DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: M7V2 Facility ID: 00941

			10 22 00			I B B C M \ B I I I O B I \ C I		1 deinty 12: 005:11
1. MEDICARE/MEDICAID (L1) 245306 2.STATE VENDOR OR MEI (L2) 307113800).	3. NAME AND AL (L3) GOLDEN L (L4) 2215 HIGHV (L5) ROCHESTE	IVINGCENTI WAY 52 NORT	ER - ROC	HESTER WEST (L6) 55901	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	ON: 7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHA (L9) 04/01/2006	NGE OF OWN	ERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint
ACCREDITATION STAT Unaccredited AOA	08/14/20 TUS: 1 TJC 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)
11LTC PERIOD OF CERTI	FICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):			A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirem	ents:
To (b):				equirements e Based On:		2. Technical Personnel 3. 24 Hour RN		
12.Total Facility Beds		54 (L18)	•	cceptable POC			7. Medical Dis 8. Patient Roo 9. Beds/Room	m Size
13.Total Certified Beds		54 (L17)	X B. Not in Con Requireme	npliance with Progents and/or Appli		* Code: A,5	(L12)	
14. LTC CERTIFIED BED B	REAKDOWN		•			15. FACILITY MEETS		
18 SNF 18	3/19 SNF 54	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
	CY REMARKS orting the fa	S (IF APPLICA cility's req	ABLE SHOW LTC CA	NCELLATION and the nuing waive	DATE): r involvi:	ng LSC K67 is being reco	mmended and for	warded to CMS for
approval. 17. SURVEYOR SIGNATU	RE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Lisa Carey (Krebs)	, HFE NE I	I	0	8/21/2015	(L19)	Kamala Fiske-Downing,	Enforcement Spec	<u>ialis</u> t 08/21/2015 (L20)
	PART I	I - TO BE	COMPLETED I	BY HCFA RI	, ,	L OFFICE OR SINGLE S	TATE AGENCY	(120)
19. DETERMINATION OF 1. Facility is E 2. Facility is n	ligible to Partici	pate (L21)		IPLIANCE WITI ITS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stmt	
22. ORIGINAL DATE	23.	LTC AGREEN	MENT 24	I. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 01/01/1986		BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		NTARY Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DAT	TE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
		A. Suspension	n of Admissions:	(T.44)		04-Other Reason for Withdrawal	07-Provid 00-Active	er Status Change
	(L27)	B. Rescind Su	uspension Date:	(L44) (L45)			oo renve	
28. TERMINATION DATE:		20). INTERMEDIARY/			30. REMARKS		
20. TERMINATION DATE.		2)		CARRIER NO.		30. KEM IKKS		
	(L28)	00454		(L31)			
31. RO RECEIPT OF CMS-1	1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(1	L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245306

August 21, 2015

Mr. Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

Dear Mr. Richardson:

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 14, 2015 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Bed

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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.

Golden Livingcenter - Rochester West August 21, 2015 Page 2

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fishe Downing

Health Regulation Division

Minnesota Department of Health

 $\underline{Kamala.Fiske-Downing@state.mn.us}$

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

August 21, 2015

Mr. Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

RE: Project Number S5306025

Dear Mr. Richardson:

On August 14, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on August 14, 2015, imposed a daily fine in the amount of \$350.00.

On August 14, 2015, an acknowledgement was received by the Department stating that the violation(s) had been corrected. A reinspection was held on August 14, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$ 350.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$ 162.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$ 512.40 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Golden Livingcenter - Rochester West August 21, 2015 Page 2

Sincerely,

Kamala Fishe Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Program Assurance Unit

Penalty Assessment Deposit Staff

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245306	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/14/2015
Name of Facility		Street Address, City, State, Zip Code		
GOLDEN LIVINGCENTER - ROCHESTER WEST		2215 HIGHWAY 52 NORTH BOCHESTER, MN 55901		

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y	(5)	Date
ID Prefix	F0314	Correction Completed 08/14/2015	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	483.25(c)									
Reg. #			Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed
Reg. #			Reg. #		Correction Completed					Correction Completed
Dog #			D #				ъ "			
Reviewed E	ByRe	viewed By	Date:	Signature of Sur	veyor:				Date:	
State Agen	cy GP	N/kfd	08/21/2015			34	985		0	8/14/2015
Reviewed E	3y Re	viewed By	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Compl 5/21/20			Check for any Uncor Uncorrected Defic					YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

