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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IYWB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245290**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OLIVIA**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

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)

6. DATE OF SURVEY **09/12/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (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
	57			
(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 :
Brenda Fischer, Unit Supervisor 09/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/16/2016 (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
09/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS
Posted 09/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/24/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245290
September 16, 2016

Ms. Theresa Pridal, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, MN 56277

Dear Ms. Pridal:

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 August 30, 2016 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 16, 2016

Ms. Theresa Pridal, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, MN 56277

RE: Project Number S5290025

Dear Ms. Pridal:

On August 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 21, 2016 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 31, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 21, 2016, effective August 30, 2016 and therefore remedies outlined in our letter to you dated August 3, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245290 Y1	A. Building B. Wing Y2	9/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	08/30/2016	LSC	08/22/2016	LSC	08/22/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0465	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.70(h)	Completed
LSC	08/22/2016	LSC	08/22/2016	LSC	08/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 09/16/2016	SIGNATURE OF SURVEYOR 10562	DATE 09/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245290 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	08/30/2016	LSC K0018	08/30/2016	LSC K0029	08/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	08/30/2016	LSC K0046	08/30/2016	LSC K0047	08/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0051	08/30/2016	LSC K0062	08/30/2016	LSC K0072	08/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	09/16/2016	34764	08/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/20/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IYWB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00939

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245290**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228497900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - OLIVIA**
(L4) **1003 WEST MAPLE**
(L5) **OLIVIA, MN** (L6) **56277**

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)

6. DATE OF SURVEY **07/21/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(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 :
Michelle Thompson, HFE NE II — 08/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS
Posted 08/24/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 3, 2016

Ms. Theresa Pridal, Administrator
Golden Livingcenter - Olivia
1003 West Maple
Olivia, MN 56277

RE: Project Number S5290025

Dear Ms. Pridal:

On July 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
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 August 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 21, 2016 (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 January 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	1003 WEST MAPLE OLIVIA, MN 56277

(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 receritification survey was conducted and complaint H5290006, H5290007 investigation was also completed at the time of the standard survey. The complaints were unsubstantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the resident's ability to safely administer medications for 1 of 1 residents (R24) observed to have medications left in his juice at bedside. Findings include: R24's quarterly Minimum Data Set (MDS) dated 4/25/16, indicated R24 had severe cognitive	F 176	GLC - Olivia realizes the importance of comprehensively assessing the resident's ability to safely administer medications. The policy and procedure of safely administering medications and performing a comprehensive assessment to safely administer medications has been reviewed for all residents including resident #24.	8/30/16

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

Electronically Signed | 08/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 07/21/2016

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F 176	Continued From page 1 impairment. During observation 7/20/16, at 7:45 a.m. registered nurse (RN)-A was observed to set up R24's medication. RN-A set up aspirin (ASA) 81 mg (milligrams), vitamin D 1000 units and crush, and tamsulosin HCL (hydrochloride, medication used to make it easier to urinate) she opened the capsule and placed the medication in R24's cranberry juice. RN-A placed the juice at R24's bedside and left the room, leaving R24 to administer their own medication. At 8:03 a.m. R24 had completed his breakfast and drank the juice. At the bottom of R24's empty juice glass were several small capsules of tamsulosin HCL medication that was not consumed. During this time RN-A did not observe or followed up with R24 to ensure he consumed all his medication. During interview 7/20/16, at 8:05 a.m. RN-A stated we place all of R24's medication in his juice because that is the only way he will take them. RN-A further stated he will refuse to take his medications without them placed in his juice which she had been doing for a long time. During interview 7/20/16 at 11:02 a.m. the director of nursing (DON) stated she was not aware that staff were placing R24's medications in his juice. They should be assessing (R24) so he could self administer his medications if they were going to place it in his juice and leave at his bedside. The DON further stated that his tamsulosin HCL capsule should not have been opened and placed in his juice. They would call the physician to see if there is another option of that medication so they could place in his juice, so he could self-administer his medications.	F 176	To prevent further incident of the deficient practice from happening to other residents, staff have been reeducated on the policy and procedure of safely administering medications and performing a comprehensive assessment to safely self administer medications. To monitor its performance and to make sure solutions are sustained, random bi-monthly audits will be completed on performing comprehensive assessments on residents to safely self administer medications and performing comprehensive assessments, by the ED/designee until February 1st, 2017. Audits will be reviewed in QAPI quarterly and as needed.	

