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		

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBEN.	A. BUILDING:		COIVIE	LETED
		00934	B. WING		10/0	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - FF	ZANKIIN	STREET SOI IN, MN 5533			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	try putting R34's mastated R34 transfer staff were to assist the lift to assist R34 confirmed it was not mattress to put the was questioned about staff was providing stated "we can't be use the full lift for transfer questioned about s R34's left side whe unable to roll out. The doing that, they are can't be doing that staff should use book SUGGESTED MET The director of nurs staff related to the care plans and more	vas told by nurse consultants to attress on the floor. The DON cred with a mechanical lift and R34 to the floor mat and use 4 off of the floor. The DON of appropriate to lift up R34's lift legs underneath. The DON out the different assistance during transfers. The DON doing that" and staff was to ransfers. The DON was also taff using a body pillow on a she was in bed so she was the DON stated "we can't be a restraining her then and we "The DON went on to say dy pillows for positioning only. THOD OF CORRECTION: sing or designee could educate need to evaluate and update nitor for compliance.				
2 830	(21) days.	R CORRECTION: Twenty One 0 Subp. 1 Adequate and re: General	2 830			11/17/16
	Subpart 1. Care in receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from the care in the comprehensive plan of care as des 4658.0405.	general. A resident must re and treatment, personal and supervision based on a preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00934	B. WING		10/0	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - FF	ZANKI IN	STREET SOI N, MN 5533	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	_	2 830			
	by: Based on observatireview, the facility finterventions, follow transfer 1 of 4 resident findings include: During the initial too mattress was observoom. On 10/4/16, at 9:04 and nursing assistaroom. A mattress w R34's room. RN-A in an assessment on with therapy and us RN-A and NA-A app waist and directed walker and assisted RN-A and NA- then down on the comm pulling down her pastated R34 did well going to tell therapy transfers. On 10/4/16, at 9:12 and stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed. NA-A stated that R34 mattress was placed determined a high fout of bed.	ent is not met as evidenced on, interview and document ailed to implement fall the care plan and safely lents (R34) reviewed for falls. For on 10/3/16, at 2:45 p.m. a reved on the floor of R34's a.m. registered nurse (RN)-A ant (NA)-A pushed R34 into her as observed on the floor of ndicated she was completing R34 to see if she could work to the commode in her room. See the commode in her room. See the commode in her room, assisted R34 to turn and sit ode after assisting her with this and incontinent pad. RN-A with this transfer and she was at to start working with her on a.m. NA-A was interviewed as all risk and had multiple falls ated R34 was assisted out of chanical lift, but in order to use		R34's bed was removed off of the and placed on a bed frame. R34 w provided a wider bed and a senso to alert staff and positioning pillow removed. All residents and staff hapotential for injury, when caring for resident whose mattress is on the Re-education provided to all staff handling of residents, proper bed positioning and use of positioning Weekly audits of resident care incitransfers and bed positioning will be completed on random residents to for ongoing compliance. Audits will be reviewed by QAPI Committee. Committee will provided irection and suggest change in an or practice when necessary based compliance noted, when reviewing audits.	vas r alarm ave the r a floor. on safe pillows. luding oe monitor e uditing on the	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:		JON ELTEB	
		00934	B. WING		10/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - FF	RANKI IN	STREET SOI N, MN 5533			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	the lift, R34 had to lift up the mattress the mattress. NA-A to hook R34 up to t around the mattress "ridiculous" and staknees to assist R34 adjustable and R34 Staff was directed t incontinent product On 10/4/16, at 2:06 asleep in her room with a blanket and a floor mat was next NA-B entered R34's to get you up for su NA-B then knelt on mattress. NA-B ren R34's left side and R34. After NA-B fin R34's wheelchair not the brakes. NA-B the position on the mat grabbed R34 by bo the mattress into a was in a standing put her hands arous steps toward the wheelchair. NA-B the wheelchair and w	be sat up in bed so staff could to put the legs of the lift under stated that was the only way he lift as the legs did not fit s. NA-A stated that was ff had to be on their hands and 4 as the bed was not was unable to be toileted. To check and change R34's every two hours. 5 p.m. R34 was observed on the mattress, covered up a body pillow on her left side. A to the mattress. At 3:45 p.m. Is room and stated "I'm going apper, ok?" R34 replied "ok." the floor mat next to R34's noved the body pillow from provided perineal (peri) care to ished pericare, NA-B brought ext to the mattress and locked then assisted R34 into a seated tress. NA-B then stood up and th hands and pulled R34 off of standing position. Once R34 to and NA-B's neck so she could the her out of the room. Wed and stated that it was hard p R34, but it was better now or mat next to the mattress. body pillow was put on her left an't crawl out of bed, she can't				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00934 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH **GOLDEN LIVINGCENTER - FRANKLIN** FRANKLIN, MN 55333 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2830 Continued From page 9 2 8 3 0 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00934	B. WING		10/0	06/2016