August 21, 2015

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Golden Livingcenter - Rochester West August 21, 2015 Page 2

Sincerely,

Kamala Fishe Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Program Assurance Unit

Penalty Assessment Deposit Staff

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00941 Name of Facility GOLDEN LIVINGCENTER - ROCHESTER WEST (Y2) Multiple Construction A. Building B. Wing (Y3) Date of Revisit 8/14/2015 Street Address, City, State, Zip Code 2215 HIGHWAY 52 NORTH

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ROCHESTER, MN 55901

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 08/14/2015	ID Prefix		Completed		ID Prefix		Completed
	MN Rule 4658.0525 Sub								
							LSC _		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				.		
							LSC _		
		Correction			Correction				Correction
ID Profiv		Completed	ID Profix		Completed		ID Profix		Completed
- "			Reg. #				D "		
LSC							LSC _		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			D #						
LSC			LSC _				LSC _		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #									
			LSC _				LSC _		
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:			Da	ite:
State Agen	GPN/kfd		08/21/2015			3498	5		08/14/2015
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:			Da	ite:
Followup t	o Survey Completed on 5/21/2015	:		Check for any Uncor Uncorrected Defic				ha Faailiu.O	ES NO
07175 505	J/Z I/ZUIJ	(0.0)		Daga 1 of 1	•		-	Front ID: M7\	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: M7V2 Facility ID: 00941

		10 22 00::11	DETED DI		EDUNITEDENCE		1 deint) 15: 00> 11
1. MEDICARE/MEDICAID PR (L1) 245306 2.STATE VENDOR OR MEDIC (L2) 307113800		3. NAME AND AI (L3) GOLDEN L (L4) 2215 HIGHY (L5) ROCHESTI	IVINGCENTI WAY 52 NORT	ER - ROCI	HESTER WEST (L6) 55901	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ION: 7 (L8) 2. Recertification 4. CHOW 6. Complaint
	07/23/20155 ^{L34)}	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 8. Full Survey Aft FISCAL YEAR END 12/31	
11LTC PERIOD OF CERTIFICATION (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BRIT 18 SNF 18/19	54 (L18) 54 (L17)	Complianc1. A X B. Not in Con	equirements be Based On: acceptable POC	gram ied Waivers:	And/Or Approved Waivers O 2. Technical Personne3. 24 Hour RN4. 7-Day RN (Rural S:X5. Life Safety Code * Code: B,5 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	el 6. Scope of S 7. Medical D	Services Limit Director nom Size
16. STATE SURVEY AGENCY Documentation support approval. 17. SURVEYOR SIGNATURE Lisa Carey (Krebs), 1	ting the facility's req	uest for a continuous Date :	ANCELLATION nuing waive	r involvin	ng LSC K67 is being recons 18. STATE SURVEY AGENCY	Y APPROVAL	Date:
	PART II - TO BE	COMPLETED I	BY HCFA RI	` '	L OFFICE OR SINGLE S	STATE AGENCY	(L20)
19. DETERMINATION OF EI 1. Facility is Elig 2. Facility is not	LIGIBILITY ible to Participate	20. COM	MPLIANCE WITI HTS ACT:		21. 1. Statement of Fina	ancial Solvency (HCFA-2: rol Interest Disclosure Stn	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1986 (L24) 25. LTC EXTENSION DATE:	A. Suspension	S DATE	4. LTC AGREEM ENDING DAY (L25) (L44) (L45)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	10 INVOLU 05-Fail to 06-Fail to ion OTHER	ider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
	(L28)	00454		(L31)			
31. RO RECEIPT OF CMS-153	39 32	. DETERMINATION	N OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN 24-5306

On July 23, 2015, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility has not achieved substantial compliance pursuant to the May 21, 2015 standard survey. The deficiency not corrected is as follows:

F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

As a result of the revisit findings, the following Category 1 remedy is being imposed:

- -State Monitoring effective August 10, 2015. (42 CFR 488.422)
- -Mandatory denial of payment for new Medicare and Medicaid admissions effective August 21, 2015 will remain in effect.(42 CFR 488.417 (b))

Refer to the CMS 2567 and CMS 2567b.

