

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245400		3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - WABASSO			4. TYPE OF ACTION: <u>7</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 854542100		(L4) 660 MAPLE STREET			1. Initial 3. Termination 5. Validation 7. On-Site Visit	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006		(L5) WABASSO, MN (L6) 56293			2. Recertification 4. CHOW 6. Complaint 9. Other	
6. DATE OF SURVEY 12/09/2016 (L34)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			12/31	
11. LTC PERIOD OF CERTIFICATION		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC				
From (a) : To (b) :		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE				
12.Total Facility Beds 44 (L18)		10.THE FACILITY IS CERTIFIED AS:				
13.Total Certified Beds 44 (L17)		X A. In Compliance With			And/Or Approved Waivers Of The Following Requirements: _____	
		Program Requirements _____ 2. Technical Personnel			_____ 6. Scope of Services Limit	
		Compliance Based On:			_____ 3. 24 Hour RN	
		_____ 1. Acceptable POC			_____ 7. Medical Director	
		B. Not in Compliance with Program			_____ 4. 7-Day RN (Rural SNF)	
		Requirements and/or Applied Waivers: * Code: A* (L12)			_____ 8. Patient Room Size	
					_____ 5. Life Safety Code	
					_____ 9. Beds/Room	
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	1861 (e) (1) or 1861 (j) (1):		(L15)
	44					
(L37)	(L38)	(L39)	(L42)	(L43)		

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

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROVAL		Date:
<u>Kathryn Serie, Unit Supervisor</u>		12/09/2016	<u>Kate JohnsTon, Program Specialist</u>		12/23/2016
		(L19)			(L20)

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate					
<input type="checkbox"/> 2. Facility is not Eligible					
		(L21)			
22. ORIGINAL DATE OF PARTICIPATION		23. LTC AGREEMENT BEGINNING DATE		24. LTC AGREEMENT ENDING DATE	
12/01/1986					
(L24)		(L41)		(L25)	
25. LTC EXTENSION DATE:		27. ALTERNATIVE SANCTIONS			
(L27)		A. Suspension of Admissions:			
		(L44)			
		B. Rescind Suspension Date:			
		(L45)			
26. TERMINATION ACTION:		(L30)			
<u>VOLUNTARY</u> 00		<u>INVOLUNTARY</u>			
01-Merger, Closure		05-Fail to Meet Health/Safety			
02-Dissatisfaction W/ Reimbursement		06-Fail to Meet Agreement			
03-Risk of Involuntary Termination		<u>OTHER</u>			
04-Other Reason for Withdrawal		07-Provider Status Change			
		00-Active			
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO.		30. REMARKS	
		00454		Posted 12/29/2016 Co.	
(L28)		(L31)			
31. RO RECEIPT OF CMS-1539		32. DETERMINATION OF APPROVAL DATE			
		12/16/2016			
(L32)		(L33)			
		DETERMINATION APPROVAL			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245400
December 23, 2016

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Wabasso
660 Maple Street
Wabasso, MN 56293

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 5, 2016 the above facility is certified for or recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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.

Golden Livingcenter - Wabasso

December 23, 2016

Page 2

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Wabasso
660 Maple Street
Wabasso, MN 56293

RE: Project Number S5400026

Dear Mr. Fischgrabe:

On November 3, 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 26, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2016, effective December 5, 2016 and therefore remedies outlined in our letter to you dated November 3, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Golden Livingcenter - Wabasso