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F 176	Continued From page 2 During interview 7/20/16, at 1:00 p.m. the facility pharmacy consultant stated he was not aware the staff were placing (R24's) medications in his juice. The tamsulosin HCL capsule should not be opened since it had a delayed release and the medication would not work correctly if the capsule was opened. The pharmacy consultant further stated there were other options for this medicaiton, so they could placed it in (R24's) juice. Review of the facility policy Self -Administration of Medications revised August 2014, indicated "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary, team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process."	F 176		
F 225 SS=E	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	F 225		8/30/16

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F 225	Continued From page 3 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). 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 facilty failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the state agency, thoroughly investigated, and residents were protected during the investigation for 4 of 6 residents (R20, R67, R3, and R46) allegations reviewed. Findings include: R20's quarterly MDS, dated 7/5/16, indicated R20 was cognitively intact, needed extensive assistance with activities of daily living, and had verbal behaviors directed toward others. R20's admission record, dated 12/22/15, indicated R20 had borderline intellectual functioning and	F 225	GLC-Olivia realizes the importance of immediate reporting of allegations of abuse, neglect, and injuries of unknown origin to the state agency. Also, to provide protection for residents while a comprehensive investigation is completed. The policy and procedure for immediate reporting of abuse and neglect allegations, and injuries of unknown origin, along with the policy and procedure of providing protection for residents during the investigation and completion of a comprehensive assessment has been reviewed for residents #20, 67, 3, and 46.	

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F 225	Continued From page 4 delusional disorders. During an interview on 7/18/16, at 6:38 p.m., R20 stated nursing assistant (NA)-F did not always treat him with respect and had treated him roughly in the past. NA-F used to throw the wheelchair toward me, she was rough and I was afraid of her but not anymore, "she got much better." A Minnesota Adult Abuse Reporting Center (MAARC) VA-CEP (Vulnerable Adult-Common Entry Point) Report, dated 6/4/16, indicated when R20 was hospitalized, he reported to hospital staff he had been handled roughly with most interactions by NA-F at the facility. R20 also reported if he doesn't answer the staff member's questions right, NA-F quits talking to him and ignores what he has to say, and, if he doesn't move fast enough, she "throws" him into his wheelchair. The facility's Verification of Investigation, dated 6/13/16, indicated the report from MAARC was received on 6/9/16. The investigative report indicated NA-F, a different nursing assistant, a trained medical assistant, a licensed practical nurse, and the business office manager, were the only persons interviewed. The investigative report indicated, "Through the interviews [sic] conducted there were no facts to support abuse as alleged. Social Services will continue to follow up with resident regarding any issues or concerns." There was no indication the facility had spoken to other residents, or other staff members to ensure an adequate investigation was completed. During an interview on 7/21/16, at 10:54 a.m., DON stated the report from MAARC was	F 225	All residents have the potential to be affected by the deficit practice. To prevent further incident to other residents, reeducation provided to staff on timely reporting of abuse, neglect allegations, and injuries of unknown origin to the state agency; and providing protection to residents during the investigation process and completion of a comprehensive assessment. To monitor its performance and to make sure solutions are sustained, random weekly audits on immediate reporting of abuse, neglect allegations, and injuries of unknown origin to the state agency, providing protection to the residents during the investigation and completion of a comprehensive assessment will be performed by the ED/designee until February 1st, 2017 with audit results reviewed in QAPI quarterly and as needed.	

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F 225	Continued From page 5	F 225		

delivered by a sheriff's deputy on 6/9/16, around 3:00 p.m. NA-F was working during this time, and kept NA-F in the facility until the end of her shift at 4:30 p.m. DON stated she interviewed NA-F and because she had completed her cares for R20 for the day, they allowed her to complete the shift. She asked NA-F to limit her interactions with R20 for a while, and to have others with her when she provided cares to him. DON stated she interviewed some staff but did not interview other residents, "because we based that on the fact that when I interviewed other staff, they had no observations of problems," with NA-F. She added, "Other residents in that general area are not interviewable and could not give me that information."

Although the facility was aware R20 had reported allegations of rough treatment by NA-F. The facility had not protected other residents during the investigation, nor did they interview other residents to determine if there were additional concerns to ensure a comprehensive investigation was completed for this allegation.

R67's significant change Minimum Data Set (MDS) dated 1/20/16, indicated he was moderate cognitive impaired, needed extensive assistance of one to two with activities of daily living and had verbal behaviors directed towards others. The MDS further indicated he did not have any wandering behaviors. R67's undated Diagnosis Sheet indicated he had dementia with behavioral disturbance and iron deficiency anemia.

A facility report titled, Minnesota Incident Report, dated 8/30/15 indicated staff noticed a "2 x 2 cm (centimeter) purple bruise (L) upper arm, 2 x 3.5 cm bruise (R) upper arm, 3.5 x 3.5 cm bruise

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F 225	Continued From page 6	F 225		

purple (L) upper wrist, 1 cm x 1 cm purple bruise (L) shin." The report indicated the resident denied pain and harm. The causal factors were identified that (R67) was independently maneuvering self in wheelchair, had diagnosis of iron deficiency anemia and wore compression stockings.