Documentation supporting the facility's request for a continuing waiver involving LSC K67 has been forwarded to CMS for approval.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 5, 2015

Mr. Jon Richardson, Administrator Golden LivingCenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

RE: Project Number S5306025

Dear Mr. Richardson:

On July 27, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 21, 2015. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on May 21, 2015, and lack of verification of substantial compliance of the health deficiencies at the time of our July 27, 2015 notice. The most serious deficiencies were found 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.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Rochester West is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency This prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

On July 23, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey completed on May 21, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2015. Based on our visit, we have determined

Golden LivingCenter - Rochester West August 5, 2015 Page 2

that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on May 21, 2015. The deficiency not corrected is as follows:

F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

The most serious deficiency in your facility was found to be an isolated deficiency that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby correction is required.

As a result of the revisit findings, the following Category 1 remedy is being imposed:

• State Monitoring effective August 10, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office, the following action related to the remedy imposed in our letter of July 27, 2015. CMS concurs and has authorized this department to notify you of the following:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 21, 2015 will remain in effect. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 21, 2015.

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:

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731

Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission..

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

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

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

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

Golden LivingCenter - Rochester West August 5, 2015 Page 4

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 November 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

Golden LivingCenter - Rochester West August 5, 2015 Page 5

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 27, 2015

Mr Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

RE: Project Number S5306025

Dear Mr. Richardson:

On June 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2015. 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.

Compliance with the health deficiencies issued pursuant to the May 21, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 21, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 21, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 21, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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

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 November 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245306	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/23/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
GOLDEN LIVINGCENTER - ROCHESTER WEST		2215 HIGHWAY 52 NORTH BOCHESTER MN 55901		

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5) Date	(Y4)	Item	(Y	5)	Date
		Correction			Correction					Correction
ID Prefix	F0279	Completed 06/30/2015	ID Prefix	F0441	Completed 06/30/2015		ID Prefix			Completed
Reg. #	483.20(d), 483.20(k)(1	_)	Reg. #		=		- "			=
			LSC		-		LSC			- -
		Correction			Correction					Correction
		Completed	#		Completed					Completed
		_			_					_
Reg. # LSC		<u> </u>	Reg. # LSC		=		Reg. # LSC			<u> </u>
		Correction			Correction					Correction
ID Profix		Completed	ID Profix		Completed		ID Profix			Completed
										_
Reg. # LSC		_ _	Reg. # LSC		-		Reg. # LSC			_
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #		-					_
-					-		LSC			_ _
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #							
			LSC		-		LSC _			_
Reviewed E	By Reviewe	d By	Date:	Signature of Su	rveyor:			С	Date:	
State Agen	cy GP	N/kfd	08/04/20	15	34083	}			07/2	23/2015
Reviewed I	By Reviewe	d By	Date:	Signature of Su	rveyor:				Date:	
CMS RO										
Followup t	o Survey Completed o	on:		Check for any Unco Uncorrected Defi	rrected Defi	ciencio	es. Was a Su	- F:::0		
	5/21/2015			Unconected Deli	Ciencies (CIV	13-230	ii) Sent to the	- i aciiity :	YES	NO

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

PRINTED: 08/26/2015 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245306	B. WING			R 23/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	077	23/2013
GOLDE	N LIVINGCENTER - RO	OCHESTER WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs .	{F 00	0}		
{F 314} SS=D	that were corrected CMS2567B. Also of be found corrected The citation will be Because you are ensignature is not requage of the CMS-25 submission of the Enverification of computer of the Enverification of computer of the Enverification of computer of the Enverification of the Enverification of computer of the Enverification of t	acceptable electronic POC, an aur facility will be conducted to antial compliance with the en attained in accordance with ENT/SVCS TO RESSURE SORES arehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that alble; and a resident having eives necessary treatment and e healing, prevent infection and from developing.	(F 31-	Submission of this Response and Correction is not a legal admission deficiency exists or that this Statem	that a	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed**