December 23, 2016

Page 2

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245400	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/9/2016	Y3
NAME OF FACILITY GOLDEN LIVINGCENTER - WABASSO			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	12/05/2016	LSC	12/05/2016	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	
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	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) KS/KJ	DATE 12/23/2016	SIGNATURE OF SURVEYOR 03048	DATE 12/9/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/26/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245400	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 12/16/2016	Y3
NAME OF FACILITY GOLDEN LIVINGCENTER - WABASSO			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0021	Correction Completed 12/05/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 12/05/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) TL/KJ	DATE 12/23/2016	SIGNATURE OF SURVEYOR 35482	DATE 12/16/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/26/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245400		3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - WABASSO			4. TYPE OF ACTION: <u>7</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 854542100		(L4) 660 MAPLE STREET			1. Initial 2. Recertification	
		(L5) WABASSO, MN (L6) 56293			3. Termination 4. CHOW	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			5. Validation 6. Complaint	
		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			7. On-Site Visit 9. Other	
6. DATE OF SURVEY 12/09/2016 (L34)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			12/31	
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:				
From (a): To (b):		<input checked="" type="checkbox"/> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements _____ 2. Technical Personnel _____ 6. Scope of Services Limit Compliance Based On: _____ 1. Acceptable POC _____ 3. 24 Hour RN _____ 7. Medical Director _____ 4. 7-Day RN (Rural SNF) _____ 8. Patient Room Size _____ 5. Life Safety Code _____ 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)				
12.Total Facility Beds 44 (L18)						
13.Total Certified Beds 44 (L17)						
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1): (L15)	
	44					
(L37)	(L38)	(L39)	(L42)	(L43)		

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

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROVAL		Date:
<u>Kathryn Serie, Unit Supervisor</u>		12/09/2016	<u>Kate JohnsTon, Program Specialist</u>		12/23/2016
		(L19)			(L20)

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19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)					
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		26. TERMINATION ACTION: (L30)	
		A. Suspension of Admissions: (L44)		VOLUNTARY <u>00</u> INVOLUNTARY	
		B. Rescind Suspension Date: (L45)		01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00454 (L28)		05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 12/16/2016 (L33)		30. REMARKS Posted 12/29/2016 Co. DETERMINATION APPROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245400
December 23, 2016

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Wabasso, MN 56293

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Golden Livingcenter - Wabasso

December 23, 2016

Page 2

Sincerely,

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Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245400	Provider/Supplier Name GOLDEN LIVINGCENTER WABASSO
------------------------------------	---

Type of Survey (select all that apply):

D					
---	--	--	--	--	--

- A Complaint Investigation E Initial Certification I Recertification
- B Dumping Investigation F Inspection of Care J Sanction/Hearing
- C Federal Monitoring G Validation K State License
- D Follow-up Visit H Life safety Code L Chow

Extent of Survey (Select all that apply):

D					
---	--	--	--	--	--

- A Routine/Standard (all providers/suppliers)
- B Extended Survey (HHA or long term care facility)
- C Partial Extended Survey (HHA)
- D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader 1. 03048			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25
 Total Clerical/Data Entry Hours..... 3.25
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? N

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245400	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/9/2016	Y3
NAME OF FACILITY GOLDEN LIVINGCENTER - WABASSO			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	12/05/2016	LSC	12/05/2016	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	
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	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) KS/KJ	DATE 12/23/2016	SIGNATURE OF SURVEYOR 03048	DATE 12/9/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/26/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245400	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 12/16/2016	Y3
NAME OF FACILITY GOLDEN LIVINGCENTER - WABASSO			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0021	Correction Completed 12/05/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 12/05/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) TL/KJ	DATE 12/23/2016	SIGNATURE OF SURVEYOR 35482	DATE 12/16/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/26/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---	--



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

Mr. Wayman Fischgrabe, Administrator
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660 Maple Street
Wabasso, MN 56293

RE: Project Number S5400026

Dear Mr. Fischgrabe:

On November 3, 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 26, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2016, effective December 5, 2016 and therefore remedies outlined in our letter to you dated November 3, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245400		3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - WABASSO (L4) 660 MAPLE STREET (L5) WABASSO, MN (L6) 56293			4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) 854542100		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006			7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 10/26/2016 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other			FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u> </u> Program Requirements <u> </u> Compliance Based On: <u> </u> 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			And/Or Approved Waivers Of The Following Requirements: <u> </u> <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room	
12. Total Facility Beds 44 (L18)		13. Total Certified Beds 44 (L17)			14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 44 (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)		16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):				
17. SURVEYOR SIGNATURE <u>Holly Kranz, HFE NE II</u> (L19)			Date : 11/18/2016		18. STATE SURVEY AGENCY APPROVAL <u>Kate JohnsTon, Program Specialist</u> (L20)	
			Date: 12/12/2016			

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

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00454 (L28) (L31)		30. REMARKS Posted 12/16/2016 Co.	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 3, 2016

