CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: IYWB

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

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	Fa	acility ID: 00939
MEDICARE/MEDICAID PROVIDE (L1)		3. NAME AND ADD (L3) GOLDEN LI (L4) 1003 WEST I (L5) OLIVIA, MN	VINGCENTER - MAPLE		(L6)	56277	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SUE	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Cor	9. Other nplaint
6. DATE OF SURVEY 0 9 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SI 57 (L37) (L38) 16. STATE SURVEY AGENCY REM	57 (L18) 57 (L17) WN NF 19 SNF (L39)	B. Not in Com Requirements a ICF (L42)	nce With quirements Based On: Acceptable POC pliance with Program and/or Applied Waiv IID (L43)	n	2. Tech 3. 24 H 4. 7-Da	nical Personnel four RN ty RN (Rural SNF) Safety Code A* MEETS	Following Requirements: 6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12) (L15)	or
17. SURVEYOR SIGNATURE Brenda Fischer,	Unit Supervise	Date :	09/12/2016	(L19)	Kate Joh	-	ogram Specialist	Date: 09/16/2016 (L20)
DETERMINATION OF ELIGIBII 1. Facility is Eligible to 2. Facility is not Eligible.	JTY Participate	20. COM	IPLIANCE WITH C		21. 1. S 2. C	Statement of Financi	ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 09/01/1985 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	_00	INVOLUNTA 05-Fail to Me	et Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involut 04-Other Reason f		OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	(L28)	0. INTERMEDIARY/C		(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION (08/24/2016	OF APPROVAL DAT	ΓΕ (L33)	Posted 09	9/23/2016 Co.	VAI	



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.

Golden Livingcenter - Olivia September 16, 2016 Page 2

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



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.

Golden Livingcenter - Olivia September 13, 2016 Page 2

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

DOST CEDTIFICATION DEVISIT DEDODT

	PU31-	CERTIFICA	ION REVISIT RE	PURI			
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONST	TRUCTION			DATE OF REVISIT		
	A. Building B. Wing			Y2	9/12/2016 _{Y3}		
NAME OF FACILITY			STREET ADDRESS, CIT	Y, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - OLIVIA	A		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	DATE	ITEM	DATE	ITEM	DATE		

ITEN	И	DATE		ITEM			DATE	ITEM			DATE
Y4		Y5		Y4			Y5	Y4			Y5
ID Prefix	F0176	Correcti	on ID F	Prefix	F0225		Correction	ID Prefix	F0226		Correction
Reg.#	483.10(n)	Complet	ted Reg		483.13(d - (4)	c)(1)(ii)-(iii), (c)(2)	Completed	Reg.#	483.13(c)		Completed
LSC		08/30/20	16 LSC	C _			08/22/2016	LSC			08/22/2016
ID Prefix	F0334	Correcti	on ID F	Prefix	F0371		Correction	ID Prefix	F0465		Correction
Reg.#	483.25(n)	Complet	ted Reg	g.#	483.35(i)	Completed	Reg.#	483.70(h)		Completed
LSC		08/22/20	16 LSC	С _			08/22/2016	LSC			08/22/2016
ID Prefix		Correcti	on ID F	Prefix			Correction	ID Prefix			Correction
Reg.#		Complet	ted Reg	g. #			Completed	Reg. #			Completed
LSC			LSC	0 -			-	LSC			
ID Prefix		Correcti	on ID F	Prefix			Correction	ID Prefix			Correction
Reg.#		Complet	ted Reg	g. #			Completed	Reg. #			Completed
LSC			LSC	0 -			-	LSC			
ID Prefix		Correcti	on ID F	Prefix			Correction	ID Prefix			Correction
Reg.#		Complet	ted Reg	g. #			Completed	Reg. #			Completed
LSC			LSC	C _			-	LSC			
REVIEWED		REVIEWED BY (INITIALS) BF/	KJ 09	TE 9/16/2	016	SIGNATURE OF SI		0562		DATE 09/12	2/2016
REVIEWED CMS RO	D BY	REVIEWED BY (INITIALS)	DAT	TE		TITLE				DATE	
FOLLOWU 7/21/2016	JP TO SURVEY CO	OMPLETED ON		_		ANY UNCORRECTE ED DEFICIENCIES				YES	. □ NO
Form CMS	s - 2567B (09/92)	EF (11/06)				Page 1 of 1			EVENT ID:	IYWB12	

POST-CERTIFICATION REVISIT REPORT

	1 001 021(111110/11101	11121101111121		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245290 _{Y1}	B. Wing	Y2	8/31/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - OLIV	A	1003 WEST MAPLE		
		OLIVIA, MN 56277		
	,	and/or Clinical Laboratory Improvement Amendments	haan	

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).

ITE:		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	01	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	NFPA 1	01	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. #	01	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			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	DATE 09/16/2016	SIGNATURE OF SU		4764		DATE 08/3	1/2016
REVIEWE CMS RO	D BY	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	в 🔲 по	

Form CMS - 2567B (09/92) EF (11/06)

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: IYWB

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	F	Facility ID: 00939
MEDICARE/MEDICAID PROVIDER (L1) 245290 2.STATE VENDOR OR MEDICAID NO. (L2) 228497900	NO.	3. NAME AND AD (L3) GOLDEN LI (L4) 1003 WEST I (L5) OLIVIA, MN	IVINGCENTER - MAPLE		П	.6) 56277	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SUI		Y 09 ESRD	` `	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	E	FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	57 (L18) 57 (L17)	X B. Not in Com	nce With	n	2. T 3. 2 4. 7	proved Waivers Of The fechnical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9 9. Beds/Room (L12)	tor
14. LTC CERTIFIED BED BREAKDOW	1	1			15. FACILIT			
18 SNF 18/19 SNF 57	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE S	URVEY AGENCY AP	PROVAL	Date:
Michelle Thomps	son, HFE NE	II	08/16/2016	(L19)	Kate Jo	ohnsTon, Pro	ogram Specialis	08/22/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILIT			MPLIANCE WITH C	CIVIL	:		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	ı-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMIN	NATION ACTION:	(L30)
OF PARTICIPATION 09/01/1985	BEGINNING		ENDING DAT		VOLUNTARY 01-Merger, Cl		INVOLUNT	
(L24)	(L41)		(L25)			ction W/ Reimbursemen	nt 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV		(L44)			coluntary Termination	OTHER 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(2)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARK	KS		
		00040						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ГЕ	Post	red 08/24/2016 Co		
	(L32)			(L33)	DETERMI	NATION APPRO	VAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391

RAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 1003 WEST MAPLE DLVIA, MN SE2T7 DLVIA, MN SE2T	1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION) DATE SURVEY COMPLETED
MANE OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA PAJD PRETIX REGULATORY STATEMENT OF DEPICIENCIES (IRACH DEPICENCIES) (IRACH DEPICENCIE				7 55.25			С
GOLDEN LIVINGCENTER - OLIVIA 1003 WEST MAPLE OLIVIA, MN 56277			245290	B. WING _			07/21/2016
GOLDEN LIVINGCENTER - OLIVIA (A4) ID PRETEX TAGE SUMMARY STATEMENT OF DEFICIENCES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 survey was conducted and complaint H5290006, H5290007 investigation was also completed at the time of the standard survey. The complaints were unsubstantiated. F 176 SS=D 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: OLIVIA, MN 56277 PRETIX (ACH CORRECTIVE ACTION SHOULD BE CACH COR	NAME OF PI	ROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OF LSC IDENTIFYING INFOMALITOR) PREFIX TAG	GOLDEN	LIVINGCENTER - OLIVIA	1				
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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 recertification survey was conducted and complaint H5290006, H5290007 investigation was also completed at the time of the standard survey. The complaints were unsubstantiated. F 176 SS=D 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 for 1 of 1 residents (R24) observed to have medications for 1 of 1 residents (R24) observed to have medications for 1 of 1 resident periodical performing a comprehensive assessment to safely		I					
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 176 483.10(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: The policy and procedure of safely administering medications and performing a comprehensive assessment to safely	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	COMPLETION
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 176 B3-D RUGS 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: 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	F 000	INITIAL COMMENTS		FO	000		
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. The policy and procedure of safely administering medications and performing a comprehensive assessment to safely	I	as your allegation of of Department's acceptate bottom of the first page be used as verification. Upon receipt of an acceptate of your facility of your facility of validate that substant regulations has been your verification. A receritification surved complaint H5290006, was also completed as survey. The complaint 483.10(n) RESIDENT DRUGS IF DEEMED. An individual resident the interdisciplinary to \$483.20(d)(2)(ii), has practice is safe. This REQUIREMENT by: Based on observation	compliance upon the ance. Your signature at the ge of the CMS-2567 form will in of compliance. compliance. compliance POC an on-site may be conducted to cial compliance with the attained in accordance with ey was conducted and H5290007 investigation at the time of the standard ints were unsubstantiated. T SELF-ADMINISTER SAFE It may self-administer drugs if eam, as defined by determined that this T is not met as evidenced In, interview and document	F 1	GLC - Olivia realizes the import		8/30/16
administering medications and performing Findings include: a comprehensive assessment to safely		assess the resident's medications for 1 of 1	ability to safely administer residents (R24) observed		ability to safely administer medic	cations.	
R24's quarterly Minimum Data Set (MDS) dated 4/25/16, indicated R24 had severe cognitive administer medications has been reviewed for all residents including resident #24.		Findings include:	num Data Set (MDS) dated		administering medications and page a comprehensive assessment to administer medications has bee reviewed for all residents including	performing safely n	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LAROPATORY	DIRECTOR'S OR REQUIRED.	SLIDDI IED DEDDESENTATIVE'S SIGNATURE		TITI E		(X6) DATE