08/11/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245306	B. WING		07/2	? 23/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	1 01/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETION DATE
{F 314}	effective to promotor pressure ulcers from residents (R5, R11 pressure ulcers. Findings Include: R5 was admitted to diagnoses to include pain, multiple sclet buttock according R5's quarterly Minit 4/10/15, indicated required extensive mobility, transfer, of MDS also included with measurement cm. Review of R5's physorders for weekly smorning. R5's Treatment Accrevealed the follow gluteal fold: cleans dry, apply moisten [medicated dressin product to surroun Cover with Nu-Derevery other day. In related to pressure All skin monitoring 7/23/15 was requestions.	ant skin interventions are the healing and prevent further of developing for 3 of 3 of 3 of 3. The facility on 11/18/14 with detail but not limited to; chronic rosis, and pressure ulcer on the to the admission sheet. Imum Data Set (MDS), dated R5 was cognitively intact and assistance of two staff for bed dressing, and toilet use. This if an unstageable pressure ulcer is of 2.4 centimeters (cm) x 0.9 of 2.4 centimeters (cm) x 0.9 of 3 of 2.4 centimeters (cm) and a sistance of two staff for bed dressing, and toilet use. This if an unstageable pressure ulcer is of 2.4 centimeters (cm) x 0.9 of 3 of 2.4 centimeters (cm) prize of 2.4 centimeters (cm) consistency of 3 of	{F 314	Deficiency was correctly cited, and not to be construed as an admissifault by the facility, the Executive or any employees, agents or othe individuals who draft or may be did in this Response and Plan of Correll naddition, preparation and submithis Plan of Correction does not can admission or agreement of any the facility of the truth of any facts or the correctness of any conclusiforth in the allegations. Accordingly, the Facility has preparation of any appeal which filed solely because of the require under state and federal law that may be submission of a Plan of Correction ten (10) days of the survey as a conton participate in Title 18 and Title programs. This plan of Correction submitted as the facility as credible allegation of compliance. F314 -Weekly skin assessments are becompleted for R5. Identified alters skin integrity are being measured Wound measurements have been obtained and are being document wound consult report for R150. Is being measured weekly at wour specialty clinic. Facility staff have directed by wound clinic to not rendressing applied at wound clinic undressing applied at wound clinic undressing becomes saturated. R11	ion of Director r scussed rection. ission of onstitute y kind by alleged ons set ared and prior to a may be ments nandate n within ondition 19 is e	

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245306	B. WING			07/2	R 23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST		22	TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH OCHESTER, MN 55901	1 01/1	-0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)				BE	(X5) COMPLETION DATE
{F 314}	R5's weekly skin as 7/16/15 indicated R and left buttock. No included. No other skin asses provided for R5 upon R117 was admitted diagnoses to includige joint prosthetic joint admission form. R117's 14 day MDS was cognitively inta assistance of two side diagnoses to include measurement of two sides desired an unhealed stage include measurement Manual defines a Signartial thickness loshallow open ulcer. Review of R117's pieckly skin assess orders for Stage 2 unedicated dressin as needed (PRN) for R117's TAR docum review to be completed. All skin monitoring signals and signals with the skin monitoring signals and signals with the skin monitoring signals.	ssessment completed on 5 had open areas on the right measurements were ssments were found or on request. to the facility on 6/17/15 with e, but not limited to; broken implant found on the staff for bed mobility, transfer, use. This MDS also included II pressure ulcer which did not ents. The State Operations tage II pressure ulcer as ss of dermis presenting as a with red-pink wound bed." hysician orders included a ment on Monday morning and ulcer to include Mepilex border g) change every 3 days and or skin breakdown.	{F 3·	14}	discharged from the facilityResidents with altered skin integrit the potential to be affected if weekl wound assessments are not compl-Licensed staff responsible for wee assessments and wound monitorin been educated on requirements for completion and documentation of viskin and wound assessmentsAudits will be conducted twice were affirm that weekly skin assessment being completed and identified are concern with skin integrity are being properly measured and documented weekly. Negative outcomes will be addressed immediately. Results wereviewed at QAPIDNS/designee will be responsibleCorrective action will be completed 8/11/15.	y leted. ekly skin og have r veekly ekly to ts are as of g ed ed	