During interview 7/20/16, at 1:16 p.m. the director of nursing (DON) stated (R67) had a diagnosis of dementia with behavioral disturbance and delusions. The DON stated he did wander in the halls and thought maybe he bumped into something, but was unsure. She was unable to find any other investigation of the bruises, reviewed R67's progress notes and there was no mention of him bumping into anything. DON stated the administrator was immediately notified but the incident was not sent to the state agency.

Although R67 was severely cognitively impaired, had multiple bruises of unknown origin that were not reported to the state agency. The facilty had not completed a thorough investigation to determine the causes of R67's bruising.

R3's quarterly MDS dated 4/26/16, indicated she was cognitively intact and needed extensive assist of two to transfer. A Incident Report submitted to the state agency on 3/16/16, indicated on 3/15/16, R3's care plan interventions were not followed. R3's needed two staff assistance with transferring which was not completed. The Facility Internal Investigation dated 3/16/16, indicated on 3/15/16, at approximately 7:00 p.m. nursing assistant (NA) (unknown) was assisting resident to bed. R3 was unable to support their weight and was lowered to

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F 225	Continued From page 7	F 225		

the floor. The report further indicated the (unknown) NA was aware of the assignment sheet intervention, but did not ask for help from their co-workers.

During interview 7/20/16, at 1:30 p.m. the DON stated the staff should have followed R3's care plan and since the staff did not follow the care plan they reported it to the state agency. The DON stated the administrator was notified immediately but the report was not sent to the state agency until the following day 3/16/16, and should have been completed that same day.

R46's quarterly MDS dated 6/8/16, indicated he was severely cognitively impaired and needed limited assist with activities of daily living. R33's annual MDS dated 4/5/16, indicated she was severely cognitively impaired, needed supervision with ambulation, had delusions and wandered.

A facility Incident Report dated 7/8/16, indicated R46 was on the memory care unit and was ambulating in the hallway when he was approached by another resident (R33). R33 was anxious, wandering in the hallway with her walker, and trying to exit the building. As R33 approached R46 she lifted her walker toward his face and R46 pushed the walker away with his hand and R33 fell, with no jury. The report identified the resident to resident incident occurred on 7/8/16 at 10:40 p.m.. The administrator (executive director) was immediately noticed of the incident, but the state agency was not contacted until 7/9/16, the next day.

During interview 7/20/16, at 1:30 p.m. with the executive director (ED) and DON stated the

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F 225	Continued From page 8 incident was not reported to the state agency because this was a reoccurrence. The incident occurred on a Friday and she came in and completed the report to the state agency the next morning. The DON stated either her or the ED complete all the reports to the state agency. They do not have the option of doing this from home so they have to come into the facility to complete the reports. The DON stated they will be looking at a different system so the reports are completed timely. A review of the facility's Policies And Procedures Regarding Investigation And Reporting Of Alleged Violations Of Federal Or State Laws Involving Maltreatment, Or Injuries Of Unknown Source In Accordance With Federal And Minnesota State Vulnerable Adult Act Requirements, dated March 2012, indicated it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property are reported immediately to the Executive Director of the facility. Reportable incidents shall be immediately reported to the Minnesota Department of Health. The facility will investigate each alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and as required by Federal law. The policy also identified other residents will be protected during the investigation, and the investigation shall include interviews of associates, visitors or resident who may have knowledge of the alleged incident.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		8/30/16

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F 226	Continued From page 9 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 facilty failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the state agency, were thoroughly investigated, and residents were protected during the investigation as identified in the facility abuse and neglect policy for 4 of 6 residents (R20, R67, R3, and R46) allegations reviewed. Findings include: A review of the facility's Policies And Procedures Regarding Investigation And Reporting Of Alleged Violations Of Federal Or State Laws Involving Maltreatment, Or Injuries Of Unknown Source In Accordance With Federal And Minnesota State Vulnerable Adult Act Requirements, dated March 2012, indicated it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property are reported immediately to the Executive Director of the facility. Reportable incidents shall be immediately reported to the Minnesota Department of Health. The facility will investigate each alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and as required by Federal law. The policy also identified other	F 226	GLC-Olivia realizes the importance of immediate reporting of allegations of abuse, neglect, and injuries of unknown origin to the state agency. Also, to provide protection for residents while a comprehensive investigation is completed. The policy and procedure for immediate reporting of abuse, neglect allegations, and injuries of unknown origin, along with the policy and procedure of providing protection for residents during the investigation and comprehensive assessment has been reviewed for residents #20, 67, 3, and 46. All residents have the potential to be affected by the deficit practice. To prevent further incident to other residents, reeducation was provided to staff on timely reporting of abuse, neglect allegations, and injuries of unknown origin to the state agency; and providing protection to residents during the investigation process and completion of a comprehensive assessment. To monitor its performance and to make sure solutions are sustained, random weekly audits on immediate reporting of	

