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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IY5E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00949

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245400**

2.STATE VENDOR OR MEDICAID NO.
(L2) **854542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WABASSO**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

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 **03/26/2015** (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 **44** (L18)

13.Total Certified Beds **44** (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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 — Date :
Jessica Sellner, Unit Supervisor 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 03/31/2015 (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
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: **00** (L30)

VOLUNTARY
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
03/30/2015
(L33)

Posted 04/02/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245400
March 31, 2015

Mr. Wayman Fischgrabe, Administrator
Golden Livingcenter - Wabasso
660 Maple Street
Wabasso, Minnesota 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 March 23, 2015 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.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 31, 2015

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

RE: Project Number S5400024

Dear Mr. Fischgrabe:

On February 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2015, effective March 23, 2015 and therefore remedies outlined in our letter to you dated February 25, 2015, 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.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245400	A. Building B. Wing	3/26/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WABASSO	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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**03/23/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**03/23/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**03/23/2015**
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

Reviewed By State Agency	**Reviewed By** JS/KJ	**Date:** 03/31/2015	**Signature of Surveyor:** 29249	**Date:** 3/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/11/2015		**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**

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(L2) **854542100**

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(L3) **GOLDEN LIVINGCENTER - WABASSO**
(L4) **660 MAPLE STREET**
(L5) **WABASSO, MN** (L6) **56293**

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 **02/11/2015** (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) :

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13.Total Certified Beds **44** (L17)

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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
	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 Date :
Holly Kranz, HFE NE II 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/27/2015 (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
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3. Both of the Above :
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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)

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
Posted 03/30/2015 Co.

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

Electronically delivered
February 25, 2015

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

RE: Project Number S5400024

Dear Mr. Fischgrabe:

On February 11, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 11, 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 August 11, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WABASSO	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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		3/23/15

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

Electronically Signed | 02/27/2015

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
	245400	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WABASSO	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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the state agency (SA) for 2 of 6 residents, (R18 and R1) who had allegations of abuse. Findings include: R18's face sheet dated 2/15, listed current diagnoses of Parkinson's disease and unspecified psychosis. R18's quarterly minimum data set (MDS) dated 11/1/14, identified R18 had moderate cognitive impairment and had a history of being physically aggressive at times. R18's care area assessment (CAA) dated 8/1/14, indicated R18 had severe cognitive impairment and was being treated for urinary tract infection. The CAA indicated R18 had poor short term	F 225	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 means to continuously improve the quality of care and comply with all state and federal regulatory requirements. F225 GLC-Wabasso realizes the importance of immediate reporting of abuse allegations to the state agency. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #1 and #18 All residents have the potential to be affected by the deficit practice. To prevent	

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	245400	A. BUILDING _____ B. WING _____	02/11/2015

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F 225	Continued From page 2 memory, required limited assistance with bed mobility and toileting, and required extensive assistance with transfers, dressing, toileting, and personal hygiene. R18's care plan dated 2/11/15, identified R18 was at risk for abuse due to decreased cognitive ability, history of wandering, rejection of personal cares and medication, history of hitting out at staff or yelling at staff, decreased physical ability, and difficulty at times communicating. The established goal was for the resident to be kept safe and free from abuse. A facility form titled Minnesota Incident Report dated 5/6/14, indicated on 5/4/14, at 9:00 a.m. nursing assistant (NA)-A approached a facility charge nurse and informed her when she and NA-B attempted to transfer R18, the resident swung at NA-B. NA-B said to R18, "Do not hit me," and then called R18, "A dick." The incident report did not indicate who the charge nurse notified of the incident, or any specific immediate action taken to keep the resident safe. Review of the online report to the SA indicated the verbal abuse to R18 had not been submitted by the facility to the SA until the next day on 5/5/14. R1's face sheet dated 2/15, indicated diagnoses including unspecified senile cataract, macular degeneration of retina, unspecified psychosis, anxiety state, depressive disorder, dementia with behavioral disturbances, and paranoid schizophrenia. R1's most current CAAs dated 4/4/14, indicated R1 was cognitively impaired and had episodes of	F 225	further incident to other residents reeducation will be provided to staff on timely reporting of abuse allegations. To monitor its performance and to make sure solutions are sustained, random Audits on immediate reporting of abuse allegations will be performed by the ED/or designee with audit results reviewed in QAPI quarterly and as needed.	

