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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRC4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

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

6. DATE OF SURVEY **06/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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):
A follow up of the Life Safety Code deficiency K038 from the October 17, 2014 which had been recommended for a temporary waiver with a date of completion of May 31, 2015 was completed on June 1, 2015 and found corrected. Refer to the CMS 2567b for results of this revisit.

17. SURVEYOR SIGNATURE Date :
Gary Schroeder DSFM 10/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 22, 2015

Ms. Emily Jenkins, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number F5324024

Dear Ms. Jenkins:

On October 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 17, 2014. 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 4, 2014, we notified you that, based on our follow-up visit completed on December 1, 2014 and November 20, 2014, we determined that your facility had corrected the deficiencies issued pursuant to our October 17, 2014 standard survey, effective November 26, 2014. On December 4, 2014, we also informed you that your request for a temporary waiver involving the Life Safety Code deficiency cited at K038, including the date of completion of May 31, 2015, had been approved.

A follow-up of the remaining Life Safety Code deficiency cited at K038 was completed on June 1, 2015 and the deficiency was found to be corrected as of May 31, 2015. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245324	A. Building B. Wing 01 - MAIN BUILDING 01	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0038	Correction Completed **05/31/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GS/mm	Date: 10/22/2015	Signature of Surveyor: 25822	Date: 06/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/14/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRC4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**

2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

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

6. DATE OF SURVEY **12/01/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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):
Facility's request for a temporary waiver involving tag K038 (replacement of concrete sidewalk) is approved.

17. SURVEYOR SIGNATURE — Date :
Gayle Lantto, Supervisor — 12/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 12/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5324

December 4, 2014

Ms. Alicia McMahon, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

Dear Ms. McMahon:

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 November 26, 2014 the above facility is certified for:

74 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 skilled nursing facility beds.

The waiver you requested for the following Life Safety Code Requirements: K038 (replacement of concrete sidewalk) has been approved.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 4, 2014

Ms. Alicia McMahon, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number S5324024

Dear Ms. McMahon:

On October 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 17, 2014. 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 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 20, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 26, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 17, 2014, effective November 26, 2014 and therefore remedies outlined in our letter to you dated October 28, 2014, will not be imposed.

Correction of the Life Safety Code deficiency cited under tag K038 at the time of the October 17, 2014 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of May 31, 2015, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245324	A. Building B. Wing	12/1/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **11/26/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **11/26/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/26/2014**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **11/26/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	12/04/2014	15507	12/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/17/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245324	A. Building B. Wing **01 - MAIN BUILDING 01**	11/20/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **11/14/2014**	ID Prefix	Correction Completed **11/03/2014**	ID Prefix	Correction Completed **11/03/2014**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **11/17/2014**	ID Prefix	Correction Completed **11/18/2014**	ID Prefix	Correction Completed **11/18/2014**
Reg. # **NFPA 101** LSC K0054		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0067	
ID Prefix	Correction Completed **10/31/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0144		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	12/04/14	25822	11/20/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/14/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRC4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - BLOOMINGTON**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **10/17/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 11/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4967

October 28, 2014

Ms. Alicia McMahon, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

RE: Project Number S5324024 and Complaint Number H5324046

Dear Ms. McMahon:

On October 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 17, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324046.

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. In addition, at the time of the October 17, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5324046 that was found to be unsubstantiated.

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

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

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

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

<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

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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 26, 2014, 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 November 26, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 17, 2015 (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 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Wednesday, November 12, 2014 9:27 AM
To: Suzuki, Jan M. (CMS/CQISCO) (Jan.Suzuki@cms.hhs.gov)
Cc: robert.rexeisen@state.mn.us; McMahon, Alicia 87 [BH02325] (Alicia.McMahon@goldenliving.com); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Golden Living Center Bloomington (245324) K38 Tempoary Waiver Request

This is to notify you that I am accepting GLC Bloomington's request for a temporary waiver until 5-31-15 for K38, for the replacement of a concrete sidewalk. The exit date was 10-17-14.