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F 226	Continued From page 10 residents will be protected during the investigation, and the investigation shall include interviews of associates, visitors or resident who may have knowledge of the alleged incident. R20's quarterly MDS, dated 7/5/16, indicated R20 was cognitively intact, needed extensive assistance with activities of daily living, and had verbal behaviors directed toward others. R20's admission record, dated 12/22/15, indicated R20 had borderline intellectual functioning and delusional disorders. During an interview on 7/18/16, at 6:38 p.m., R20 stated nursing assistant (NA)-F did not always treat him with respect and had treated him roughly in the past. NA-F used to throw the wheelchair toward me, she was rough and I was afraid of her but not anymore, "she got much better." A Minnesota Adult Abuse Reporting Center (MAARC) VA-CEP (Vulnerable Adult-Common Entry Point) Report, dated 6/4/16, indicated when R20 was hospitalized, he reported to hospital staff he had been handled roughly with most interactions by NA-F at the facility. R20 also reported if he doesn't answer the staff member's questions right, NA-F quits talking to him and ignores what he has to say, and, if he doesn't move fast enough, she "throws" him into his wheelchair. The facility's Verification of Investigation, dated 6/13/16, indicated the report from MAARC was received on 6/9/16. The investigative report indicated NA-F, a different nursing assistant, a trained medical assistant, a licensed practical nurse, and the business office manager, were the	F 226	abuse, neglect allegations, and injuries of unknown origin to the state agency, and providing protection to residents during the investigation and completion of a comprehensive assessment will be performed by the ED/designee until February 1, 2017 with audit results reviewed in QAPI quarterly and as needed.	

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F 226	Continued From page 11	F 226		

only persons interviewed. The investigative report indicated, "Through the interviews [sic] conducted there were no facts to support abuse as alleged. Social Services will continue to follow up with resident regarding any issues or concerns." There was no indication the facility had spoken to other residents, or other staff members to ensure an adequate investigation was completed.

During an interview on 7/21/16, at 10:54 a.m., DON stated the report from MAARC was delivered by a sheriff's deputy on 6/9/16, around 3:00 p.m. NA-F was working during this time, and they kept NA-F in the facility working with residents until the end of her shift at 4:30 p.m. DON stated she interviewed NA-F and because she had completed her cares for R20, they allowed her to complete the shift. She asked NA-F to limit her interactions with R20 for a while, and to have others with her when she provided cares to him. DON stated she interviewed some staff but did not interview other residents, "because we based that on the fact that when I interviewed other staff, they had no observations of problems," with NA-F. She added, "Other residents in that general area are not interviewable and could not give me that information."

Although the facility was aware R20 had reported allegations of rough treatment by NA-F. The facility had not protected other residents during the investigation, nor did they interview other residents to determine if there were additional concerns to ensure a comprehensive investigation was completed as identified by the facilty policy.

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F 226	Continued From page 12	F 226		

R67's significant change Minimum Data Set (MDS) dated 1/20/16, indicated he was moderate cognitive impaired, needed extensive assistance of one to two with activities of daily living and had verbal behaviors directed towards others. The MDS further indicated he did not have any wandering behaviors. R67's undated Diagnosis Sheet indicated he had dementia with behavioral disturbance and iron deficiency anemia.

A facility report titled, Minnesota Incident Report, dated 8/30/15 indicated staff noticed a "2 x 2 cm (centimeter) purple bruise (L) upper arm, 2 x 3.5 cm bruise (R) upper arm, 3.5 x 3.5 cm bruise purple (L) upper wrist, 1 cm x 1 cm purple bruise (L) shin." The report indicated the resident denied pain and harm. The causal factors were identified that (R67) was independently maneuvering self in wheelchair, had diagnosis of iron deficiency anemia and wore compression stockings.

During interview 7/20/16, at 1:16 p.m. the director of nursing (DON) stated (R67) had a diagnosis of dementia with behavioral disturbance and delusions. The DON stated he did wander in the halls and thought maybe he bumped into something, but was unsure. She was unable to find any other investigation of the bruises, reviewed R67's progress notes and there was no mention of him bumping into anything. DON stated the administrator was immediately notified but the incident was not sent to the state agency, as identified by the facilty policy.