	PROVIDER OR SUPPLIER	ANKLIN 900 3RD S	DRESS, CITY, S STREET SOUN, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	for transfers every to the confirmed the use of the mattress by hould not be transfer R34 from the staff would not be on provide additional on the continuous RN-A was interview who stated R34 did having four falls from that due to multiple was made to take a a mattress on the flue transfer R34 from the transfer R34 from the continuous went on to say staff transfer R34 from the continuous the lift RN-A was not aware without the use of the should not be transforthed the care went through incided interdisciplinary team the intervention put fall was not implement should have been of the director of nurse the dire	wo hours and as needed. a.m. NA-D and NA-E were ted R34 was to be transferred a gait belt. The two staff were up and grab on to her walker in wheelchair and then the two 34 on to the mattress and staff in the floor on their knees to are assistance. NA-D and used to have a higher bed a falls from bed was removed. The document of the decision that we are a bed due to her in bed. RN-A went on to say falls from bed the decision that way R34's bed frame and put oor. RN-A stated R34 was to ga full mechanical lift. RN-A were to use a sheet to the mattress to the floor mat at to assist R34 off of the floor. The of R34 being transferred the lift. RN-A confirmed staff ferring R34 by pulling her off the hands. RN-A was tare plan only including the erses the nursing assistant the staff to use the lift. RN-A plan was inconsistent. RN-A that reports and fall into place after R34's 5/21/16, ented. RN-A confirmed that completed and confirmed R34.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		00934	B. WING		10/0	06/2016
	PROVIDER OR SUPPLIER	SANKI IN 900 3RD S	ORESS, CITY, S STREET SOUN, MN 5533			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	multiple falls out of interventions she w try putting R34's ma stated R34 transfer staff were to assist the lift to assist R34 confirmed it was no mattress to put the was questioned about staff was providing stated "we can't be use the full lift for tr questioned about staff should use both staff should use both SUGGESTED MET Director of Nursing polices and procedimonitoring safe tran Nursing or her designation of the designati	ge 11 bed and when she ran out of as told by nurse consultants to attress on the floor. The DON red with a mechanical lift and R34 to the floor mat and use off of the floor. The DON at appropriate to lift up R34's lift legs underneath. The DON out the different assistance during transfers. The DON doing that" and staff was to ansfers. The DON was also taff using a body pillow on a she was in bed so she was he DON stated "we can't be restraining her then and we" The DON went on to say dy pillows for positioning only. THOD OF CORRECTION: The or her designee could develop ures regarding assessing and asfers. The Director of gnee could develop a to ensue residents receive the	2 830			
	appropriate care. Time period for core	rection: Twenty-one (21) days.				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance	O Subp. 4 A-I Infection Control and procedures. The infection ast include policies and provide for the following: based on systematic data a nosocomial infections in	21390			11/17/16

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COIVIPL	LIED
		00934	B. WING		10/06	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TWINE OF T	TIOVIDEIT OIT OOF T EIEFT		STREET SOI			
GOLDEN	I LIVINGCENTER - FF	ΣΔΝΚΙΙΝ	N, MN 5533			
	OUR MAA DV OTA		<u>-</u>			
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
21390	Continued From pa	ge 12	21390			
	•					
		detection, investigation, and				
		s of infectious diseases;				
		d precautions systems to mission of infectious agents;				
		ducation in infection				
	prevention and con					
		ealth program including an				
		am, a tuberculosis program as				
		8.0810, and policies and				
	procedures of resident care practices to assist in					
	the prevention and treatment of infections;					
	F. the development and implementation of					
		olicies and infection control				
	practices, including a tuberculosis program as					
	defined in part 4658.0815;					
	G. a system for reviewing antibiotic use;					
		r review and evaluation of				
	•	ect infection control, such as				
	disinfectants, antise					
	incontinence products; and I. methods for maintaining awareness of					
	current standards of practice in infection control.					
	our one otarida do o	in practice in innection control				
	This MN Requirement is not met as evidenced					
	by:					
		on, interview and document		It is the policy of Golden Living Ce		
		ailed to implement infection		Franklin that the facility must estab		
	•	es related to hand washing		maintain and Infection Control Pro	_	
		or 3 of 3 residents (R24, R13,		designed to provide a safe, sanital		
	R34) reviewed duri	ng tne survey.		comfortable environment and to he		
	Findings include:			prevent the development and trans of disease and infection.	SIIIISSIOII	
	Findings include:			טו טוספמספ מווט וווופטנוטוו.		