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

Name of Facility **2000 CODE**

245324- Bloomington- Golden LivingCenter- Bloomington

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K038 A temporary waiver is requested for K038	A temporary waiver for K Tag 038 is being requested until the date of May 31, 2015. A temporary waiver for K038 is needed because the cold weather and snow causes a hardship for a contractor to come out and replace cerement to correct the more than 1/2 inch at discharge to ground. Doing this in the spring allows for facility to get bids and a contractor to come out a fix affected discharges. The affected areas are not normally used by patients or visitors. Many other exits in compliance.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 11-12-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed for H5324046 at the time of the standard recertification survey and was unsubstantiated. POC accepted as far as to 11/7/14 RECEIVED NOV 0 6 2014	F 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which 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.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/5/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	10/17/2014

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F 280	Continued From page 1 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R72) comprehensively assessed with dental needs. Findings include: R72's dental Chart Progress Notes dated 12/4/13, revealed heavy calculus build up was found during a dental exam on that date. The problem required full mouth debridement in order to comprehensively evaluate and diagnose any oral issues. A treatment plan was subsequently developed which included recommendations for an oral exam every six months, prophylaxis every three months and a return to the clinic for fillings.	F 280	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 2 The notes also indicated the treatment plan was sent to R72's responsible party for approval. R72's care plan dated 5/2/14 and reviewed in 9/14, however, lacked information noting the the recommended dental plan. The care plan only addressed R72's need for set-up and cueing for brushing teeth and that the resident had some missing teeth. On 10/16/14, at 10:37 a.m. medical records (MR)-A verified the care plan did not address the dental treatment plan.	F 280	F280 • (R72) care plan has been revised to include dental chart progress notes dated 12/04/2013 and most recent visit 11/04/2014 • Review all other patient care plans who see the dentist to ensure dental recommendations are included in plan of care • Nursing to audit monthly to ensure compliance maintained • DNS/Nursing designee will report results of audits of dental care plans to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued monthly, less than or more than monthly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Completion date: November 26, 2014	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure preventative dental services were provided, according to a treatment plan developed by a dentist for 1 of 3 residents (R72) comprehensively assessed with dental needs. Findings include:	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 412	Continued From page 3 R72 was observed on 10/13/14, at 11:19 a.m. During conversation, some missing teeth were noted on the lower and upper gums, the resident's gums were puffy and deep pink in color. No halitosis (bad breath) was noted. On 10/16/14, at 8:08 a.m. after supplies had been set up by the nursing assistant (NA)-A, R72 was observed brushing his teeth. When R72 was expelling the toothpaste and water from his mouth, the fluid being expelled was red streaked. At 8:22 a.m. NA-A reported she thought the red streak may have been from food the night before, but as R72 continued to brush his teeth and expel the toothpaste and water, NA-A verified the fluid was red-tinged and contained no food particles. After completing oral care, R72 was asked about his toothbrush, which he reported had soft bristles, and he denied experiencing any pain with toothbrushing. R72's dental Chart Progress Notes dated 12/4/13, revealed heavy calculus build up was found during a dental exam on that date. The problem required full mouth debridement in order to comprehensively evaluate and diagnose any oral issues. A treatment plan was subsequently developed which included recommendations for an oral exam every six months, prophylaxis every three months and a return to the clinic for fillings. The notes also indicated the treatment plan was sent to R72's responsible party for approval. A form titled MDS (Minimum Data Set) 3.0 Oral/Dental Assessment Form revealed an oral exam had been completed by a registered dental hygienist on 2/6/14. The assessment revealed there were no dental problems noted and the	F 412	F412 • (R72) saw dentist on 11/04/2014. Based on this examination, dentist revised treatment plan. Revised treatment plan reviewed with patient's responsible party and determined revised treatment plan was appropriate. • Treatment plan provided is included in patient (R72) plan of care and reviewed quarterly. • All other patients who see contracted dental services have reviewed dental treatment plans to ensure properly carried out and include in plan of care. • DNS/Nursing designee will audit monthly to ensure compliance maintained. • DNS/Nursing designee will report results of audits of dental care plans to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued monthly, less than or more than monthly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Completion date: November 26, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 412	Continued From page 4	F 412		

recommendation was to "continue with current recall interval."

There was no documentation found in either the EHR or the paper health record R72 had returned to the dentist to have the fillings, nor was there any documentation to support the dental prophylaxis every three months was provided, or an oral exam had been completed for R72 after 2/6/14.

R72's care plan dated 5/2/14 and reviewed in 9/14, however, lacked information noting the the recommended dental plan. The care plan only addressed R72's need for set-up and cueing for brushing teeth, use a soft bristled brush and that the resident had some missing teeth. Staff was directed to report any bleeding with oral care, as R72 was on anticoagulant therapy.

On 10/16/14, at 10:37 a.m. medical records (MR)-A stated the dental clinic sent the facility the Chart Progress Notes for residents. However, the dental clinic had not informed the facility whether or not the dental treatment plan had been approved by R72's responsible party.