Electronically Signed

08/11/2016

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		245290	B. WING _		07/2	; 21/2016
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	•	.1/2010
				1003 WEST MAPLE		
GOLDEN	LIVINGCENTER - OLIVIA	A		OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 176	R24's medication. Rimg (milligrams), vitar and tamsulosin HCL used to make it easie capsule and placed the cranberry juice. RN-bedside and left their administer their own R24 had completed higher. At the bottom owere several small camedication that was at time RN-A did not obe R24 to ensure he cordinated we place all of juice because that is them. RN-A further shis medications without which she had been of During interview 7/20 of nursing (DON) statistaff were placing R2 They should be assess administer his medication that in his juice. They would have a solution of the place it in his juice. They would have a solution in the place in the place.	/20/16, at 7:45 a.m.)-A was observed to set up N-A set up aspirin (ASA) 81 min D 1000 units and crush, (hydrochloride, medication er to urinate) she opened the he medication in R24's A placed the juice at R24's room, leaving R24 to medication. At 8:03 a.m. his breakfast and drank the off R24's empty juice glass apsules of tamsulosin HCL hot consumed. During this serve or followed up with his umed all his medication. /16, at 8:05 a.m. RN-A iff R24's medication in his the only way he will take that them placed in his juice doing for a long time. /16 at 11:02 a.m. the director ted she was not aware that A's medications in his juice. ssing (R24) so he could self ations if they were going to had leave at his bedside. The hat his tamsulosin HCL ave been opened and placed ald call the physician to see if on of that medication so they be, so he could	F1	To prevent further incident practice from happening is residents, staff have been the policy and procedure administering medications a comprehensive assessing self administer medication. To monitor its performance sure solutions are sustain bi-monthly audits will be comperforming comprehensive on residents to safely self medications and performing comprehensive assessments. ED/designee until Februar Audits will be reviewed in and as needed.	to other in reeducated on of safely s and performing ment to safely ins. the and to make fined, random completed on five assessments of administer fing ents, by the ary 1st, 2017.	

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TO 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 medication, 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,		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	C	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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) 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							С	
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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					1003 WEST MAPLE			
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physical, and visual ability to carry out this responsibility during the care planning process." F 225 SS=E #8.30(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	During interview 7/20 pharmacy consultant staff were placing (R2 juice. The tamsulosin opened since it had a medication would not was opened. The phastated there were oth medicaiton, so they conjuice. Review of the facility Medications revised A resident desires to se an assessment is confinterdisciplinary, team physical, and visual a responsibility during the 483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPC ALLEGATIONS/INDIVITY The facility must not been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misappend report any knowled court of law against a indicate unfitness for other facility staff to the or licensing authoritie. The facility must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty must ensurinvolving mistreatmer including injuries of uniterior to the staff to the court of guilty of a mistreatmer including injuries of uniterior to the staff to the court of guilty of a mistreatmer including injuries of uniterior to the staff to the court of guilty of a mistreatment of the staff to the court of guilty of a mistreatment of the court of guilty of a mistreatmen	2/16, at 1:00 p.m. the facility stated he was not aware the 2/4's) medications in his HCL capsule should not be delayed release and the work correctly if the capsule armacy consultant further er options for this ould placed it in (R24's) policy Self -Administration of August 2014, indicated "If the If-administer medications, inducted by the in of the resident's cognitive, bility to carry out this he care planning process." (2)(2) - (4) PRT /IDUALS employ individuals who have into the State nurse aide puse, neglect, mistreatment propriation of their property; and get it has of actions by a nemployee, which would service as a nurse aide or ne State nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide or ne State nurse aide or ne State nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide registry in the state nurse aide or ne State nurse aide registry in the state nurse aide reg				8	3/30/16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	l' '	3) DATE SURVEY COMPLETED	
		245290	B. WING_			C 07/21/2016	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277		3772 1720 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 225	to other officials in act through established postablished postables are survey and cert. The facility must have violations are thorough prevent further potential investigation is in proof to the administrator of the administrator of the results of all investigation and to with State law (includicertification agency) incident, and if the all	Iministrator of the facility and cordance with State law procedures (including to the ification agency). The evidence that all alleged the investigated, and must that abuse while the gress.	F2	225			
	by: Based on interview a facilty failed to ensure neglect and injuries o immediately reported thoroughly investigate protected during the i residents (R20, R67, reviewed. Findings include: R20's quarterly MDS, was cognitively intact assistance with activi verbal behaviors dire	ed, and residents were nvestigation for 4 of 6 R3, and R46) allegations dated 7/5/16, indicated R20 , needed extensive ties of daily living, and had cted toward others. R20's ted 12/22/15, indicated R20		GLC-Olivia realizes the in immediate reporting of alle abuse, neglect, and injurie origin to the state agency. protection for residents who comprehensive investigation completed. The policy and procedure reporting of abuse and neallegations, and injuries of origin, along with the policing of providing protection for the investigation and components where the comprehensive assessments are viewed for residents #20	egations of es of unknown Also, to provide nile a ion is for immediate glect f unknown ey and procedure residents during pletion of a ent has been		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
		245290	B. WING			C 07/21/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - OLIVIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277		7772172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	delusional disorders. During an interview o stated nursing assistatreat him with respect roughly in the past. N wheelchair toward me afraid of her but not a better." A Minnesota Adult Ab (MAARC) VA-CEP (VEntry Point) Report, or R20 was hospitalized he had been handled interactions by NA-Freported if he doesn't questions right, NA-Fignores what he has a move fast enough, shwheelchair. The facility's Verificate 6/13/16, indicated the received on 6/9/16. Tindicated NA-F, a differ trained medical assist nurse, and the busine only persons interview indicated, "Through the there were no facts to Social Services will coresident regarding an There was no indication other residents, or other and equate investigated."	n 7/18/16, at 6:38 p.m., R20 ant (NA)-F did not always and had treated him A-F used to throw the e, she was rough and I was nymore, "she got much use Reporting Center ulnerable Adult-Common lated 6/4/16, indicated when , he reported to hospital staff roughly with most at the facility. R20 also answer the staff member's quits talking to him and to say, and, if he doesn't the "throws" him into his at a time investigative report the erent nursing assistant, a tant, a licensed practical tess office manager, were the wed. The investigative report the interviews [sic] conducted to support abuse as alleged. The investigative had spoken to the restaff members to ensure	F 22	All residents have the potential affected by the deficit practice. further incident to other resider reeducation provided to staff or reporting of abuse, neglect aller and injuries of unknown origin agency; and providing protectic residents during the investigation and completion of a compreher assessment. To monitor its performance and sure solutions are sustained, reweekly audits on immediate relabuse, neglect allegations, and unknown origin to the state age providing protection to the residuring the investigation and coal comprehensive assessment performed by the ED/designee February 1st, 2017 with audit reviewed in QAPI quarterly and needed.	To prevent onts, on timely egations, to the state on to on process on noisive of the dinjuries of ency, dents ompletion of will be a until esults	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245290	B. WING		C 07/21/2016
	ROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	1 01/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 225	delivered by a sheriff 3:00 p.m. NA-F was and kept NA-F in the shift at 4:30 p.m. DO NA-F and because stor R20 for the day, the shift. She asked I with R20 for a while, when she provided conterviewed some staresidents, "because that when I interviewed observations of probloadded, "Other resident information." Although the facility wallegations of rough the facility had not proted the investigation, nor residents to determine concerns to ensure a investigation was cornected in the concerns to ensure a investigation was cornected	's deputy on 6/9/16, around working during this time, facility until the end of her N stated she interviewed he had completed her cares hey allowed her to complete NA-F to limit her interactions and to have others with her ares to him. DON stated she off but did not interview other we based that on the fact end other staff, they had no ems," with NA-F. She ents in that general area are did could not give me that was aware R20 had reported treatment by NA-F. The extend other residents during did they interview other in if there were additional a comprehensive empleted for this allegation. Inge Minimum Data Set indicated he was moderate ended extensive assistance trivities of daily living and had concern the did not have any in R67's undated Diagnosis and dementia with behavioral	F 22	5	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X:	3) DATE SURVEY COMPLETED
		245290	B. WING			C 07/21/2016
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	1	07/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	purple (L) upper wrist (L) shin." The report denied pain and harm identified that (R67) was maneuvering self in viron deficiency anemistockings. During interview 7/20 of nursing (DON) stated dementia with behave delusions. The DON halls and thought masomething, but was usefind any other investigned any other investigned and the administration of him bump stated the administration of him bump stated the incident was an Although R67 was seen had multiple bruises and the same than the incident was seen and multiple bruises and the same than the incident was seen and multiple bruises and the same than the incident was seen and multiple bruises and the same than the sam	t, 1 cm x 1 cm purple bruise indicated the resident n. The causal factors were was independently wheelchair, had diagnosis of a and wore compression 1/16, at 1:16 p.m. the director ted (R67) had a diagnosis of foral disturbance and stated he did wander in the tybe he bumped into insure. She was unable to gation of the bruises, tess notes and there was no ing into anything. DON tor was immediately notified not sent to the state agency. Everely cognitively impaired, of unknown origin that were tate agency. The facilty had bugh investigation to	F 2	25		
	was cognitively intact assist of two to transf submitted to the state indicated on 3/15/16, interventions were no staff assistance with completed. The Facil dated 3/16/16, indica approximately 7:00 p (unknown) was assis	R3's care plan of followed. R3's needed two transferring which was not ity Internal Investigation				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE	SURVEY
		245290	B. WING			1	C 21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, 1003 WEST MAPLE OLIVIA, MN 5627		1 077	21/2010
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F 225	the floor. The report (unknown) NA was an sheet intervention, but their co-workers. During interview 7/20 stated the staff should plan and since the staplan they reported it to DON stated the admit immediately but the restate agency until the should have been con R46's quarterly MDS was severely cognitively limited assist with act annual MDS dated 4/severely cognitively in with ambulation, had	further indicated the ware of the assignment at did not ask for help from 1/16, at 1:30 p.m. the DON d have followed R3's care aff did not follow the care to the state agency. The nistrator was notified eport was not sent to the following day 3/16/16, and impleted that same day. dated 6/8/16, indicated he rely impaired and needed ivities of daily living. R33's 5/16, indicated she was impaired, needed supervision delusions and wandered.	F	225			
	anxious, wandering ir and trying to exit the R46 she lifted her wa pushed the walker aw fell, with no jury. The to resident incident or p.m The administrat immediately noticed of agency was not contaday. During interview 7/20	er resident (R33). R33 was in the hallway with her walker, building. As R33 approached lker toward his face and R46 way with his hand and R33 report identified the resident occurred on 7/8/16 at 10:40 or (executive director) was of the incident, but the state acted until 7/9/16, the next					