R3's quarterly MDS dated 4/26/16, indicated she was cognitively intact and needed extensive

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assist of two to transfer. A Incident Report submitted to the state agency on 3/16/16, indicated on 3/15/16, R3's care plan interventions were not followed. R3's needed two staff assistance with transferring which was not completed. The Facility Internal Investigation dated 3/16/16, indicated on 3/15/16, at approximately 7:00 p.m. nursing assistant (NA) (unknown) was assisting resident to bed. R3 was unable to support their weight and was lowered to the floor. The report further indicated the (unknown) NA was aware of the assignment sheet intervention, but did not ask for help from their co-workers.

During interview 7/20/16, at 1:30 p.m. the DON stated the staff should have followed R3's care plan and since the staff did not follow the care plan they reported it to the state agency. The DON stated the administrator was notified immediately but the report was not sent to the state agency until the following day 3/16/16, and should have been completed that same day, as identified by the facilty policy.

R46's quarterly MDS dated 6/8/16, indicated he was severely cognitively impaired and needed limited assist with activities of daily living. R33's annual MDS dated 4/5/16, indicated she was severely cognitively impaired, needed supervision with ambulation, had delusions and wandered.

A facility Incident Report dated 7/8/16, indicated R46 was on the memory care unit and was ambulating in the hallway when he was approached by another resident (R33). R33 was

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F 226	Continued From page 14 anxious, wandering in the hallway with her walker, and trying to exit the building. As R33 approached R46 she lifted her walker toward his face and R46 pushed the walker away with his hand and R33 fell, with no jury. The report identified the resident to resident incident occurred on 7/8/16 at 10:40 p.m.. The administrator (executive director) was immediately noticed of the incident, but the state agency was not contacted until 7/9/16, the next day. During interview 7/20/16, at 1:30 p.m. with the executive director (ED) and DON stated the incident was not reported to the state agency because this was a reoccurrence. The incident occurred on a Friday and she came in and completed the report to the state agency the next morning, even though the facility policy identifies this should be reported to the state agency immediately.	F 226		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		8/30/16

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F 334	Continued From page 15 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 16 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policy related to pneumococcal conjugate vaccine (PCV13) for 5 of 10 residents (R46,R51,R27,R19 and R52) whose vaccination histories were reviewed. Findings include: Center for Disease Control and Prevention identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R46's Clinical Immunizations report undated indicated the 85 year old resident had received the 23-valent pneumococcal vaccine (PPSV23) on 05/06/2011, but never offered the PCV13 according to the centers for disease control (CDC) guidelines.	F 334	GLC-Olivia realizes the importance of implementing a policy and procedure regarding pneumococcal vaccinations. The policy and procedures for pneumococcal immunizations has been reviewed, assessments have been completed, and immunizations administered according to policy for residents # 46, 51, 27, 19, and 52. To prevent further incident, the staff have been educated on the facility policy and procedure regarding pneumococcal vaccinations, residents have been assessed, and immunizations have been administered according to policy. To monitor performance and to make sure solutions are sustained, random bi-monthly audits will be completed on the administration of the pneumococcal vaccinations according to facility policy, by the ED/designee until February 1st, 2017 with audit results reviewed in QAPI quarterly and as needed.	

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R51's Clinical Immunizations report undated indicated the 77 year old had received the Pneumovax dose one on 5/20/15, but was never offered the PCV13.

R27's Diagnosis Report sheet dated 7/21/16, indicated she had chronic obstructive pulmonary disease. R27's Clinical Immunizations report undated indicated the 82 year old had received the PPSV23 on 11/07/11, but was never offered the PCV13.

R19's Clinical Immunizations report undated indicated the 87 year old had received the PPSV23 on 8/28/12, but never received the PCV13.

R52's Clinical Immunizations report undated indicated the Pneumovax dose one on 9/25/13, but was never offered the PCV13.

During interview 7/19/16, at 9:14 a.m. the facility director of nursing (DON) stated they currently are not offering the PCV13 and the facility is planning to offer the PCV13 to the residents during the flu season. The DON further indicated the company is having a phone conference tomorrow to discuss this.

Review of the facility policy Influenza/Pneumococcal Immunization Guideline dated 5/2/16, indicated "Living Centers will offer and encourage that each resident receive immunization against Influenza annually, as well as lifetime immunization against Pneumococcal disease. This immunization will be administered unless it is contraindicated, the resident has already been immunized or the resident and/or the responsible party refuses the immunization."