On 10/17/14, at 9:42 a.m. MR-A stated she had spoken with someone from the dental clinic and was told by the clinic staff member R72's dental plan had been sent out to the responsible family member, but was never returned. MR-A stated she had asked the dental clinic staff what the clinic did if a treatment plan was not returned. According to MR-A, the dental clinic employee told MR-A the clinic did not have the resources,or the staff to be calling nursing homes and inform the facility if the plan had or had not been returned and approved. MR-A stated because the

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F 412	Continued From page 5 facility did not know if the treatment plan had been approved or not, they did not know if they were supposed to follow up on the treatment plan for R72. R72's responsible party was R72 and was unavailable for an interview.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 • Education will be provided to staff nurses regarding the infection control procedure for glucometers. • DCE/DNS/Nurse Manager will randomly audit infection control procedures for glucometer use at least monthly. • DNS/Nursing designee will report results of audits of infection control procedure for glucometers compliance to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued monthly, less than or more than monthly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Completion Date: November 26, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 6	F 441		

professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure appropriate disinfection of multi-use glucometers between residents for 1 of 2 residents (R62) who had a blood glucose testing with a shared glucometer.

Findings include:

R119's blood glucose testing was completed on 10/13/14, at 7:27 a.m. by a registered nurse (RN)-B. RN-B reported the glucometer in use was a multi-use glucometer. After the testing was completed, RN-B removed her gloves, washed her hands, placed the glucometer into a plastic container, and placed the container on the top of the medication cart. A note taped to the edge of the container directed staff to clean glucometers with Dispatch wipes after each use and allow the glucometer to dry for one minute. The glucometer was not cleansed with any type of disinfectant at the time of the observation.

R62's glucometer check was readied by RN-B at 7:48 a.m. using the same glucometer machine. RN-B washed her hands, donned gloves, removed gloves after testing, and again cleaned her hands. After the blood sugar test was completed for R62 RN-B removed their gloves

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 441	Continued From page 7 and cleansed their hands. The glucometer was then placed back in the plastic container without having been cleansed. On 10/16/14, at 8:36 a.m. the director or nurses (DON) provided a copy of the facility's glucometer cleaning policy. After reviewing the glucometer policy the DON was informed RN-B had not cleansed the glucometer according to policy. DON stated, "I knew she did not," as she had had heard from another staff member and RN-B was then re-educated. A review of the facility's 2007 revised policy and procedure titled Blood Glucose Monitor Decontamination revealed the glucometer was to be cleansed and disinfected with wipes following each resident use when glucometers were shared by multiple residents. The policy directed after the testing a Dispatch wipe was to be used to clean all external parts of the glucometer and a second wipe was to be used to "disinfect the blood glucose monitor." A review of the wipes used to cleanse the glucometer revealed the wipes used by the facility were Clorox disinfectant wipes and were tubercidal, bactericidal and virucidal. These wipes were not kept on the medication cart, but instead were kept locked in a treatment cart, located in a different hallway than where the observation took place.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520	Continued From page 8	F 520		

assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee identified quality concerns regarding contracted dental services, which potentially affected all 64 residents in the facility.

Findings include:

Refer to F412 dental services: The facility failed to provide dental services for R72, in accordance with a dental treatment plan developed by the dentist on 12/3/14.

The director of nursing (DON) was interviewed

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F 520	Continued From page 9 regarding the frequency of contracted dental services provided on 10/16/14, at 11:00 a.m. to which the DON replied, "No, I was not aware." On 10/16/14, at 12:30 p.m. a medical records staff person (MR)-A stated she thought the QA committee met at least monthly, to discuss ways to improve care and mentioned dietary and safety issues as examples. MR-A stated that if she had a concern, she would probably take it to the DON, however, she had not taken annual dental visit concerns to the DON or any other committee member. MR-A reported the contracting dental services would not come to the facility if a resident needed emergency treatment, rather the resident would need to travel to a clinic approximately 28 miles from the facility, or MR-A tried to find a closer clinic for a resident. MR-A explained that the contracted dental services changed their policy to come to the facility biannually to only coming when the facility had 12 residents in need of dental services in order to visit. MR-A stated there had been times when a resident had discharged, but was purposefully left on the list to ensure the dental service visited, otherwise she became "nervous" that they would otherwise cancel. Even when 12 names were on the list, the dentist did not always have time to see all 12 residents. On 10/17/14, at 9:05 a.m. the administrator stated the facility paid the contracting dental service about $400 monthly for services, and was unaware they were only visiting the facility annually, and only when 12 residents were on the list to be seen. At 9:42 a.m. the administrator stated the previous administrator had informed her of the issue.	F 520	F 520 • Quality Assurance Meeting held October 29, 2014 where routine dental services were placed on to the minutes • Within that QA & A meeting it was determined that when patient list is provided to Apple Tree Dental (current contract dental service) to inform them of which patients the need to see, GLC- Bloomington will keep a copy of that list • When patient returns from seeing in house dentist, GLC-Bloomington will request copies of treatment plans • Medical records (or designee) will review treatment plans to ensure no follow up action is required. If follow up action is required, then Medical Records or designee will input orders for follow up, and complete necessary follow up with responsible party and dental service provider • Nursing will review/audit all resident dental treatment plans to determine appropriateness of plan and to schedule follow up if needed • DNS/Nursing designee will report results of audits of dental review to the QA committee. • Completion date: November 26, 2014	