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F 225	Continued From page 3	F 225		

physical and verbal behaviors, and refused cares at times due to her cognitive impairment. R1 did not respond appropriately at times to what was being said, and required extensive assistance from staff with most of her activities of daily living.

R1's care plan dated 2/11/15, identified R1 was at risk for abuse due to decreased cognitive ability, decreased physical ability, and behaviors. The goal was for the resident to be kept safe and free from abuse.

A facility form titled Minnesota Incident Report dated 5/6/14, indicated on 5/4/14, at 9:00 a.m. NA-A informed the facility charge NA-B, "Got into [R1's] face." The incident report did not indicate who the charge nurse notified or any immediate action taken to keep the resident safe.

Review of the online report made to the SA indicated R1's incident was not submitted by the facility to the SA until 5/5/14, the following day after the incident.

During interview on 2/09/15, at 3:41 p.m. the director of nurses (DON), social worker (SW-A) and the administrator stated the charge nurse immediately notified the administrator of the incidents for R1 and R18 involving NA-B, and the administrator then contacted the DON. The DON and SW-A stated they came to the facility on 5/4/14, and did not immediately report the incidents to the SA as they were unsure of the specifics of the incidents, and did not know if the incident was reportable. They acknowledged they immediately suspended NA-B pending results of the investigation, however, did not report the incidents to the SA until the next day. The DON stated she was aware it was required to

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F 225	Continued From page 4 report all allegation of abuse to the SA immediately, however, she stated she needed to determine if any other resident may have been affected or abused by the staff person prior to reporting the incidents. The administrator indicated the allegation was not reported immediately to the SA because they needed to do an investigation to determine if the incident was reportable. During interview on 2/10/15, at 2:43 p.m. NA-A stated she witnessed NA-B being verbally abusive to R18 and R1 in 5/14, and had reported it to the charge nurse. She stated R18 was swinging and hitting at staff and this made NA-B mad. She stated NA-B got very close to R18's face and stated, "I'm tired of you hitting me, you are a dick!" NA-A stated NA-B had a very angry look on her face when she made this statement to R18. NA-A stated she was also aware NA-B had been verbally aggressive to R1 in the shower room, when NA-B got very close to R1's face and stated "I'm sick of you acting this way, knock it off!" NA-A reported R1 looked very scared when NA-B said this to her. The facility's Abuse Policy dated 5/12, directed all staff who has reason to believe a resident is being, or has been, maltreated shall report to the executive director (administrator) immediately. The Executive Director shall determine if the internal report must be reported to the state and reportable incidents must be reported immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		3/23/15

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F 226	Continued From page 5 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy regarding immediately reporting allegations of abuse to the state agency (SA) for 2 of 6 residents, (R18 and R1) who had allegations of abuse. Findings include: The facility's Abuse Policy dated 5/12, directed all staff who has reason to believe a resident is being, or has been, maltreated shall report to the executive director (administrator) immediately. The Executive Director shall determine if the internal report must be reported to the state and reportable incidents must be reported immediately. R18's face sheet dated 2/15, listed current diagnoses of Parkinson's disease and unspecified psychosis. R18's quarterly minimum data set (MDS) dated 11/1/14, identified R18 had moderate cognitive impairment and had a history of being physically aggressive at times. R18's care area assessment (CAA) dated 8/1/14, indicated R18 had severe cognitive impairment and was being treated for urinary tract infection. The CAA indicated R18 had poor short term memory, required limited assistance with bed	F 226	GLC-Wabasso realizes the importance of following our policy and procedure of immediate reporting of abuse allegations to the state agency. The policy and procedure for immediate reporting of abuse allegations has been reviewed for resident #1 and #18 All residents have the potential to be affected by the deficit practice. To prevent further incident to other residents reeducation will be provided to staff on timely reporting of abuse allegations. To monitor performance and make sure solutions are sustained, random Audits on immediate reporting of allegations will be performed by the ED/or designee with audit results reviewed in QAPI quarterly and as needed.	