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that food preparation equipment was properly sanitized to prevent food born illness which had the potential to affect 49 of 49 residents in the facility who are provided food from the kitchen. Findings include: On 7/18/16, at 1:56 p.m. during the initial tour of the kitchen completed with dietary supervisor (DS)-A, a free standing food slicer was noted to have visible white debris under the blade guard and slicer housing. DS-A stated that only the DS and dietary manager (DM)-A were allowed to operate the food slicer. DS-A stated, it looks like that it was not taken apart when it was last used. It should not be used because it was a "bacterial cesspool." DS-A stated the food slicer was last used two weeks ago when ham was sliced for a meal. Review of the menu identiifed ham was served the evening of 7/7/16. During interview on 7/21/16	F 371	GLC-Olivia realizes the importance of maintaining a clean and sanitary food slicer. The policy and procedure for cleaning the food slicer has been reviewed. To prevent further incident, and staff have been reeducated on the proper cleaning and the importance of maintaining a clean food slicer. To monitor performance and to make sure solutions are sustained, random weekly audits will be performed by the ED/or designee, on food slicer cleanliness until February 1st, 2017 with audit results reviewed in QAPI quarterly and as needed.	8/30/16

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at 1:15 p.m., DS-A stated the ham sliced on the food slicer was served for all food consistencies, including regular texture, ground, and pureed foods.

The above infomraiton and observation was discussed with registered dietitian (RD)-A on 7/20/16 at 11:08 a.m., and stated the food slicer was cleaned after the meal on 7/7/16, however, the slicer was not dissembled because the assembly was tightened too firmly. The RD-A stated the assembly now had been dissembled and thoroughly cleansed. The food slicer was observed at this time, and was clean from visible debris.

On 7/20/16 at 11:32 a.m., DM-A stated that the process for cleaning the food slicer included : disassembly of food slicer, rinsing the blade off using the spray attachment in the dishwashing room, process through the dishwasher, and allow it to air dry. The main structure of the food slicer is to be washed with soap and water, wiped with a sanitizer, and allowed to air dry. DM-A stated when the food slicer was last used, DM-A was unable to remove the mount/blade so the food slicer was cleansed using soap and water, followed by the sanitizer, however, as the DM-A was unable to remove the top fastening device, the blade was not properly cleaned.

A review of the policy, Cleaning Food Slicer's, last reviewed 2/29/16, identifies under step three to remove blade cover, guards, and sharpening unit. At hat time, both sides of the blades are to be washed in a solution of hot water and detergent as indicated in step four. In step nine of the process, the policy identified that staff are to assure that slicer and work areas are free of food

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F 371	Continued From page 20 particles.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facilty failed to ensure resident rooms had dust, cob webs, build-up of debris around toilets/rooms edges, and had multiple scratches, scrapes, chips in room furnishing which affected 6 of 9 random resident rooms (C2, C4, C5, C10, C15, and N4) and North dining room reviewed during the environmental tour. In addition, the facility failed to ensure an odor free environment for 1 of 1 resident (R19) room with a persistent, strong urine odor. Findings include: On 7/21/16, at 8:35 a.m., during a tour of the facility with the maintenance manager (MM)-A and the housekeeping supervisor (HS)-A. The following concerns were observed: Room C2, the inside of the bathroom door had a large area with gouges and scratches on the lower 1/4 of the door, exposing a rough uncleanable surface. In addition, dirt and debris was noted behind the toilet and in the corners of the bathroom floor.	F 465	GLC-Olivia realizes the importance of providing a safe, functional, and sanitary environment for residents, staff, and the public. The policy and procedure of the 5-step daily patient room cleaning has been reviewed and completed for rooms C2, C4, C5, C10, C15, N4, north dining room, north hallway, and for odors in resident #19's room (S 11-1). The handrails in room C4 and C15 have been removed. The door gouges in C2 have been assessed and repaired, and the elevated toilet seat in N4 has been replaced. To prevent further incident, staff have been reeducated on the 5-step patient room cleaning process, appropriately addressing odors, monitoring and repairing of gouges in doors, and missing baseboards as needed, as well as replacement of toilet seats. To monitor performances and to make sure solutions are sustained, random	8/30/16

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F 465	Continued From page 21 -In room C4, a handrail approximately three feet in length, located on the left wall upon entering the room, was scratched and scraped along the length of the handrail, exposing a rough uncleanable surface. In addition, the floor in the bathroom had dirt and debris in the corners and around the toilet. -In room C5, dirt and debris was noted on the bathroom floor, especially in the corners, and on the floor around the door entering the room. The baseboard behind the door was scratched and soiled. Cobwebs were noted behind the door, along the floor and in the corners of the wall. -In room C10, the floor in the bathroom had dirt and debris, especially in the corners. A removable dark substance was noted around the toilet. -In room C15, a metal handrail was noted on the wall in front of the toilet, approximately two feet in length. The handrail was painted black but had many scrapes and scratches with chips of paint missing along the entire surface, exposing a rough uncleanable surface. -In room N4, the portable elevated toilet seat, situated over the toilet, had plastic armrests. The armrest on the right side had a 3-4 inch area that was scraped and the plastic was peeling, exposing a rough uncleanable surface. -In the North dining room, dirt and debris was noted on the floor in the hallway outside of the dining room and in the corners around the entrance into the dining room. Cobwebs were noted along the floor and in the corners of the wall entering the dining room.	F 465	bi-monthly audits will be performed by the ED/or designee until February 1st, 2017, on room cleanliness, odors, door gouges, and baseboards. Audit results will be reviewed in QAPI quarterly and as needed.	