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245290	B. WING				21/2016
NAME OF PR	ROVIDER OR SUPPLIER		Ī		TREET ADDRESS, CITY, STATE, ZIP CODE	077	21/2016
					003 WEST MAPLE		
GOLDEN I	LIVINGCENTER - OLIVIA			c	DLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	because this was a re occurred on a Friday completed the report morning. The DON s complete all the report do not have the option they have to come intreports. The DON stadifferent system so the timely. A review of the facility Regarding Investigation Violations Of Federal Maltreatment, Or Injury Accordance With Fed Vulnerable Adult Act Fed 2012, indicated it is that take appropriate steps of abuse, neglect, mis injuries of unknown so fresident property a the Executive Director incidents shall be immediated to minimesota Department investigate each allegate report the results of a Minnesota Department by Federal law. The presidents will be protested.	rted to the state agency eoccurrence. The incident and she came in and to the state agency the next tated either her or the ED ts to the state agency. They not doing this from home so to the facility to complete the ated they will be looking at a decreports are completed. The Policies And Procedures on And Reporting Of Alleged Or State Laws Involving ries Of Unknown Source In deral And Minnesota State. Requirements, dated March the policy of the facility to so to prevent the occurrence estreatment, maltreatment, cource and misappropriation are reported immediately to a rof the facility. Reportable the mediately reported to the mediately reported to the mediately reported to the mediately response to the of Health. The facility will ded violation thoroughly and all investigations to the mediately also identified other.	Fź	2225			
F 226 SS=E	may have knowledge 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		F2	226			8/30/16
	The identity must dove						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	I ' '	DATE SURVEY COMPLETED
		245290	B. WING _			C 07/21/2016
	ROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	'	07/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	and misappropriation		F 2	26		
	facilty failed to ensur neglect and injuries immediately reported thoroughly investigat protected during the the facility abuse and	and document review the re allegations of abuse, of unknown origin were to the state agency, were ted, and residents were investigation as identified in the diagram in the legical policy for 4 of 6 regions.		GLC-Olivia realizes the import immediate reporting of allegation abuse, neglect, and injuries of origin to the state agency. Also protection for residents while a comprehensive investigation is completed.	ons of unknown o, to provide	
	Regarding Investigativiolations Of Federal Maltreatment, Or Injugaccordance With Fe Vulnerable Adult Act 2012, indicated it is take appropriate step of abuse, neglect, minjuries of unknowns of resident property at the Executive Direction incidents shall be immunesota Department investigate each aller report the results of a Minnesota Department.	y's Policies And Procedures ion And Reporting Of Alleged I Or State Laws Involving uries Of Unknown Source In deral And Minnesota State Requirements, dated March the policy of the facility to be to prevent the occurrence istreatment, maltreatment, source and misappropriation are reported immediately to be or of the facility. Reportable mediately reported to the ent of Health. The facility will ged violation thoroughly and all investigations to the ent of Health and as required policy also identified other		The policy and procedure for in reporting of abuse, neglect alle and injuries of unknown origin, the policy and procedure of proprotection for residents during investigation and comprehensi assessment has been revieweresidents #20, 67, 3, and 46. All residents have the potential affected by the deficit practice further incident to other resider reeducation was provided to stimely reporting of abuse, negliallegations, and injuries of unk to the state agency; and provice protection to residents during to investigation process and common comprehensive assessment. To monitor its performance and sure solutions are sustained, raweekly audits on immediate residents.	egations, along with oviding the ve d for l to be To prevent hts, aff on ect nown origin ling he pletion of a d to make andom	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	l` /	E SURVEY PLETED
		245290	B. WING			1	C / 21/2016
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE DLIVIA, MN 56277	1 07	72172010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE			
F 226	residents will be proteinvestigation, and the interviews of associat may have knowledge R20's quarterly MDS, was cognitively intact assistance with activitiverbal behaviors direct admission record, dath had borderline intelled delusional disorders. During an interview of stated nursing assistate thim with respect roughly in the past. Nowheelchair toward meafraid of her but not a better." A Minnesota Adult Ab (MAARC) VA-CEP (Ventry Point) Report, of R20 was hospitalized he had been handled interactions by NA-Fireported if he doesn't questions right, NA-Fignores what he has to move fast enough, showheelchair. The facility's Verification of 6/9/16. The secretal may be associated assoc	ected during the investigation shall include es, visitors or resident who of the alleged incident. dated 7/5/16, indicated R20, needed extensive ties of daily living, and had cted toward others. R20's ted 12/22/15, indicated R20 ctual functioning and n 7/18/16, at 6:38 p.m., R20 ant (NA)-F did not always and had treated him A-F used to throw the et, she was rough and I was nymore, "she got much use Reporting Center ulnerable Adult-Common lated 6/4/16, indicated when the reported to hospital staff roughly with most eat the facility. R20 also answer the staff member's quits talking to him and to say, and, if he doesn't e "throws" him into his	F	2226	abuse, neglect allegations, and injuries unknown origin to the state agency, an 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.	d	
	move fast enough, she wheelchair. The facility's Verification 6/13/16, indicated the received on 6/9/16. Tindicated NA-F, a different medical assistance of the control of	e "throws" him into his on of Investigation, dated report from MAARC was					