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F 226	Continued From page 6	F 226		

mobility and toileting, and required extensive assistance with transfers, dressing, toileting, and personal hygiene.

R18's care plan dated 2/11/15, identified R18 was at risk for abuse due to decreased cognitive ability, history of wandering, rejection of personal cares and medication, history of hitting out at staff or yelling at staff, decreased physical ability, and difficulty at times communicating. The established goal was for the resident to be kept safe and free from abuse.

A facility form titled Minnesota Incident Report dated 5/6/14, indicated on 5/4/14, at 9:00 a.m. nursing assistant (NA)-A approached a facility charge nurse and informed her when she and NA-B attempted to transfer R18, the resident swung at NA-B. NA-B said to R18, "Do not hit me," and then called R18, "A dick." The incident report did not indicate who the charge nurse notified of the incident, or any specific immediate action taken to keep the resident safe.

Review of the online report to the SA indicated the verbal abuse to R18 had not been submitted by the facility to the SA until the next day on 5/5/14, and not immediately as directed by the facility abuse policy.

R1's face sheet dated 2/15, indicated diagnoses including unspecified senile cataract, macular degeneration of retina, unspecified psychosis, anxiety state, depressive disorder, dementia with behavioral disturbances, and paranoid schizophrenia.

R1's most current CAAs dated 4/4/14, indicated R1 was cognitively impaired and had episodes of

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F 226	Continued From page 7	F 226		

physical and verbal behaviors, and refused cares at times due to her cognitive impairment. R1 did not respond appropriately at times to what was being said, and required extensive assistance from staff with most of her activities of daily living.

R1's care plan dated 2/11/15, identified R1 was at risk for abuse due to decreased cognitive ability, decreased physical ability, and behaviors. The goal was for the resident to be kept safe and free from abuse.

A facility form titled Minnesota Incident Report dated 5/6/14, indicated on 5/4/14, at 9:00 a.m. NA-A informed the facility charge NA-B, "Got into [R1's] face." The incident report did not indicate who the charge nurse notified or any immediate action taken to keep the resident safe.

Review of the online report made to the SA indicated R1's incident was not submitted by the facility to the SA until the next day 5/5/14, and not immediately per facility policy.

During interview on 2/09/15, at 3:41 p.m. the director of nurses (DON), social worker (SW-A) and the administrator stated the charge nurse immediately notified the administrator of the incidents for R1 and R18 involving NA-B, and the administrator then contacted the DON. The DON and SW-A stated they came to the facility on 5/4/14, and did not immediately report the incidents to the SA as they were unsure of the specifics of the incidents, and did not know if the incident was reportable. They acknowledged they immediately suspended NA-B pending results of the investigation, however, did not report the incidents to the SA until the next day. The DON stated she was aware it was required to

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F 226	Continued From page 8 report all allegation of abuse to the SA immediately according to facility policy, however, she stated she needed to determine if any other resident may have been affected or abused by the staff person prior to reporting the incidents. The administrator indicated the allegation was not reported immediately to the SA per facility policy because they needed to do an investigation to determine if the incident was reportable. During interview on 2/10/15, at 2:43 p.m. NA-A stated she witnessed NA-B being verbally abusive to R18 and R1 in 5/14, and had reported it to the charge nurse. She stated R18 was swinging and hitting at staff and this made NA-B mad. She stated NA-B got very close to R18's face and stated, "I'm tired of you hitting me, you are a dick!" NA-A stated NA-B had a very angry look on her face when she made this statement to R18. NA-A stated she was also aware NA-B had been verbally aggressive to R1 in the shower room, when NA-B got very close to R1's face and stated "I'm sick of you acting this way, knock it off!" NA-A reported R1 looked very scared when NA-B said this to her.	F 226		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		3/23/15

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F 431	Continued From page 9 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure accurate medication labels for 1 of 25 resident medication labels, (R19) observed during medication pass. In addition, the facility failed to ensure proper disposal of Fentanyl patches (a narcotic analgesic patch applied to the skin) for 1 of 1 resident (R31) receiving Fentanyl patches to minimize the risk of drug diversion, nor did the facility have a specific policy directing staff on disposal of used Fentanyl patches. Findings include:	F 431	F431 GLC-Wabasso realizes the importance of accurate labeling of medication and proper destruction of Fentanyl patches. The policy and procedure of medications and related supplies Policy 5.5 which included destruction of Fentanyl patches has been reviewed for resident #31. To prevent further injury to other residents staff will be reeducated on the policy and procedure of proper destruction of	