Mr. Wayman Fischgrabe, Administrator
Golden LivingCenter - Wabasso
660 Maple Street
Wabasso, MN 56293

RE: Project Number S5400026

Dear Mr. Fischgrabe:

On October 26, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

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 December 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 5, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 26, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Golden Livingcenter - Wabasso

November 3, 2016

Page 6

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

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

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

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

PRINTED: 11/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/26/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WABASSO			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		12/5/16	

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

TITLE

(X6) DATE

Electronically Signed

11/03/2016

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

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F 279	<p>Continued From page 1</p> <p>by: Based on observation, interview, and document review the facility failed to develop a comprehensive care plan that identified risks, goals, and interventions related to oral/dental care for 1 of 2 residents (R8) who had loose, broken and/or missing teeth.</p> <p>Findings include:</p> <p>R8's admission record dated 7/11/16, listed current diagnoses including: epilepsy, obesity and muscle weakness. R8's admission Minimum Data Set (MDS) assessment dated 7/18/16, revealed the oral/dental status was incorrectly coded, indicating there were no problems with oral/dental status. The MDS also reveals a BIMS (Brief Interview for Mental Status) score of 13/15, indicating intact cognition.</p> <p>The form titled: Clinical health status, dated 7/18/16, revealed the condition of teeth/oral cavity of R8: no dentures and has broken, loose or carious teeth.</p> <p>Review of the care plan dated 7/18/16, reveals that R8 did not have any oral/dental status care plan initiated until 10/26/16, the last day of the survey.</p> <p>During observation and interview on 10/24/16 at 3:59 p.m. with R8, it was noted she had few of her own teeth and they appeared loose and cracked. R8 stated during this interview she does not have dentures and wants to have her teeth repaired and dentures made. R8 stated that she was unaware of any plan to pursue dental services. R8 denied any problems with chewing and/or swallowing.</p>	F 279	<p>Preparation, submission and implementation of this Plan of correction does not constitute an admission of agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the Quality of care and to comply with all applicable state and federal regulations.</p> <p>GLC-Wabasso realizes the importance of developing a comprehensive care plan for residents that includes measurable objectives and timelines. The Care Plan, Clinical Health Status and MDS for resident #8 has been reviewed and the MDS has been modified and care plan updated to reflect the oral/dental status.</p> <p>GLC-Wabasso has reviewed all residents MDS section L their care plan and clinical health status oral status section. Care plans have been updated for all residents to reflect their oral health status as needed.</p> <p>To prevent further occurrence education has been provided to staff involved on section L of the MDS and care planning of oral/dental status.</p> <p>To monitor performance and make sure solutions are sustained, random bi-monthly audits will be completed by the E.D./designee on proper coding of section L on the MDS and appropriate care planning of oral/dental status until May 1st</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/26/2016
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F 279	Continued From page 2 When interviewed on 10/26/16, at 12:37 p.m. registered nurse (RN)-A confirmed that R8's oral/dental problems had not been identified on the care plan and stated she would add it to the care plan. RN-A also confirmed the MDS was not properly coded to indicate that R8 had loose, carious and missing teeth. On 10/27/16, at 3:04 p.m., the care plan policy was requested from the director of nurses (DON). The DON confirmed via facsimile that the facility does not have a specific care plan policy.	F 279	2016 and random there after as needed with audit results reviewed in QAPI quarterly and as needed.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		12/5/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/26/2016
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F 441	<p>Continued From page 3</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize the spread of infection and ensure proper hand hygiene was performed between medication passes for 3 of 11 resident (R1, R10, R33) medication passes observed.</p> <p>Findings include:</p> <p>On 10/25/16 at 2:26 p.m. licensed practical nurse (LPN)-A was observed to set up three medications for R33 during medication pass. After administering the medications to R33, LPN-A returned to the medication cart and proceeded to document the medications as administered. LPN-A failed to perform handwashing and/or apply alcohol hand sanitizer gel. After LPN-A referenced the medication orders on the computer, she set up the medication order for R10. Without handwashing, LPN-A administered the medications to R10, returned to the medication cart and preceded to</p>	F 441	<p>GLC-Wabasso realizes the importance of staff washing hands after direct contact with residents during medication pass.</p> <p>The policy and procedure has been reviewed for residents #1,10 and 33.</p> <p>To prevent further occurrence staff involved with medication pass have been reeducated on the importance of infection control and hand washing during medication pass.</p> <p>To monitor performance and to make sure solutions are sustained random bi-monthly audits will be performed by the E.D or designee until May 1st 2017 and randomly there after on infection control and hand washing during medication pass. With audit results reviewed in QAPI quarterly and as needed.</p>		