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET		OATE SURVEY OMPLETED			
		245290	B. WING			C
	ROVIDER OR SUPPLIER LIVINGCENTER - OLIVIA		B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 1003 WEST MAPLE OLIVIA, MN 56277		07/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 226	only persons interview indicated, "Through the there were no facts to Social Services will corresident regarding and There was no indication other residents, or other an adequate investigation of the residents of the report delivered by a sheriff of 3:00 p.m. NA-F was and they kept NA-F in residents until the end DON stated she interviewed her to complet NA-F to limit her interview of the investigation of problems," with NA residents in that gene interviewable and could information." Although the facility wallegations of rough tresidents to determine concerns to ensure a	wed. The investigative report the interviews [sic] conducted asupport abuse as alleged. Sontinue to follow up with any issues or concerns." In the facility had spoken to the staff members to ensure ation was completed. In 7/21/16, at 10:54 a.m., at from MAARC was as deputy on 6/9/16, around working during this time, at the facility working with at of her shift at 4:30 p.m. wiewed NA-F and because for cares for R20, they are the shift. She asked actions with R20 for a while, the her when she provided attend she interviewed some item of the fact that when I for they had no observations at on the fact that when I for they had no observations are are not all not give me that the same are not all not give me that the same R20 had reported the deatment by NA-F. The tend other residents during did they interview other as if there were additional	F 2	226		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
		245290	B. WING			C 07/21/2016
	ROVIDER OR SUPPLIER	\ \		STREET ADDRESS, CITY, STATE, ZIP CO 1003 WEST MAPLE OLIVIA, MN 56277	ODE	0172172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	(MDS) dated 1/20/16 cognitive impaired, no fone to two with activerbal behaviors dired MDS further indicated wandering behaviors. Sheet indicated he hadisturbance and iron. A facility report titled, dated 8/30/15 indicated (centimeter) purple bear bruise (R) upper apurple (L) upper wrise (L) shin." The report denied pain and harm identified that (R67) maneuvering self in wiron deficiency anem stockings. During interview 7/20 of nursing (DON) stated dementia with behave delusions. The DON halls and thought massomething, but was usefind any other investive reviewed R67's programention of him bump stated the administrations.	nge Minimum Data Set , indicated he was moderate eeded extensive assistance tivities of daily living and had cted towards others. The d he did not have any . R67's undated Diagnosis lad dementia with behavioral deficiency anemia. Minnesota Incident Report, led staff noticed a "2 x 2 cm ruise (L) upper arm, 2 x 3.5 larm, 3.5 x 3.5 cm bruise lt, 1 cm x 1 cm purple bruise indicated the resident in. The causal factors were livas independently wheelchair, had diagnosis of lia and wore compression 1/16, at 1:16 p.m. the director led (R67) had a diagnosis of lia and wore and stated he did wander in the lybe he bumped into linsure. She was unable to gation of the bruises, less notes and there was no ling into anything. DON ltor was immediately notified linot sent to the state agency,	F	226		
		dated 4/26/16, indicated she tand needed extensive				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	I' '	OATE SURVEY COMPLETED
		245290	B. WING			C 07/21/2016
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	I	0772172016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	submitted to the state indicated on 3/15/16, interventions were no staff assistance with completed. The Facil dated 3/16/16, indica approximately 7:00 p (unknown) was assist unable to support the the floor. The report (unknown) NA was a sheet intervention, but their co-workers. During interview 7/20 stated the staff shoul plan and since the stiplan they reported it is DON stated the admit immediately but the ristate agency until the	fer. A Incident Report agency on 3/16/16, R3's care plan of followed. R3's needed two transferring which was not ity Internal Investigation ted on 3/15/16, at .m. nursing assistant (NA) ting resident to bed. R3 was ir weight and was lowered to further indicated the ware of the assignment of the did not ask for help from 1/16, at 1:30 p.m. the DON d have followed R3's care aff did not follow the care to the state agency. The nistrator was notified eport was not sent to the a following day 3/16/16, and impleted that same day, as	F 23	26		
	was severely cognitively imited assist with action annual MDS dated 40 severely cognitively in the severely cognitively in the severely cognitively in the severely cognitive	dated 6/8/16, indicated he vely impaired and needed tivities of daily living. R33's /5/16, indicated she was mpaired, needed supervision delusions and wandered.				
	R46 was on the mem ambulating in the hal	port dated 7/8/16, indicated nory care unit and was lway when he was er resident (R33). R33 was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY
		0.45000			1	С
NAME OF D	ROVIDER OR SUPPLIER	245290	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	21/2016
	LIVINGCENTER - OLIVIA			1003 WEST MAPLE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 226	anxious, wandering in and trying to exit the IR46 she lifted her wal pushed the walker aw fell, with no jury. The to resident incident or p.m The administrati immediately noticed or agency was not contaday. During interview 7/20 executive director (Elincident was not report because this was a reoccurred on a Friday completed the report morning, even though this should be reported immediately. 483.25(n) INFLUENZ IMMUNIZATIONS The facility must devet that ensure that (i) Before offering the each resident, or the representative received benefits and potential immunization; (ii) Each resident is of immunization October annually, unless the incontraindicated or the immunized during this (iii) The resident or the	the hallway with her walker, building. As R33 approached liker toward his face and R46 ray with his hand and R33 report identified the resident courred on 7/8/16 at 10:40 for (executive director) was of the incident, but the state acted until 7/9/16, the next little to the state agency execurrence. The incident and she came in and to the state agency the next little facility policy identifies and to the state agency little facility policy identifies and to the state agency little facility policy identifies and to the state agency little facility policy identifies and to the state agency little facility policy identifies and to the state agency little facility policy identifies and to the state agency little facility policy identifies and the state agency little facility policies and procedures little policies and procedures influenza immunization, resident's legal less education regarding the side effects of the little facility little facility little facility is resident has already been at time period;		334		8/30/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		245290	B. WING		C 07/21/2016
	ROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	1 01/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETION
F 334	documentation that in following: (A) That the resider representative was puthe benefits and pote immunization; and (B) That the resider influenza immunization influenza immunization contraindications or recontraindications or recontraindication, each relegal representative the benefits and pote immunization; (ii) Each resident is communization; (iii) Each resident is communication unless medically contraindical already been immunication; and (ivi) The resident or the representative has the immunization; and (ivi) The resident's medicumentation that infollowing: (A) That the resider representative was puthe benefits and pote pneumococcal immunication immuni	edical record includes indicates, at a minimum, the set or resident's legal rovided education regarding ential side effects of influenza and either received the control or did not receive the control or did not resident's receives education regarding ential side effects of the control or the resident has fixed; are resident's legal record includes indicated, at a minimum, the control or resident's legal rovided education regarding ential side effects of nization; and at either received the nization or did not receive inmunization due to medical	F 33	4	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		245290	B. WING _			C 07/21/2016
	ROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	'	517 <u>2</u> 17 <u>2</u> 015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	and practitioner recor pneumococcal immury years following the fir immunization, unless the resident or the re- refuses the second in	based on an assessment mmendation, a second nization may be given after 5 ret pneumococcal medically contraindicated or sident's legal representative nmunization.	F 3	34		
	by: Based on interview a facility failed to implei related to pneumococ (PCV13) for 5 of 10 m and R52) whose vacc reviewed. Findings include: Center for Disease C identified, "Adults 65 have not previously recei PPSV23 [pneumococ 23] should receive a PCV13 should be giv receipt of the most re R46's Clinical Immun indicated the 85 year the 23-valent pneumo on 05/06/2011, but ne	and document review, the ment their facility policy ccal conjugate vaccine esidents (R46,R51,R27,R19 cination histories were ontrol and Prevention years of age or older who eceived PCV13 and who ived one or more doses of ccal polysaccharide vaccine dose of PCV13. The dose of en at least 1 year after ecent PPSV23 dose." izations report undated old resident had received pcoccal vaccine (PPSV23) ever offered the PCV13 ers for disease control		GLC-Olivia realizes the importal implementing a policy and procedures for pregarding pneumococcal vaccin. The policy and procedures for pneumococcal immunizations have been completed, and immunizations administered according to policy residents # 46, 51, 27, 19, and 8. To prevent further incident, the seen educated on the facility por procedure regarding pneumocovaccinations, residents have been assessed, and immunizations hadministered according to policy. To monitor performance and to solutions are sustained, random bi-monthly audits will be compleadministration of the pneumocovaccinations according to facility the ED/designee until February	edure ations. as been een y for 52. staff have slicy and ccal en ave been y. make sure n sted on the ccal y policy, by	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	l` ′	ATE SURVEY OMPLETED
		245290	B. WING			C 07/21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	I	0772172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334	indicated the 77 year Pneumovax dose one offered the PCV13. R27's Diagnosis Regindicated she had ch disease. R27's Clinical undated indicated the the PPSV23 on 11/07 the PCV13. R19's Clinical Immunindicated the 87 year PPSV23 on 8/28/12, PCV13. R52's Clinical Immunindicated the Pneumout was never offered During interview 7/19 director of nursing (Dare not offering the Pplanning to offer the during the flu season the company is having tomorrow to discuss Review of the facility Influenza/Pneumocod dated 5/2/16, indicate and encourage that eximmunization against as lifetime immunization against as lifetime immunization aready been immunical diready been immunical already been immunication offer immunication aready been immunication aready been immunication of the facility incleases. This immunication aready been immunication aready been immunication of the facility incleases it is contrained already been immunication of the facility incleases. This immunication aready been immunication of the facility incleases it is contrained already been immunication of the facility incleases. This immunication aready been immunication of the facility incleases it is contrained already been immunication of the facility incleases.	dizations report undated old had received the e on 5/20/15, but was never cort sheet dated 7/21/16, ronic obstructive pulmonary al Immunizations report e 82 year old had received 7/11, but was never offered cold had received the but never received the but never received the cold had received the but never received the but never received the cold had received the cold had received the but never received the cold had	F 33	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245290	B. WING _			C 07/21/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 1003 WEST MAPLE OLIVIA, MN 56277	CODE	1 0112112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA	
F 371 SS=F	authorities; and (2) Store, prepare, dis under sanitary conditi	sources approved or ry by Federal, State or local stribute and serve food	F3	71		8/30/16
	by: Based on observation review, the facility fail preparation equipmer prevent food born illnot of affect 49 of 49 resign provided food from the Findings include: On 7/18/16, at 1:56 puthe kitchen completed (DS)-A, a free standing have visible white defined slicer housing. Do and dietary manager operate the food slice that it was not taken at the should not be used cesspool." DS-A statused two weeks ago meal. Review of the menu in	n, interview and document ed to ensure that food at was properly sanitized to ess which had the potential dents in the facility who are		GLC-Olivia realizes the immaintaining a clean and sa slicer. The policy and procedure food slicer has been review. To prevent further incident been reeducated on the prand the importance of mai food slicer. To monitor performance ar solutions are sustained, ra audits will be performed by designee, on food slicer cl February 1st, 2017 with au reviewed in QAPI quarterly needed.	for cleaning to wed. , and staff has roper cleaning a cleaning a cleaning to make so and to mak	the ave ag ean eure y