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During an interview on 7/21/16, at 9:05 a.m., MM-A stated the bathroom door in C2 needed to be fixed or replaced, the handrail in room C4 needed to be repaired, the baseboard behind the door in room C5 was missed. The metal handrail in room C15 needed to be removed, and the elevated toilet seat in room N4 should be replaced.

Review of the housekeeping cleaning schedules for the North and South wings included, "All floors need to be swept and mopped in every room every Monday." During the first week of each month, the cleaning schedule included cleaning each resident's room by pulling out the furniture, dusting and scrubbing the floors and mop boards, wiping off the heat vents, cleaning the floor and door edges and wiping off the light tops with a wet cloth. During the fourth week of each month, the cleaning schedule included cleaning each resident's room by scrubbing the bathroom and doorframe floor edges.

During an interview on 7/21/16, at 9:20 a.m., HS-A stated staff should be cleaning along the baseboards and corners of the rooms, and had recently purchased special brooms so housekeeping staff could adequately clean these areas. The housekeeping staff are given an assignment sheet each day and they were to check off the assigned duties as they completed them. HS-A stated she collected the assignment sheets at the end of the day and reviewed them to ensure assigned duties were completed. HS-A indicated she felt the cleaning schedule was adequate to ensure a clean, sanitary environment, but stated, "we have a lot of new housekeeping staff."

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Review of the facility's Housekeeping In-Service, 5-Step Daily Patient Room Cleaning, dated 1/1/2000, directed staff to dust mop the entire floor, especially behind dressers and beds, and all corners and along all baseboards to prevent buildup. Maintenance and housekeeping policies were requested, but was not provided.

ODOR
During observation on 7/18/16, at 3:13 p.m., a strong, lingering urine odor was observed when entering R19's room.

During observation of personal cares on 7/2016 at 1:20 p.m., R19's room was again noted to have an strong urine odor. The odor of urine was more pronounced near the reclining chair in the room, where a cloth protective pad was in the seat of the chair. Nursing assistant (NA)-A stated the protective pad is changed when it was visibly soiled or damp. NA-A stated the protective pad in the chair was dry. NA-A stated, the chair "does have an odor." NA-A additionally commented that housekeeping supervisor, (HS)-A had shampooed the chair on 7/19/16 because of the urine odor.
.
During interview on 7/20/16, at 2:57 p.m., HS-A stated housekeeping staff checks chairs daily. If the chairs are soiled, they are cleaned by housekeeping and are sprayed daily with Air-X, a spray disinfectant.

During interview on 7/21/16 at 12:17 p.m., housekeeping assistant (HA)-E stated routine room cleaning included, "wiping the mattress, bed rails, and the floor." The chairs in the resident

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rooms were dusted. If they have a stain, we will steam clean them and they wipe down the chair with a damp cloth every other day.

During observation on 7/21/16, at 12:25 p.m. a strong urine odor was noted in the room, and the floor was slightly tacky when walking across the room. There were no visible stain or discoloration on the floor.

During interview on 7/21/16 at 12:35 p.m. with Alzheimer's care director (ACD) entered R19's room, and also identified a urine odor presence. ACD stated they provide R19 with assistance for personal cares, and the chair pads should be changed daily, which should be on the care sheets for the nursing assistants. ACD stated that at times R19 toilets herself independently and experiences dribbling of urine, causing a presence of odor and tackiness to the floor. ACD stated R19's room need to have additional cleaning.

The facility policy, entitled Healthcare Services Group, Inc. Housekeeping In-Service, with reference date on the bottom of the document 1/1/2000, identified under the 5-Step Patient Room Cleaning Procedure, number 2, Horizontal Surfaces-disinfected, that "table tops, headboards, window sills, chairs-should all be done."