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F 520	Continued From page 10	F 520		

On 10/17/14, at 9:15 a.m. MR-A stated the previous administrator had been informed of the problem with the contracted dental service, as well as having conversations with several nurses at the facility regarding the problem.

The dental services contract signed by the previous administrator on 8/1/10, was reviewed. Wording in the contract read, "Contractor shall provide, on a non-exclusive basis, routine and emergency dental and hygiene services to facility residents, including without limitation...." In addition, direct dental services would be provided at the request of a resident or their responsible party. The services would include periodic oral exams and cleaning, tooth repair and denture services; consultative dental health services upon request of the medical director, attending physician and other appropriate staff. The dental contract ensured licensed medical practitioners would be reasonably available and personally present at the facility as necessary to perform the services. "Contractor shall provide the services promptly and in accordance with the medical needs of the residents." No language in the contract indicated services would only be provided annually or when a minimum of 12 residents requested/required services.

The facility's QA plan, revised 2013, revealed that an algorithm was utilized to identify quality problems. Documentation in the QA plan revealed the facility conducted Performance Improvement Projects (PIPs) to examine or improve care or services in areas in need of attention. PIPs typically involved a concentrated effort on a particular problem in one area of the facility or facility wide. This involved gathering information systematically to clarify issues or problems and

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F 520	Continued From page 11 intervening for improvements. PIPs were selected in areas important and meaningful for the specific type and scope of services unique to each facility. No evidence was found to show the QA committee responded to concerns brought to the attention of the previous administrator by MR-A regarding the contracted dental service.	F 520		

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

F5324024

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FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter- Bloomington was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok w/TW for K38 FS 11-12-14 RECEIVED NOV - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 10-17-14 DC: 11-26-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	11-7-14

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter-Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. In 1999, an addition was constructed and was determined to be Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 74 beds and had a census of 65 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, observation revealed, that the following was found: 1. Basement - boiler room door does not positively latch 2. 1st floor - copy supply room (over 50 sq ft) no automatic door closer	K 029	K029 • Basement boiler room door has had the panic bar unlocked to ensure door will positively latch in accordance with 2000 NFPA 101 section 19.3.2.1. • 1st floor copy supply room has a door closer ordered and installed by Maintenance Director to ensure it will positively latch • Executive Director or designee will monitor for continued compliance • Completion date: November 14, 2014	

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K 029	Continued From page 3 These deficient practices were confirmed by the Director of Maintenance (TG) at the time of discovery.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect 40 out of 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, observation revealed, that the following was found: 1. 1st floor - back stairwell - required exit door from corridor to stairwell, door handle is located 6 ft. off of floor 2. 1st floor - back stairwell and sunshine exit discharge, has an elevation change of more than 1/2 inch (check all exit discharges for this deficiency) These deficient practices were confirmed by the	K 038	K 038 • First floor back stairwell exit door from corridor to stairwell, door handle will be been relocated to 39 inches from bottom of door in accordance with 2000 NFPA 101 life safety code on November 18, 2014 • In need of a temporary waiver for the elevation change of more then 1/2 inch at 1st floor back stairwell and sunshine discharges. • Would like waiver until May, 31 2015. In need of waiver because of impending cold weather and limited time to pour concrete to fix elevation change. • Completion date: May 31, 2015	

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K 038	Continued From page 4 Director of Maintenance (TG) at the time of discovery.	K 038		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide reliable lighting for all components of the means of egress as required by 2000 NFPA 101, Section 19..2.9.1, 7.8, and 7.9. The deficient practice could affect 40 out of 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, observation revealed, that the following exit discharge do not have a two bulb fixture on exterior of building: 1. Back stairwell 2. 200 wing NOTE: Check ALL exterior lights for this deficiency These deficient practices were confirmed by the Director of Maintenance (TG) at the time of	K 045	K045 • New 2 light LED fixtures were installed at the exit discharges of the back stairwell and 200 wing in accordance with the NFPA 101 Life Safety Code • All other exterior lights evaluated to ensure compliance • Completion date: November 3, 2014	