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION IG	l\ /	(X3) DATE SURVEY COMPLETED	
		245290	B. WING _			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	- 1	07/21/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371	food slicer was serve including regular text foods. The above infomraited discussed with regis 7/20/16 at 11:08 a.m was cleaned after the the slicer was not discussed with regis assembly was tighter stated the assembly and thoroughly clean observed at this time debris. On 7/20/16 at 11:32 process for cleaning disassembly of food using the spray attact room, process through it to air dry. The main is to be washed with a sanitizer, and allow when the food slicer unable to remove the slicer was cleansed using the spray attact of the policy was unable to remove the slicer was cleansed using the spray attact of the policy reviewed 2/29/16, idea remove blade cover, At hat time, both side washed in a solution as indicated in step for process, the policy in	ated the ham sliced on the d for all food consistencies, ure, ground, and pureed on and observation was tered dietitian (RD)-A on and stated the food slicer e meal on 7/7/16, however, sembled because the ned too firmly. The RD-A now had been dissembled sed. The food slicer was and was clean from visible a.m., DM-A stated that the the food slicer included: slicer, rinsing the blade off hment in the dishwashing of the dishwasher, and allow a structure of the food slicer soap and water, wiped with red to air dry. DM-A stated was last used, DM-A was a mount/blade so the food using soap and water, zer, however, as the DM-A e the top fastening device,	F 3	71			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245290	B. WING		C 07/21/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	1 07/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION	
F 371 F 465 SS=E	SAFE/FUNCTIONAL/ E ENVIRON The facility must prov sanitary, and comfort: residents, staff and the same and the same and the same and the same area with gouge lower 1/4 of the door, uncleanable surface.	ide a safe, functional, able environment for the public. This not met as evidenced and interview and document dotoensure resident rooms build-up of debris around and had multiple scratches, and furnishing which affected and trooms (C2, C4, C5, C10, orth dining room reviewed and tour. In addition, the ean odor free environment (19) room with a persistent, This is not met as evidenced and to ensure resident rooms around and had multiple scratches, and furnishing which affected and the rooms (C2, C4, C5, C10, orth dining room reviewed and the same of the ensure environment (19) room with a persistent, The end of the enance manager (MM)-A graph supervisor (HS)-A. The ene observed:	F 46		sanitary and the i-step een s C2, ng room, sident is in oved. n levated id. save atient tely missing s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245290	B. WING _			1	C / 21/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				10	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE LIVIA, MN 56277	1 077	21/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)			(X5) COMPLETION DATE			
F 465	in length, located on the room, was scratch length of the handrail uncleanable surface. bathroom had dirt and around the toilet. In room C5, dirt and bathroom floor, espect the floor around the cobaseboard behind the soiled. Cobwebs were along the floor and in the floor and in the floor and debris, especially dark substance was related to the floor and the toil length. The handrail of many scrapes and somissing along the entrough uncleanable surface over the toile armrest on the right swas scraped and the exposing a rough uncleanable in the North dining room and in the entrance into the dinition to the dinition of the diniting room and in the entrance into the dinition.	ail approximately three feet the left wall upon entering hed and scraped along the personal arough. In addition, the floor in the didebris in the corners and debris was noted on the cially in the corners, and on loor entering the room. The edoor was scratched and enoted behind the door, the corners of the wall. For in the bathroom had dirty in the corners. A removable noted around the toilet. If handrail was noted on the et, approximately two feet in was painted black but had eratches with chips of paint cire surface, exposing a urface. The ide had a 3-4 inch area that plastic was peeling, cleanable surface. The ide had a 3-4 inch area that plastic was peeling, cleanable surface. The ide had a debris was the hallway outside of the ecorners around the ng room. Cobwebs were and in the corners of the	F	465	bi-monthly audits will be performed by ED/or designee until February 1st, 201 on room cleanliness, odors, door goug and baseboards. Audit results will be reviewed in QAPI quarterly and as needed.	7,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245290	B. WING _			1	C 21/2016
			1003 WES	ST MAPLE	1 011	21/2010
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFI TAG	((X5) COMPLETION DATE
During an interview of MM-A stated the bath be fixed or replaced, the needed to be repaired door in room C5 was in room C15 needed the elevated toilet seat in replaced. Review of the housek for the North and Souneed to be swept and every Monday." Durin month, the cleaning sheach resident's room dusting and scrubbing wiping off the heat very door edges and wiping cloth. During the fourticleaning schedule incresident's room by so doorframe floor edges. During an interview of HS-A stated staff should baseboards and cornerecently purchased sphousekeeping staff coareas. The housekeep assignment sheet each check off the assigned them. HS-A stated she sheets at the end of the adequate to ensure a supplement of the state of the state of the state of the consure assigned durindicated she felt the adequate to ensure a	n 7/21/16, at 9:05 a.m., room door in C2 needed to the handrail in room C4 d, the baseboard behind the missed. The metal handrail to be removed, and the room N4 should be eeping cleaning schedules the wings included, "All floors mopped in every room g the first week of each chedule included cleaning by pulling out the furniture, gother the light tops with a wet he week of each month, the luded cleaning each rubbing the bathroom and standard the rooms so build adequately clean these poing staff are given another day and they were to did duties as they completed ecollected the assignment me day and reviewed them uties were completed. HS-A cleaning schedule was clean, sanitary	F	165			
поиѕекееріпд ѕтап.						
	CORRECTION SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTORY OR	ROVIDER OR SUPPLIER LIVINGCENTER - OLIVIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 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	CORRECTION 245290 B. WING_ ROVIDER OR SUPPLIER LIVINGCENTER - OLIVIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 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." 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HS-A indicated she felt the cleaning schedule was adequate to ensure a clean, sanitary environment, but stated, "we have a lot of new	A BUILDING B WIND	A BUILDING 245299 B. WING STREET ADDRESS. CITY, STATE. ZIP CODE 1003 WEST MAPLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST REPRECEDED BY FUIL, REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 22 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 handrall in room C4 needed to be replaced, the handrall in room C4 needed to be repaired, the baseboard behind 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." 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HS-A indicated she felt the cleaning schedule was adequate to ensure a signed duties were completed them to find the day and reviewed them to ensure assignment sheets at the end of the day and reviewed them to ensure assign duties were completed them to the same as adequate to ensure a clean, sanitary