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

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				COMPLETED
		245306	B. WING				R 07/23/2015
	ROVIDER OR SUPPLIER	OCHESTER WEST		2215 HIGH	DRESS, CITY, STATE, ZIP CODE WAY 52 NORTH TER, MN 55901	I	01/23/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	
	7/20/15 indicated R left outer calf. Resideg when it occurred intact. Resident has Reports scratching. or notes of a pressuprovided. R117's Bath Sheet CNA[certified nurse 7/20/15, were revier (redness) in the groskin alteration on the bruising on the lowe wound measureme when requested. No other skin assess provided for R117 under the skin alteration on the lower wound measureme when requested. R150 was admitted diagnoses to included diagnoses to include diagnoses	Assessment completed on 117 had a "1 cm skin tear on dent states she scratched her d. Skin pulled across and s 2 scratches on right cheek. "However, no measurements are ulcer were located or and Skin Assessment assistant]/Nurses, dated wed and revealed erythema oin and coccyx area, a surgical se left upper leg, and old er left leg. Again a lack of ints were included or provided sements were found or upon request from facility. to the facility on 7/6/15 with e, but not limited to, delirium, and pneumonia which were	{F 3:	14}			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245306	B. WING				R 23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST		22	TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH COCHESTER, MN 55901	1 0171	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	weekly skin assess Isodosorb Gel 0.9% right heel ulcer, clear Isodosorb and curis tegaderm silicone for daily. All skin monitoring auntil 7/23/15 was reprovided or found in record. Weekly Skin Asses 7/22/15 in progress but no information of 7/20/15 "Previously right heel." No mea 7/13/15 "Open area shin and heel of rle Dressings being coirritation around pej Again no measurer 7/6/15 read, "Unsta IV], Isodosorb/hydrifull thick serosangid dressing 85% grant Aquacel AG covere Right lower extremi 2/5 x 3 cm. Mepilite No other skin assess	shysician orders included a ment on Monday morning and (a [wound cleanser] apply to anse with saline apply 50:50 sol to wound, cover with oam dressing and change starting from admission date equested. The following was in the electronic medical sments dated: I was the computer message completed. I documented pressure ulcer to surements included. Is on abdomen, knee, calf, [right lower extremity]. Impleted as ordered. No in tube. Open area to coccyx." I ments were completed. I geable pressure ulcer [stage ogel mepiborder. 3.5 x 1.8 cm. ulineous [blood/serum mix] ulating with 15% fibrinous. I with mepiborder 2.5 x .3 cm. ity scab. 4 x 1.8 cm right upper	{F 3	14}			
	(DON) was asked v	3 p.m. the director of nursing where weekly skin ocated especially for R5, R117,					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING	` ,	(X3) DATE SURVEY COMPLETED	
		245306	B. WING			R /22/2015
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		/23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 314}	& R150. The DON do them electronical week with a shower notify higher level in DON verified weekl completed for R5, Freviewed the electronical completed for correction in regal issued on the surversion of change status for R123/15 at 12:30 Sheet and Skin Assistant was completed days. The DON version of cated on these for surveyor, "I know the reference to meeting for F314]." On 7/23/15 at 12:50 (RN)-A, charge nurresponsible for compassessment consists of changes. RN-A significant is given nursing assistant] with the resident is given nursing assistant] with the nurse control of the province of the pr	stated, "It is a new system to ally. We are doing them once a r sheet. The nurses would nanagement of concerns." The ly skin assessments were not R117, & R150. The DON onic medical record (Point recyors then said, "I will have paperwork in my office to find." The DON stated she knew impliance with their written plantards to F314 which had been be experied 5/21/15. DON said, are monitored weekly with the eright is healing." Again the surrent weekly skin of contain measurements and	{F 3	14}		

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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245306	B. WING		07	R / 23/2015		
	PROVIDER OR SUPPLIER	OCHESTER WEST		STREET ADDRESS, CITY, STATE, ZII 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		720/2010		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			
{F 314}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 3·	14}				

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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245306	B. WING		07	R	
NAME OF I	PROVIDER OR SUPPLIER	243300	B. WING	STREET ADDRESS, CITY, STATE, ZIP COL	•	/23/2015	
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST		2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 314}	they will be completed ones. I measure the after. It's an ongoing figure who does who have the site of	ting the measuring of existing enew ones and they follow up g process we are just trying to at." CLIN513 Weekly Skin Review assessments), dated 5/13/15 inpletion entified-dry, rash, redness, other-the nurse is to indicate op down boxes, utilizing the ered indicators on the figures g the type of alteration and is identified the licensed nurse the Wound Evaluation Flow each alteration identified. /NP[nurse practitioner] are to kin alterations, as well as the disher responsible party." Ices, Skin Integrity Guideline, ition of Weekly Skin attions read, I be responsible for valuation/observation weekly, Skin Review UDA document weekly on identified de Evaluation Flow Sheet UDA	{F 3	14}			



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on August 4, 2015.