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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 FORM-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, on July 20, 2016. At the time of this survey, Golden LivingCenter Olivia was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - OLIVIA	**1003 WEST MAPLE** **OLIVIA, MN 56277**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Golden LivingCenter Olivia was constructed as follows: The original building was constructed in 1955, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1st addition was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2nd addition was constructed in 1967, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 3rd addition was constructed in 1976, is one-story height, has a partial 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	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)	K 017	A smoke detector has been installed in the north wing family seating area. According to NFPA 101 sections 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5	8/30/16

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K 017	Continued From page 3 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, it was observed: 1) Family sitting area on the North wing did not have smoke detection.	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is	K 018	The corridors to linen storage have been replaced with doors that fit tightly in the framed and are positively latched. Doors in rooms C9, C13, S7, and S9 have been adjusted to fit properly. To meet the expectations of Life safety code NFPA 101. Section 19.3.6.3.6.	8/30/16

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K 018	Continued From page 4 no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, it was observed: 1) The corridor doors to all of the Linen Storage did not fit tightly into the frame and would not positively latch into the frame. 2) Rooms C9, C13, 57 and 59 did not fit tightly into the frame and would not positively latch into the frame.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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: One hour fire rated construction (with one hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029	The central supply door had a closure added. The water heater room has been vented to the outside and a self closing	8/30/16

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K 029	Continued From page 5 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 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/20/2016, observations revealed the following deficient conditions were identified: 1) The door to the Central Supply Room did not have a door closure. 2) The door to the water heater did not have a door on it.	K 029	door has been added. According to NFPA 101. Life safety code standards section 19.3.2.1.	
K 038 SS=D	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: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations and staff interview revealed the exterior walking surface at the exit of the South Wing exceeded the allowable height difference. Does not meet the requirements for residents to get to the public way.	K 038	The area between the south wing exit and the alley has had two feet of concrete added to level the area. According to NFPA 101 sections 7.1 and 19.2.1.	8/30/16
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		8/30/16

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K 046 SS=C	Continued From page 6 Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations revealed there is no emergency lighting at the exit from the kitchen.	K 046	Emergency lighting/exit sign has been added to the exit outside of the kitchen and meets the 1 1/2 hour duration according to NFPA Life safety code 101 sections 7.9.18.2.9.1, 19.2.9.1.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations revealed there was no exit sign out of the kitchen.	K 047	Emergency lighting/exit sign has been added to the exit outside of the kitchen and meets the 1 1/2 hour duration according to NFPA Life safety code 101 section 18.2.10.1 and 19.2.10.1.	8/30/16
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code	K 051		8/30/16

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K 051	Continued From page 7 and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in	K 051	The vendor has been contacted and an additional panel will be installed at the south nurses station. A smoke detector has been installed in the north wing family seating area. According to NFPA 70 and 72 section 18.3.4, 19.3.4, 9.6.	

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K 051	Continued From page 8 the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations and interview revealed: 1) Fire Alarm Panel was not located in a monitored location.	K 051		
K 062 SS=C	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 This STANDARD is not met as evidenced by: 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 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, a review of documentation and interview revealed: 1) Missing ceiling tiles in the North Exit and tub room 14.	K 062	The missing ceiling tiles in the north wing exit and tub room # 14 have been replaced. According to NFPA 101 section 13, 25, 9.7.5.	8/30/16
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		8/30/16

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K 072	Continued From page 9 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, Observations revealed both inside and out of the North Exit had combustible storage in the exit passage way.	K 072	The combustible items in the north exit area have been removed. According to NFPA 101 section 7.1.10, 18.2.1, 19.2.1.	

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Golden LivingCenter Olivia was constructed as follows: The original building was constructed in 1955, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1st addition was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2nd addition was constructed in 1967, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 3rd addition was constructed in 1976, is one-story height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door	K 018		

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	245290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

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K 018	Continued From page 3 and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, it was observed: 1) The corridor doors to all of the Linen Storage did not fit tightly into the frame and would not positively latch into the frame. 2) Rooms C9, C13, 57 and 59 did not fit tightly into the frame and would not positively latch into the frame.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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	K 029		

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K 029	Continued From page 4 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with one 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 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/20/2016, observations revealed the following deficient conditions were identified: 1) The door to the Central Supply Room did not have a door closure. 2) The door to the water heater did not have a door on it.	K 029		
K 038 SS=D	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: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on	K 038		

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K 038	Continued From page 5 07/20/2016, observations and staff interview revealed the exterior walking surface at the exit of the South Wing exceeded the allowable height difference. Does not meet the requirements for residents to get to the public way.	K 038		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations revealed there is no emergency lighting at the exit from the kitchen.	K 046		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on	K 047		

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K 047	Continued From page 6 07/20/2016, observations revealed there was no exit sign out of the kitchen.	K 047		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system.	K 051		

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K 051	Continued From page 7 Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, observations and interview revealed: 1) Fire Alarm Panel was not located in a monitored location. 2) Family sitting area on the North wing did not have smoke detection.	K 051		
K 062 SS=C	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 This STANDARD is not met as evidenced by: 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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K 062	Continued From page 8 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, a review of documentation and interview revealed: 1) Missing ceiling tiles in the North Exit and tub room 14.	K 062		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Findings include: On facility tour between 08:30 AM to 12:30 PM on 07/20/2016, Observations revealed both inside and out of the North Exit had combustible storage in the exit passage way.	K 072		