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	I' '	ATE SURVEY OMPLETED
		245290	B. WING _			C 07/21/2016
	ROVIDER OR SUPPLIER	\ \		STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277		0172172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 465	5-Step Daily Patient 1 1/1/2000, directed sta floor, especially behin all corners and along	s Housekeeping In-Service, Room Cleaning, dated aff to dust mop the entire and dressers and beds, and all baseboards to prevent and housekeeping policies	F	465		
	strong, lingering urine entering R19's room. During observation of at 1:20 p.m., R19's room, R19's ro	f personal cares on 7/2016 from was again noted to have The odor of urine was more reclining chair in the room, ive pad was in the seat of sistant (NA)-A stated the nged when it was visibly A stated the protective pad in A-A stated, the chair "does additionally commented that visor, (HS)-A had on 7/19/16 because of the 1/20/16, at 2:57 p.m., HS-A staff checks chairs daily. If they are cleaned by the sprayed daily with Air-X, a				
	housekeeping assista	7/21/16 at 12:17 p.m., ant (HA)-E stated routine ed, "wiping the mattress, bed The chairs in the resident				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245290	B. WING _			C 07/21/2016	
				STREET ADDRESS, CITY, STATE, ZIP COD 1003 WEST MAPLE OLIVIA, MN 56277		3772172010	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 465	rooms were dusted. It steam clean them and with a damp cloth ever During observation or strong urine odor was floor was slightly tack room. There were not on the floor. During interview on 7. Alzheimer's care direct room, and also identified ACD stated they proving personal cares, and the changed daily, which sheets for the nursing that at times R19 toile and experiences dribling presence of odor and stated R19's room necleaning. The facility policy, enter Group, Inc. Housekeet reference date on the 1/1/2000, identified up Room Cleaning Processurfaces-disinfected,	If they have a stain, we will determine they wipe down the chair ary other day. In 7/21/16, at 12:25 p.m. a sended in the room, and they when walking across the visible stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16 at 12:35 p.m. with expected the stain or discoloration In 7/21/16, at 12:25 p.m. a sended the stain or discoloration In 7/21/16, at 12:35 p.m. a sended the stain or discoloration In 7/21/16, at 12:35 p.m. a sended the stain or discoloration I	F 4	965			

PRINTED: 08/19/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245290 B. WING 07/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE **GOLDEN LIVINGCENTER - OLIVIA OLIVIA, MN 56277** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 (X6) DATE

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

TITLE

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.

Facility ID: 00939

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DA). 0938-039 TE SURVEY MPLETED
		245290	B. WING		07	/20/2016
	PROVIDER OR SUPPLIER	LIVIA		STREET ADDRESS, CITY, STATE, ZIP (1003 WEST MAPLE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	Angela.Kappenma <mailto:angela.kap 1.="" 1st="" 2.="" 3.="" a="" actual,="" addition="" and="" be="" buildin="" co="" construction="" corprevent="" correct="" defic="" deficiency="" description="" fire="" following="" follows:="" for="" fully="" golden="" he="" height="" height,="" ii(000)="" in="" info="" livingcent="" mus="" name="" of="" one-story="" or="" oresponsible="" original="" plan="" pr="" protected="" pto="" reoccurre="" s<="" seen="" should="" sprinkler="" story="" td="" the="" to="" type="" was=""><td>state.mn.us iitney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date, or title of the person rection and monitoring to ence of the deficiency er Olivia was constructed as g was constructed in 1955, is, has a partial basement, is rotected and was determined constructed in 1963, is has no basement, is fully fire and was determined to be of ruction; was constructed in 1967, is has no basement, is fully fire and was determined to be of</td><td>K 00</td><td>0</td><td></td><td></td></mailto:angela.kap>	state.mn.us iitney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date, or title of the person rection and monitoring to ence of the deficiency er Olivia was constructed as g was constructed in 1955, is, has a partial basement, is rotected and was determined constructed in 1963, is has no basement, is fully fire and was determined to be of ruction; was constructed in 1967, is has no basement, is fully fire and was determined to be of	K 00	0		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			E SURVEY IPLETED
		245290	B. WING		07/	20/2016
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA			10	REET ADDRESS, CITY, STATE, ZIP CODE 103 WEST MAPLE LIVIA, MN 56277	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	corridors, which is department notifical capacity of 57 beds time of the survey.	age 2 ridors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 49 at	K	000		
K 017 SS=F	NOT MET as evide NFPA 101 LIFE SA Corridors are sepa constructed with at rating. In fully sprin partitions are only of smoke. In non-sextend to the unde above the ceiling. (at the underside of permitted by Code waiting areas, dinir may be open to co specified in the Coseparated from coif the gift shop is fully a separated from coif the gift shop is fully a separated from coif the gift shop is fully as a separat	rated from use areas by walls least 1/2 hour fire resistance klered smoke compartments, required to resist the passage prinklered buildings, walls raide of the floor or roof deck (Corridor walls may terminate ceilings where specifically Charting and clerical stations, ag rooms, and activity spaces rridor under certain conditions de. Gift shops may be rridors by non-fire rated walls ally sprinklered.)	K	017		8/30/16
	Corridors are sepa constructed with at rating. In fully sprin partitions are only of smoke. In non-s extend to the unde above the ceiling. It at the underside of permitted by Code waiting areas, dining may be open to co specified in the Co	is not met as evidenced by: arated from use areas by walls t least 1/2 hour fire resistance aklered smoke compartments, required to resist the passage aprinklered buildings, walls recorded of the floor or roof deck (Corridor walls may terminate f ceilings where specifically . Charting and clerical stations, and rooms, and activity spaces rridor under certain conditions de. Gift shops may be rridors by non-fire rated walls			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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A, BUILDING 01 - MAIN		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245290	B. WING			07/2	20/2016
	PROVIDER OR SUPPLIER	LIVIA		10	TREET ADDRESS, CITY, STATE, ZIP CODE DO3 WEST MAPLE DLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 017	19.3.6.1, 19.3.6.2, Findings include:	19.3.6.4, 19.3.6.5 veen 08:30 AM to 12:30 PM on	K	017			
K 018 SS=E	have smoke detect NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas s as those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the no impediment to to open devices that in pushed or pulled a provided with a medoor closed. Dutch	ea on the North wing did not cion. FETY CODE STANDARD orridor openings in other than so f vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ince between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the doors meeting 19.3.6.3.6 are the mes shall be labeled and	K	018			8/30/16
	with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Doors protecting or required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Clears and floor covering in fully sprinklered	ther materials in compliance er latches are prohibited by a all health care facilities. It is not met as evidenced by: corridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is			The corridors to linen storage have replaced with doors that fit tightly in framed and are positively latched. D in rooms C9, C13, S7, and S9 have adjusted to fit properly. To meet the expectations of Life safety code NFF 101. Section 19.3.6.3.6.	the oors been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ECTION IDENTIFICATION NUMBER: A. BUILDIN		DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277			7/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 018	open devices that pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or owith 8.2.3.2.1. Roll	age 4 the closing of the doors. Hold release when the door is are permitted. Doors shall be eans suitable for keeping the a doors meeting 19.3.6.3.6 are ames shall be labeled and ther materials in compliance er latches are prohibited by a all health care facilities.	K 01	8			
K 029 SS=D	07/20/2016, it was 1) The corridor dodid not fit tightly integrated into the frame and the frame. NFPA 101 LIFE SA One hour fire rated fire-rated doors) of extinguishing system and/or 19.3.5.4 protection is used, the other spaces by singuishing control is used, the other spaces by singuishing consumer field-applied protection is used. This STANDARD	ors to all of the Linen Storage to the frame and would not to the frame. 3, 57 and 59 did not fit tightly would not positively latch into AFETY CODE STANDARD disconstruction (with o hour or an approved automatic fire the em in accordance with 8.4.1 of the extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or cive plates that do not exceed to bottom of the door are	K 02	9 The central supply door had	d a closure	8/30/16	

CENTER	42 LOK MEDICAKE	& MEDICAID SERVICES			0	VID IVO.	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION 01 - Main Building 01		SURVEY PLETED
		245290	B. WING			07/2	20/2016
	E OF PROVIDER OR SUPPLIER LDEN LIVINGCENTER - OLIVIA			10	TREET ADDRESS, CITY, STATE, ZIP CODE DO3 WEST MAPLE DLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 029	the approved autor option is used, the other spaces by so doors. Doors are sield-applied protections.	stects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are	KO)29	door has been added. According to 101. Life safety code standards see 19.3.2.1.		
	AM on 07/20/2016 following deficient 1) The door to the have a door closur						
K 038 SS=D	door on it. NFPA 101 LIFE SA Exit access is arra accessible at all tir 7.1. 19.2.1 This STANDARD Exit access is arra	water heater did not have a AFETY CODE STANDARD Inged so that exits are readily Ines in accordance with section It is not met as evidenced by: Inged so that exits are readily Ines in accordance with section	K)38	The area between the south wing and the alley has had two feet of c added to level the area. According NFPA 101 sections 7.1 and 19.2.1	oncrete to	8/30/16
K 046	07/20/2016, observevealed the exterior the South Wing ex difference. Does residents to get to	ween 08:30 AM to 12:30 PM on vations and staff interview or walking surface at the exit of ceeded the allowable height not meet the requirements for the public way. AFETY CODE STANDARD		046			8/30/16