August 4, 2015

Mr. Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

Re: Project # S5306025

Dear Mr. Richardson:

On July 23, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 21, 2015 with orders received by you electronically on .

State licensing orders issued pursuant to the last survey completed on May 21, 2015 and found corrected at the time of this July 23, 2015 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on May 21, 2015, found not corrected at the time of this July 23, 2015 revisit and subject to penalty assessment are as follows:

20900 -- S/S: -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers \$350.00

The details of the violations noted at the time of this revisit completed on July 23, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the

Golden Livingcenter - Rochester West August 4, 2015 Page 2

Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 gary.nederhoff@state.mn.us

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Golden Livingcenter - Rochester West August 4, 2015 Page 3

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00941 (Y2) Multiple Construction A. Building B. Wing (Y3) Date of Revisit 7/23/2015 Name of Facility Street Address, City, State, Zip Code 2215 HIGHWAY 52 NORTH

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ROCHESTER, MN 55901

(Y4) Item	((Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	20302	Correction Completed 06/30/2015	ID Prefix	20560	Correction Completed 06/30/2015		ID Prefix	21390	Correction Completed 06/30/2015
	MN State Statute 14			MN Rule 4658.0405 Sub				MN Rule 4658.080	
ID Prefix		Correction Completed 06/30/2015	ID Prefix Reg. #		Correction Completed		ID Prefix		Correction Completed
Reg. #			Reg. #				Reg. #		
Reg.#			Reg. #		Correction Completed				
ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reviewed B		ved By	Date:	Signature of Sur	veyor:			Dat	e:
State Agend Reviewed B CMS RO	-	ved By	Date:	Signature of Sur	veyor:			Dat	e:
Followup to Survey Completed on: 5/21/2015				Check for any Uncor Uncorrected Defic					

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. 50.25.140.		R
		00941	B. WING		07/23/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO FER, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{2 000}	Initial Comments		{2 000}		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deposition of the Minnesota Deposition of the Minnesota MN Rumber and MN Rumbe	hether a violation has been			
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	23, 2015. During th determined that the # 0900 had not bee order will remain in	visit was completed on July is onsite visit it was following corrections orders/s in corrected. This uncorrected effect and will be reviewed at and will be reviewed for		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/11/15

TITLE

STATE FORM 6899 M7V212 If continuation sheet 1 of 10 Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2)		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		00941	B. WING			3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NC FER, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETE DATE
{2 000}	Continued From pa	ge 1	{2 000}			
				The assigned tag number appears far left column entitled "ID Prefix T The state statute/rule out of complisted in the "Summary Statement of Deficiencies" column and replaces Comply" portion of the correction of This column also includes the finding which are in violation of the state in as evidence by." Following the sunfindings are the Suggested Method Correction and Time period for Column The Fourth Column which states after the statement, "This Rule is in as evidence by." Following the sunfindings are the Suggested Method Correction and Time period for Column The Fourth Column which states, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION OF MINNESOTA ST STATUTES/RULES.	Tag." iance is of the "To order. ings tatute not met veyors d of rrection. DING OF THIS	
{2 900}	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}			8/11/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 2 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
	00941		B. WING			3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER WEST	HWAY 52 NC TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 2	{2 900}			
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	by: This licensing order Based on observatireview the facility facomprehensive wed determine if current effective to promote pressure ulcers from residents (R5, R117 pressure ulcers. Findings Include: R5 was admitted to diagnoses to include pain, multiple sclero buttock according to the control of the	ent is not met as evidenced r was not corrected due to: on, interview, and document alled to complete ekly skin assessments to a skin interventions are explained and prevent further of developing for 3 of 3 of 3 of 3. The facility on 11/18/14 with the explained and pressure ulcer on the or the admission sheet. The developing for 3 of 3 of 3 of 3 of 3. The facility on 11/18/14 with the explained and pressure ulcer on the or the admission sheet. The facility on 11/18/14 with the explained and assistance of two staff for bed are sing, and toilet use. This an unstageable pressure ulcer is of 2.4 centimeters (cm) x 0.9 of 2.4 centimeters (cm) x 0.9 of 2.4 centimeters (cm) Thursday		Submission of this Response and Correction is not a legal admission deficiency exists or that this State Deficiency was correctly cited, and not to be construed as an admissi fault by the facility, the Executive I or any employees, agents or other individuals who draft or may be dis in this Response and Plan of Correll In addition, preparation and submithis Plan of Correction does not coan admission or agreement of any the facility of the truth of any facts or the correctness of any conclusiforth in the allegations. Accordingly, the Facility has prepasubmitted this Plan of Correction the resolution of any appeal which filed solely because of the required under state and federal law that musubmission of a Plan of Correction ten (10) days of the survey as a coat to participate in Title 18 and Title 1 programs. This plan of Correction submitted as the facility a credible allegation of compliance.	n that a ment of d is also on of Director	
	R5's Treatment Adr	ninistration Record (TAR)		F314		