	R24:			Plan of correction for identified inc	idents:	
	During on observation on 10/5/16, at 10:13 a.m.,					
		s room to complete a dressing		All residents have the potential to I	be	
change to her right hip. RN-B carried a plastic			affected by not following protocol for			
		om, set it down on a side table.		hygiene.		
		r of gloves and removed the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00934	B. WING		10/06/2016		
GOLDEN	PROVIDER OR SUPPLIER I LIVINGCENTER - FR	SANKLIN 900 3RD S	DDRESS, CITY, STATE, ZIP CODE STREET SOUTH IN, MN 55333				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE		
21390	dressing from R24's name tag, irrigated powder to the outsing grabbed a pair of so basket. After meast hisg the wound, RN returned the scisso garbage and left the his gloves or wash/during the dressing. During an interview RN-B stated he sho after removing his gwash between the company and interveiw RN-C stated she exwhen entering a roow wash of sanitize haprior to applying a releaving the room. So not be touching oth A facility policy titled Handwashing/Handindicated the facility the praminary mean infections. The policibefore and after directions.	s hip. RN-B then touched his the wound and applied de of the open wound. He then cissirs and a q-tip out of the urinhe should have washed I-B covered the wound, rs to the basket, grabbed the e room. RN-B did not change sanitize his hands at any time change. Ton 10/5/16, at 10:23 a.m., ould have washed his hands gloves. He stated, "I didn't clean and the dirty." Ton 10/6/16, at 9:12 a.m., expected staff to wash hands om and to change gloves and nds after removing a dressing new treatment and before the further stated staff should er items with gloves on. Id Golden Living, Id Hygeine, dated August 2014 or considers hand hygeine to be not oprevent the spread of cry directed staff to wash hands ect contact with residents, ndling clean or soiled	21390	Staff will receive education in regathe infection control policy and the importance of proper hand hygien prevent the spread of infection. DNS/Designee will complete week random audits to monitor for compof infection control policy. Audits will be reviewed by QAPI Committee. Committee will provid direction and suggest change in a or practice when necessary based compliance noted, when reviewing DNS/designee is responsible for compliance.	e to kly bliance e uditing I on the		
	R13: On 10/4/16 at 3:27 R13's room to assis wheelchair. Prior to	p.m. NA-B and NA-C entered at her out of bed and into her assisting R13 out of bed, nned gloves and directed R13					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	:			
		00934	B. WING		10/0	06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
GOLDEN LIVINGCENTER - FRANKLIN 900 3RD STREET SOUTH FRANKLIN, MN 55333							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21390	to roll side to side to incontinent product toward NA-C, NA-E incontinent product product underneath perineal care after incontinent product gloves before placin product under R13. R13 with pulling up from the bed to the mechanical lift. At 3 interviewed and star gloves before placin underneath R13. Not completed perineal product change but to complete R13's princontinent product NA-B wincontinent product NA-B donned glove incontinent product NA-B donned glove incontinent pad and R34'S floor mat. NA-B wincontinent pad and R34'S floor mat. NA-B area, then had R34 continued to provid from her buttocks to front) and then witowards her buttock on the floor on the	o assist R13 with an change. As R13 was turned removed R13's soiled and placed a new incontinent R13. NA-B did not perform removing the soiled and did not remove her dirtying the clean incontinent. NA-B and NA-C then assisted her pants and assited her wheelchair using a 3:34 p.m. NA-B was ated she did not remove her ng a clean incontient product A-B stated that she usually care with every incontinent to did not have wipes near her pericare. NA-B stated R13's	d				

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PRINTED: 11/21/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00934 10/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH **GOLDEN LIVINGCENTER - FRANKLIN** FRANKLIN, MN 55333 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21390 Continued From page 15 21390 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.

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