CENTER	42 LOK MEDICAKI	E & MEDICAID SERVICES			CIVID NO	. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I , ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED 07/20/2016	
		245290	B. WING _		07		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1003 WEST MAPLE OLIVIA, MN 56277			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
K 046 SS=C	Continued From p	age 6	K 04	46			
	is provided autom. 18.2.9.1, 19.2.9.1. This STANDARD Emergency lightir is provided autom 18.2.9.1, 19.2.9.1. Findings include: On facility tour bet	g of at least 1 1/2 hour duration atically in accordance with 7.9. is not met as evidenced by: ng of at least 1 1/2 hour duration atically in accordance with 7.9. ween 08:30 AM to 12:30 PM on vations revealed there is no		Emergency lighting/exit sign added to the exit outside of the and meets the 1 1/2 hour dura according to NFPA Life safety sections 7.9.18.2.9.1, 19.2.9.	e kitchen ation code 101		
K 047 SS=D	Exit and directional accordance with 7 also served by the 18.2.10.1, 19.2.10 (Indicate N/A in or with less than 30 of travel is obvious.) This STANDARD Exit and direction accordance with 7	ne story existing occupancies occupants where the line of exit is not met as evidenced by: al signs are displayed in 1.10 with continuous illumination emergency lighting system.	К 0	Emergency lighting/exit sign added to the exit outside of the and meets the 1 1/2 hour duraccording to NFPA Life safety	e kitchen ation code 101	8/30/16	
K 051 SS=F	07/20/2016, observed sign out of the NFPA 101 LIFE S. A fire alarm system components appropriate the system of th	tween 08:30 AM to 12:30 PM on evations revealed there was no exitchen. AFETY CODE STANDARD In is installed with systems and oved for the purpose in NFPA 70, National Electric Code	ΚO	section 18.2.10.1 and 19.2.10).1.	8/30/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	COME	E SURVEY PLETED
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA		1	STREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE DLIVIA, MN 56277	07/20/2016 IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 051	provide effective w building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each r boxes in patient sle required at exits if located at all nurse notification is provisignals. In critical osufficient. The fire alarm automatically the event of fire. The activates required records are mainta 18.3.4, 19.3.4, 9.6. This STANDARD A fire alarm system components approaccordance with N and NFPA 72, Natiprovide effective w building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each required at exits if located at all nurse notification is provisignals. In critical osufficient. The fire sufficient. The fire	age 7 conal Fire Alarm Code to arning of fire in any part of the in system wiring or other are monitored for integrity. alarm system is by manual required sprinkler system evice, or detection system. As are provided in the path of required exit. Manual alarm exping areas shall not be manual alarm boxes are alarm system transmits the yet on otify emergency forces in the fire alarm automatically control functions. System and and readily available. It is not met as evidenced by: In is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the manual system is by manual required sprinkler system exice, or detection system. The same provided in the path of required exit. Manual alarm exping areas shall not be manual alarm boxes are alarm system transmits the yet on otify emergency forces in alarm system transmits the yet on otify emergency forces in	K 051	The vendor has been contacted additional panel will be installed a south nurses station. A smoke detector has been instathe north wing family seating are According to NFPA 70 and 72 se 18.3.4, 19.3.4, 9.6.	at the alled in ea.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		OATE SURVEY OMPLETED
		245290	B. WING		7/20/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - OI	LIVIA	10	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE LIVIA, MN 56277	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 051	activates required of records are mainta 18.3.4, 19.3.4, 9.6 Findings include:	ne fire alarm automatically control functions. System ined and readily available.	K 051	5	
K 062 SS=C	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. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating		K 062		8/30/16
	periodically. 19.7 9.7.5 This STANDARD Required automat continuously maint condition and are in	rspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: ic sprinkler systems are ained in reliable operating rspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,		The missing ceiling tiles in the north wiexit and tub room # 14 have been replaced. According to NFPA 101 section 13, 25, 9.7.5.	
		ween 08:30 AM to 12:30 PM on ew of documentation and			
K 072 SS=D	room 14. NFPA 101 LIFE SA Means of egress s free of all obstructi	iles in the North Exit and tub AFETY CODE STANDARD hall be continuously maintained ons or impediments to full case of fire or other emergency.	K 072		8/30/16

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245290	B. WING		07/	20/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER - OL	-IVIA		STREET ADDRESS, CITY, STATE, ZIP 1003 WEST MAPLE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 072	obstruct exits, accessor visibility thereof structs 7.1.10. 18.2.1, 19.2 This STANDARD is Means of egress structure and the structure of the s	corations, or other objects shall ass thereto, egress there from, shall be in accordance with a shall be in accordance with a shall be continuously all obstructions or instant use in the case of fire a No furnishings, decorations, all obstruct exits, access a from, or visibility thereof nace with 7.1.10. 18.2.1, 19.2.1 ween 08:30 AM to 12:30 PM on vations revealed both inside the Exit had combustible storage	KO	The combustible items in area have been removed. NFPA 101 section 7.1.10,	According to	

PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245290	B. WING _			07/	20/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - OLIVIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
	ALLEGATION OF CODEPARTMENT'S AC SIGNATURE AT THE PAGE OF THE CMS USED AS VERIFICAT UPON RECEIPT OF CONDUCTED TO VASUBSTANTIAL COMIREGULATIONS HAS ACCORDANCE WITH A Life Safety Code Suminesota Department Fire Marshal Division, time of this survey, Gwas found not to be in with the requirements Medicare/Medicaid at 483.70(a), Life Safety	BOTTOM OF THE FIRST FORM-2567 WILL BE FION OF COMPLIANCE. AN ACCEPTABLE POC, AN F YOUR FACILITY MAY BE LIDATE THAT PLIANCE WITH THE BEEN ATTAINED IN H YOUR VERIFICATION. LIVEY WAS CONDUCTED by the nt of Public Safety, State n on July 20, 2016. At the colden LivingCenter Olivia n substantial compliance of for participation in					
		ty Code (LSC), Chapter 19 Occupancies. HE PLAN OF THE FIRE SAFETY ections vision uite 145					

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

TITLE (X6) DATE

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

PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245290	B. WING			07/	20/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				1	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE DLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page By email to: Marian.Whitney@stat <mailto:marian.whitn- 1.="" 1st="" 2.="" 2nd="" 3.="" <mailto:angela.kappe="" a="" actual,="" addition="" an="" and="" angela.kappenman@="" be="" building="" construct="" corf="" correct="" deficiency="" deficient="" description="" fire="" following="" follows:="" for="" fully="" golden="" ha="" ha<="" height,="" ii(000)="" in="" infor="" livingcenter="" must="" name="" of="" one-story="" or="" original="" plan="" prevent="" prop="" prot="" protected="" reoccurrence="" responsible="" sprinkler="" td="" the="" ti="" to="" type="" was="" wh="" wone-story=""><td>e.mn.us ey@state.mn.us> and estate.mn.us enman@state.mn.us> RECTION FOR EACH INCLUDE ALL OF THE MATION: at has been, or will be, done cy. osed, completion date. tile of the person ction and monitoring to be of the deficiency Olivia was constructed as was constructed in 1955, is as a partial basement, is ected and was determined construction; constructed in 1963, is as no basement, is fully fire ind was determined to be of tion; constructed in 1967, is as no basement, is fully fire ind was determined to be of</td><td></td><td>0000</td><td></td><td>ME.</td><td>DALE</td></mailto:marian.whitn->	e.mn.us ey@state.mn.us> and estate.mn.us enman@state.mn.us> RECTION FOR EACH INCLUDE ALL OF THE MATION: at has been, or will be, done cy. osed, completion date. tile of the person ction and monitoring to be of the deficiency Olivia was constructed as was constructed in 1955, is as a partial basement, is ected and was determined construction; constructed in 1963, is as no basement, is fully fire ind was determined to be of tion; constructed in 1967, is as no basement, is fully fire ind was determined to be of		0000		ME.	DALE
	The 3rd addition was one-story height, has	constructed in 1976, is a partial basement, is fully d and was determined to be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245290	B. WING			07/	20/2016
	ROVIDER OR SUPPLIER		•	10	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE DLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page	e 2 alarm system with smoke	К	000			
	detection in the corrid corridors, which is mo department notification	ors and spaces open to the onitored for automatic fire					
K 018 SS=E	NOT MET as evidence NFPA 101 LIFE SAFE Doors protecting corrirequired enclosures of hazardous areas shall as those constructed core wood, or capable 20 minutes. Clearance and floor covering is rin fully sprinklered sm required to resist the no impediment to the open devices that relepushed or pulled are provided with a mean door closed. Dutch do permitted. Door frame made of steel or othe with 8.2.3.2.1. Roller CMS regulations in all 19.3.6.3 This STANDARD is roors protecting corriequired enclosures of hazardous areas shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corriections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are shall as those constructed core wood, or capable corrections are constructed core wood, or capable corrections are corrected core wood, or capable corrections are corrected core wood, or capable corrections ar	dor openings in other than if vertical openings, exits, or I be substantial doors, such of 13/4 inch solid-bonded of of resisting fire for at least be between bottom of door not exceeding 1 inch. Doors toke compartments are only passage of smoke. There is closing of the doors. Hold	K	018			