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F 431	Continued From page 10 During interview on 2/08/15, at 7:17 p.m. licensed practical nurse (LPN)-A stated they placed used Fentanyl patches into the medical hazardous waste bin in the maintenance room. The disposal of the patch was not witnessed by another staff person. R31's medication administration record (MAR) dated 1/15, indicated R31 received Fentanyl patch, 25 micrograms, one patch transdermally, every 72 hours, and one 12 mcg patch every 72 hours. During interview on 2/09/15, at 2:16 p.m. registered nurse (RN)-A stated when a Fentanyl patch was removed from a resident she took the patch off and placed it in the medical waste disposal bin, which was observed to be a locked garbage can. The destruction of the patch was unwitnessed and all thirteen licensed nurses working in the facility had access to the disposal area and the bin containing the used Fentanyl patches. During interview on 2/10/15, at 10:08 a.m. the CP (consultant pharmacist) stated used Fentanyl patches should be placed on a tissue and flushed down the toilet with a witness when disposed of. The CP confirmed the locked bin being utilized for disposal was a potential risk for drug diversion, as significant amounts of Fentanyl were retained in the used patches. CP stated the disposal of the patches should be witnessed by two nursing staff, and signed off in the bound narcotic log the witnessing of destruction. During interview on 2/11/15, at 10:44 a.m. the director of nursing (DON) stated staff should be	F 431	fentanyl patches. Immediately after communication with the surveyor the nurse clarified the Cosopt order for resident #19. The current order was to administer 1 gtt. in affected eye(s)this was also the labeling on the medication bottle of the eye drops. Upon recommendation from the surveyor a clarification was made with the physician and the order was changed to 1 gtt in each eye ou. A change in direction label was then placed on the bottle to indicate the change. To prevent potential injury to other residents staff have been reeducated on the policy and procedure of medication change they have been instructed that the current practice was followed and will continue to be followed. To monitor its performance and to make sure solutions are sustained, random audits will be completed on proper destruction of fentanyl patches and eye drop medication labeling by the DNS/ or Designee with audit results taken to QAPI quarterly and as needed	

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F 431	Continued From page 11	F 431		

flushing used Fentanyl patches down the toilet with a witness, and she was aware all staff had not been following this protocol. The DON confirmed another nurse should witness and cosign the destruction of the Fentanyl patches at the time of the removal, and verified all nurses had access to the hazardous waste bin which could be a concern for drug diversion. DON stated the facility did not have a specific policy on disposal of Fentanyl patches.

The facility policy titled Medication Destruction dated 5/12, indicated medication destruction should occur in the presence of two licensed professionals according to regulation and applicable law. The facility had no specific policy instructing staff on destruction of Fentanyl patches.

Medication labeling:

During observation of medication pass on 2/10/15, at 8:34 a.m. R19's Cosopt (an eye drop used to reduce pressure in the eye) was observed labeled with directions for use listed as to apply to affected eye(s). During interview at this time LPN-C stated the eye drops were for both eyes and confirmed the medication label was unclear, and should contain directions to direct staff which eye to apply the drops to.

Review of R19's current medication sheets, dated 2/15 indicated the current orders for the Cosopt eye drop were for one drop to each eye, twice daily.

During interview on 2/10/15, at 10:08 a.m. the CP stated eye drops should be labeled with the number of drops to use and to which specific

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F 431	Continued From page 12 eyes, and confirmed R19's Cosopt solution label should match the physician order for use, as well as the MAR. During interview on 2/11/14, at 10:44 a.m. the DON stated if the medication label did not match the physician's instructions and/ or MAR for use, or was unclear, a label should have been placed on the eye drops to refer to the MAR and the pharmacy should have been contacted for a label with instructions.	F 431		

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	245400	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2015**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 17, 2015. At the time of this survey, Golden LivingCenter Wabasso was found to be in 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.. 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 28 at time of the survey.	K 000		

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

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