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

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F 441	<p>Continued From page 4</p> <p>document the medications as administered. LPN-A proceeded to reference the medication orders via the computer, set up 5 medications for R1 and then administered the medications to R1, who was lying in bed. Without washing her hands and/or applying alcohol sanitizing gel, LPN-A returned to the medication cart and document the medications just administered to R1. Upon completion of the medication pass for R33, R10 and R1, LPN-A was reminded to implement handwashing. It was confirmed that R1 had symptoms of an active gastrointestinal illness.</p> <p>When interviewed on 10/25/16, at 2:35 p.m. LPN-A confirmed she had not washed nor sanitized her hands between administering medications to the three observed residents (R33, R10, R1).</p> <p>During a interview with the director of nursing (DON) on 10/26/16 at 11:56 a.m. she verified staff should wash or sanitize their hands between medication passes.</p> <p>The facility policy titled, Medication Administration - General Guidelines, Revised 6/2016 was reviewed and the following was noted: Preparation- (1) Handwashing and hand sanitation: The person administering medications adheres to good hand hygiene, which includes washing hands strenuously: before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations and before and after administration of medications -</p>	F 441			

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

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F 441	<p>Continued From page 5 via enteral tubes.</p> <p>(2) Hand sanitization is done with an approved sanitizer: between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface). at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated.</p> <p>(3) Sanitization is not a substitute for proper handwashing, and washing should be done if there is a question.</p> <p>Document review of a Minnesota Department of Health Gastrointestinal illness report dated 10/25/16, which was presented to the surveyors after admission to the facility revealed that R1, was confirmed to have gastrointestinal symptoms beginning on 10/21/16. The census during the survey was 37 and 11 residents were affected.</p>	F 441			

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


F5400026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - WABASSO	STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 26, 2016. At the time of this survey, Golden LivingCenter Wabasso was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p> <p>By email to:</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/03/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Wabasso was constructed as follows: The original building was constructed in 1964, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1994 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021	NFPA 101 LIFE SAFETY CODE STANDARD	K 021		12/5/16

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K 021 SS=F	Continued From page 2 Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. <u>This STANDARD is not met as evidenced by:</u> Based on observation and interview the facility failed to maintain doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2	K 021	The magnetic holding will be replaced with a magnetic lock tied into the fire alarm system. The maintenance director will be responsible to monitor proper function of the magnetic lock to ensure it is working condition	

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K 021	<p>Continued From page 3</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>This deficient practice could affect 37 of the 37 residents, visitors and staff.</p> <p>FINDINGS INCLUDE:</p> <p>On 10/26/2016, between the hours of 10:00AM and 1:00PM, it was observed that the door from the Kitchen to the Dining Room was observed being held open by a magnetic hold open device. This hold open device was not connected to the Facility's Fire Alarm System that would allow the door to release and close if the Building's Fire Alarm activated.</p> <p><i>This deficient practice was verified by the Facility Maintenance Director.</i></p>	K 021			
K 144 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by: Based on documentation review and interview it was revealed that the documentation on the Monthly Generator Test Log did not contain all of the required information in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p>	K 144	<p>The generator test log has been revised to include all required information. Random audits will be performed by Ed/Designee to ensure proper completion form and cool down temp</p>	12/5/16	

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K 144	Continued From page 4 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This deficient practice could affect 10 of the 37 residents, visitors and staff. FINDINGS INCLUDE: On 10/26/2016, between the hours of 10:00AM and 1:00PM, during documentation review, it was revealed that during the Monthly Generator Test the cool down time was not being documented. This deficient practice was verified by the Facility Maintenance Director.	K 144		