AND DLAN OF CORRECTION IDENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(3) DATE SURVEY COMPLETED		
		245290	B. WING _			07/20/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				STREET ADDRESS, CITY, STATE, ZIP CODE 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 018	and floor covering is r in fully sprinklered sm required to resist the no impediment to the open devices that rele pushed or pulled are provided with a mean door closed. Dutch do permitted. Door frame made of steel or othe with 8.2.3.2.1. Roller CMS regulations in al 19.3.6.3 Findings include: On facility tour between	not exceeding 1 inch. Doors loke compartments are only passage of smoke. There is closing of the doors. Hold lease when the door is permitted. Doors shall be soutable for keeping the lors meeting 19.3.6.3.6 are less shall be labeled and materials in compliance latches are prohibited by I health care facilities.	K	018			
K 029 SS=D	did not fit tightly into the positively latch into the 2) Rooms C9, C13, 5 into the frame and wo the frame. NFPA 101 LIFE SAFE One hour fire rated confire-rated doors) or an extinguishing system and/or 19.3.5.4 protect the approved automa option is used, the arrother spaces by smoldoors. Doors are self-	to all of the Linen Storage the frame and would not e frame. 7 and 59 did not fit tightly ould not positively latch into ETY CODE STANDARD In approved automatic fire in accordance with 8.4.1 ots hazardous areas. When tic fire extinguishing system the east are separated from the resisting partitions and 6-closing and non-rated or the plates that do not exceed	K	029			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245290	B. WING		07/20/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277	0.120.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
K 029	permitted. 19.3.2.1 This STANDARD is r One hour fire rated of fire-rated doors) or ar extinguishing system and/or 19.3.5.4 protect the approved automatoption is used, the arother spaces by smold doors. Doors are self field-applied protective 48 inches from the body permitted. 19.3.2.1 Findings include: On the facility tour be AM on 07/20/2016, old following deficient control of the Centrol of the door on it. NFPA 101 LIFE SAFE Exit access is arrange accessible at all times 7.1. 19.2.1 This STANDARD is r Exit access is arrange accessible at all times 7.1. 19.2.1 Findings include:	not met as evidenced by: construction (with one hour approved automatic fire in accordance with 8.4.1 cts hazardous areas. When tic fire extinguishing system eas are separated from the resisting partitions and f-closing and non-rated or the plates that do not exceed the office of the door are tween 08:30 AM to 11:30 conservations revealed the inditions were identified: Intral Supply Room did not ter heater did not have a ETY CODE STANDARD and so that exits are readily as in accordance with section and met as evidenced by: and accordance with section and met as evidenced with section and met as evidenced with section and met as evidenced with section	K 02		
	7.1. 19.2.1 Findings include:	en 08:30 AM to 12:30 PM on			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245290	B. WING	B. WING		07/	20/2016
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 003 WEST MAPLE OLIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 038	revealed the exterior the South Wing exceed	ions and staff interview walking surface at the exit of eded the allowable height meet the requirements for	К	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:		K 046				
K 047 SS=D	07/20/2016, observatemergency lighting at NFPA 101 LIFE SAFE Exit and directional si accordance with 7.10 also served by the en 18.2.10.1, 19.2.10.1 (Indicate N/A in one swith less than 30 occurravel is obvious.) This STANDARD is result and directional saccordance with 7.10	with continuous illumination nergency lighting system. story existing occupancies upants where the line of exit not met as evidenced by:	K	047			
	On facility tour between	en 08:30 AM to 12:30 PM on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	ULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245290	B. WING			07/	20/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				100	REET ADDRESS, CITY, STATE, ZIP CODE 03 WEST MAPLE LIVIA, MN 56277	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 047 K 051 SS=F	07/20/2016, observate exit sign out of the kit NFPA 101 LIFE SAFE A fire alarm system is components approve accordance with NFP and NFPA 72, Nation provide effective warr building. Fire alarm stransmission paths ar Initiation of the fire alarms and by any realarm, detection device Manual alarm boxes egress near each required at exits if malocated at all nurse's notification is provide signals. In critical care sufficient. The fire alarm automatically to the event of fire. The activates required correcords are maintained 18.3.4, 19.3.4, 9.6 This STANDARD is real A fire alarm system is components approve accordance with NFP and NFPA 72, Nation provide effective warr building. Fire alarms stransmission paths ar	ions revealed there was no chen. ETY CODE STANDARD installed with systems and d for the purpose in A 70, National Electric Code al Fire Alarm Code to hing of fire in any part of the system wiring or other e monitored for integrity. For arm system is by manual quired sprinkler system are provided in the path of uired exit. Manual alarm bing areas shall not be stations. Occupant d by audible and visual e areas, visual alarms are arm system transmits the ponotify emergency forces in fire alarm automatically introl functions. System ed and readily available. In the tas evidenced by: In the tas installed with systems and d for the purpose in A 70, National Electric Code		047				
		quired sprinkler system ce, or detection system.						

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277 ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE OLIVIA, MN 56277 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
GOLDEN LIVINGCENTER - OLIVIA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 1003 WEST MAPLE OLIVIA, MN 56277 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIC DATE OATE			245290	B. WING		07/	20/2016	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETIC DATE			A.		10	003 WEST MAPLE		
	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
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 system transmits the 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. A 662 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 N SS=C	Manual alarm boxes egress near each required at exits if malocated at all nurse's notification is provide signals. In critical carsufficient. The fire ala alarm automatically to the event of fire. The activates required correcords are maintained 18.3.4, 19.3.4, 9.6 Findings include: On facility tour betwee 07/20/2016, observatory 1) Fire Alarm Panel with monitored location. 2) Family sitting area have smoke detection NFPA 101 LIFE SAFE Required automatic scontinuously maintain condition and are insperiodically. 19.7.6 9.7.5 This STANDARD is required automatic scontinuously maintain condition and are insperiodically. 19.7.6 9.7.5	are provided in the path of quired exit. Manual alarm ping areas shall not be anual alarm boxes are stations. Occupant ed by audible and visual re areas, visual alarms are arm system transmits the o notify emergency forces in fire alarm automatically introl functions. System ed and readily available. Seen 08:30 AM to 12:30 PM on tions and interview revealed: I ava not located in a I on the North wing did not in. ETY CODE STANDARD Sprinkler systems are ined in reliable operating pected and tested in a sprinkler systems are ined in reliable operating pected in reliable operating pected in reliable operating pected and tested					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245290	B. WING			07/	20/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - OLIVIA				10	REET ADDRESS, CITY, STATE, ZIP CODE 03 WEST MAPLE LIVIA, MN 56277		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 062 K 072 SS=D	07/20/2016, a review interview revealed: 1) Missing ceiling tiles room 14. NFPA 101 LIFE SAFE Means of egress shalfree of all obstructions instant use in the cas No furnishings, decor obstruct exits, access or visibility thereof shalf. 7.1.10. 18.2.1, 19.2.1 This STANDARD is reference of all impediments to full in or other emergency. If or other objects shall thereto, egress there shall be in accordance. Findings include: On facility tour between 07/20/2016, Observation.	en 08:30 AM to 12:30 PM on of documentation and s in the North Exit and tub erry CODE STANDARD I be continuously maintained or impediments to full error of the emergency, ations, or other objects shall thereto, egress there from, all be in accordance with enter as evidenced by: Il be continuously obstructions or stant use in the case of fire No furnishings, decorations, obstruct exits, access from, or visibility thereof er with 7.1.10. 18.2.1, 19.2.1		062	DEFICIENCY)		
	in the exit passage w	Exit had combustible storage ay.					