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING	····	R 07/23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 HIGH	DRESS, CITY, : HWAY 52 NO FER, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
{2 900}	revealed the following luteal fold: cleans of dry, apply moistene [medicated dressing product to surround Cover with Nu-Derrevery other day. In related to pressure All skin monitoring 7/23/15 was request provided or found in record. R5's weekly skin as 7/16/15 indicated Rand left buttock. No included. No other skin assess provided for R5 upon R117 was admitted diagnoses to include diagnoses to include joint prosthetic joint admission form. R117's 14 day MDS was cognitively inta assistance of two serious dressing, and toilet an unhealed stage include measuremed Manual defines a Serious partial thickness los shallow open ulcer.	ng order: "Right and left with NS [normal saline], pat of Promogran Prisma g] to wound bed, apply barrier ling wound area, allow to dry. In [dressing] border. Change the morning on odd days ulcer buttock." starting from 6/30/15 through sted. The following was in the electronic medical seessment completed on 5 had open areas on the right of measurements were	{2 900}	-Weekly skin assessments are be completed for R5. Identified alter skin integrity are being measured Wound measurements have been obtained and are being document wound consult report for R150. is being measured weekly at wou specialty clinic. Facility staff have directed by wound clinic to not reduce dressing applied at wound clinic to dressing becomes saturated. R11 discharged from the facility. Residents with altered skin integrithe potential to be affected if week wound assessments are not completion and wound monitor been educated on requirements from pletion and documentation of skin and wound assessments. Audits will be conducted twice we affirm that weekly skin assessments being completed and identified ar concern with skin integrity are being completed and document weekly. Negative outcomes will be addressed immediately. Results reviewed at QAPI. DNS/designee will be responsible. Corrective action will be completed 8/11/15.	ations in weekly. In weekly. In weekly. In weekly. In weekly. In weekly seekly skin ang have or weekly. In weekly to onts are eas of ang ted one well be will be

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00941	B. WING			R 23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 4	{2 900}			
		ulcer to include Mepilex border g) change every 3 days and or skin breakdown.				
	R117's TAR docum review to be completed	entation included weekly skin eted.				
	7/23/15 had been re	starting from 6/30/15 through equested and the following lirected to check the electronic				
	7/20/15 indicated R left outer calf. Resid leg when it occurred intact. Resident has Reports scratching.	n Assessment completed on 117 had a "1 cm skin tear on dent states she scratched her d. Skin pulled across and s 2 scratches on right cheek." However, no measurements are ulcer were located or				
	CNA[certified nurse 7/20/15, were revie (redness) in the gro skin alteration on the bruising on the lowe	and Skin Assessment e assistant]/Nurses, dated wed and revealed erythema in and coccyx area, a surgical le left upper leg, and old er left leg. Again a lack of ints were included or provided				
		ssments were found or upon request from facility.				
	diagnoses to includ	to the facility on 7/6/15 with e, but not limited to, delirium, and pneumonia which were ission form.				
		MDS, dated 7/13/15, revealed sly intact and required				

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 5 of 10

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00941	B. WING			R 23/2015
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	STATE, ZIP CODE	, , ,	
GOLDEN	N LIVINGCENTER - RO	OCHESTER WEST	HIGHWAY 52 NO			
	T	ROCI	HESTER, MN 559			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 5	{2 900}			
	transfer, dressing, a indicated R150 had an unhealed stage measurements of 3 Operations Manual ulcer "an observabl of intact skin", stage loss." and a stage I with exposed bone, Review of R150's p weekly skin assess Isodosorb Gel 0.9% right heel ulcer, cleated by the stage of R150's p weekly skin assess Isodosorb and curis	te of two staff for bed mobile and toilet use. The MDS also a stage I pressure ulcer are III or IV pressure ulcer with a cm x 3 cm. The State defines a stage I pressure e, pressure-related alteration of the III as "full thickness tissue of the III as "full thickness tis	on e oss			
	until 7/23/15 was re	starting from admission dat equested. The following was n the electronic medical				
	but no information of 7/20/15 "Previously right heel." No mea 7/13/15 "Open area shin and heel of rle Dressings being co irritation around pej Again no measuren 7/6/15 read, "Unsta IV], Isodosorb/hydro Full thick serosangi dressing 85% grant Aquacel AG covere	was the computer messag	er to ." ge cm.			