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K 045	Continued From page 5 discovery.	K 045		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, the review of the fire drill documentation for the past 12 months (October 2013 to September 2014) revealed that the drills for the day shifts were completed but did not sufficiently vary the times that the drills were conducted - 0900, 1320, 0945 and 0945 hours. This deficient practice was confirmed by the Director of Maintenance (TG) at the time of	K 050	K050 • A fire drill schedule has been updated to include having varying times for each fire drill on each shift per quarter as indicated by NFPA 101 Life safety code standard. • Maintenance director and E.D. will be responsible to monitor for compliance before each fire drill is completed. • Completion date: November 3, 2014	

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K 050	Continued From page 6 discovery.	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, the review of the sensitivity report from MN Conway, dated 4/29/2014, revealed that (6) duct smokes detectors did not have sensitivity done on them. This deficient practice was confirmed by the Director of Maintenance (TG) at the time of discovery.	K 054	K054 • MN Conway to complete sensitivity testing on November 12th on (6) duct smoke detectors, and provide proper documentation by November 17, 2014. • Maintenance Director and ED will be responsible for monitoring for compliance that routine documentation and testing is completed. • Completion Date: November 17, 2014.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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K 062	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, as well as 1998 NFPA 25, section 2-2.1.21, 2-2.1.2 and 2-4.1.4. This deficient practice could affect all 30 out of 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, observation revealed that the following was found: 1. Basement - laundry room several missing ceiling tile 2. 1st floor - Spare sprinkler head box - does not contain (2) spare sprinkler heads of each type 3. 1st floor - ADU med room - sprinkler head is obstructed by new med machines These deficient practices were confirmed by the Director of Maintenance (TG) at the time of discovery.	K 062	K062 • New ceiling tile installed on October 30, 2014 in Laundry Room • Summit Fire provided (2) spare sprinkler heads of each type on November 14, 2014. • Summit Fire to move sprinkler head in medication ADU room so it is not obstructed. They will move sprinkler head on November 11, 2014. • Maintenance Director and ED will be responsible to ensure that (2) spare sprinkler heads of each type are maintained in facility. • Completion Date: November 18, 2014	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BLOOMINGTON	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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K 067	Continued From page 8 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, documentation review of fire damper log indicated there were no fire dampers located in facility. On tour a fire damper was found in the laundry room. No documentation stating that the damper has been tested every 4 years. NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the Director of Maintenance (TG) at the time of discovery.	K 067	K067- • Summit Fire inspected, tested, lubricated and replaced fusible links on fire dampers on November 12, 2014. • Summit Fire provided documentation of that the above services were completed in accordance of NFPA 90A by November 18, 2014. • Maintenance Director and ED will be responsible for ensuring testing and documentation is in compliance. • Completion Date: November 18, 2014	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
-	245324	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 9 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to insure the emergency generator as a reliable fuel source in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 65 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/14/2014, the documentation review of the natural gas emergency generator revealed and the Facility Maintenance Director confirmed the fuel source is natural gas for the emergency generator. The Facility Maintenance Director confirmed the facility did have a letter. The letter needs to contain all five points as required below: 1. A statement of reasonable reliability of the natural gas delivery 2. A brief description that supports the statement regarding the reliability 3. A statement that there is a low probability of interruption of the natural gas 4. A brief description that supports the statement regarding the low probability of interruption 5. The signature of technical personnel from the natural gas vendor. This deficient practice was confirmed by the Director of Maintenance (TG) at the time of discovery.	K 144	K144 • Letter dated October 28, 2014 from Centerpoint Energy confirming reasonable reliability of natural gas delivery, a brief description that supports the statement regarding reliability, that there is low probability of interruption of the natural gas along with a supporting statement and is signed by technical personnel from Centerpoint Energy. • Completion Date: October 31, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/14/2014

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K 144	Continued From page 10	K 144		

TEAM COMPOSITION
Gary Schroeder, Life Safety Code Spc.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4967

October 28, 2014

Ms. Alicia McMahon, Administrator
Golden LivingCenter - Bloomington
9200 Nicollet Avenue South
Bloomington, Minnesota 55420

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5324024 and Complaint Number H5324046

Dear Ms. McMahon:

The above facility was surveyed on October 13, 2014 through October 17, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5324046 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 immediately contact me.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures
cc: Original - Facility
Licensing and Certification File