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 6 of 10

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00941	B. WING	·····		? 23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 HIGH	DRESS, CITY, S HWAY 52 NO FER, MN 559		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{2 900}	2/5 x 3 cm. Mepilite No other skin asses provided for R150 to facility. On 7/23/15 at 12:13 (DON) was asked wassessments are lowed to them electronical week with a shower notify higher level modern DON verified week completed for R5, Freviewed the electroclick Care) with surtodig through the path shower sheets. They were not in corroction in regains and on the surveillance of the current of the surveillance of the current of the curren	ssments were found or upon requesting them from the property points and property points are specially for R5, R117, stated, "It is a new system to ally. We are doing them once a respect. The nurses would management of concerns." The yeskin assessments were not R117, & R150. The DON onic medical record (Point reyors then said, "I will have aperwork in my office to find the The DON stated she knew mpliance with their written plantards to F314 which had been by exited 5/21/15. DON said, a monitored weekly with the plantards it is healing." Again the arrent weekly skin of contain measurements and 5, R117, & R150.	{2 900}			
	Sheet and Skin Ass that was completed days. The DON ver measurements or a located on these for surveyor, "I know the reference to meeting for F314]."	D p.m. the DON delivered Bath dessment CNA/Nurses form on the resident's shower ified there were no wound assessed status of wounds rms. DON then said to nat is not good enough [in g the minimum requirement of p.m. registered nurse				
		se, was asked who is				

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 7 of 10

PRINTED: 08/26/2015 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	?
		00941	B. WING		07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 7	{2 900}			
	responsible for comassessments and vassessment consists of changes. RN-As the resident is given nursing assistant] value to each check. Chenew skin check. Chenew skin issue to nursing assistant of correction was to each check. Chenew skin issue to nurse to each check.	apleting the weekly skin what does the weekly skin t of, and who would be notified said, "Should be nurses when a bath. The CNA [certified will give the nurses the bath will go do a complete head to ecking all over, if there is a otify me [RN-A] or DON and to CC (Point Click Care). As of we expect to measure wounds				
	reviews skin assess to the ADON (assis is absent right now, and I review the neassessment sheet, transcribed in PCC has not then we trathem complete." Thare ensuring the plate followed and stated audits because I wassessment is how of correction is bein have been following residents due to be On 7/23/15 at 1:48 responsible for comassessments, what	sments. DON stated, "They go tant director of nursing), who Currently they come to me xt day. We have the skin double check if it has been as the weekly skin review, if it ck down the nurse and have ne DON was asked how they an of correction is being I, "The ADON was completing as out. The weekly skin we are making sure the planing followed. Pressure ulcers I g, I have been relearning ing absent for a bit." p.m. RN-B was asked who is a pleting the weekly skin to does the weekly skin				
	of changes. RN-B s scheduled on show and tell me when the	t of, and who would be notified stated, "Skin assessments are er days, they [CNAs] pop in he resident is in the shower or I are back in their room. I give				

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 8 of 10

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00941	B. WING			R 23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 HIGH	DRESS, CITY, S HWAY 52 NO FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{2 900}	the bath sheet to the enter it into the comsheets." RN-B was wound/s especially measurements. If it There is a process ADON that they will they will be completed ones. I measure the after. It's an ongoin figure who does who aread, "Steps for configure who does who alteration is ideal of the site (s) in the dreat anatomically number provided, describing location. If a skin alteration is is to initiate/update UDA, one UDA for MD[medical doctor] be notified of any should be notified any should be no	e aide and add my stuff to it. Inputer and then I recycle the asked about [reference to pressure ulcer/s] is a new open area I will. with old areas that the DON or be reviewing the old wounds, ting the measuring of existing enew ones and they follow up g process we are just trying to at." CLIN513 Weekly Skin Review assessments), dated 5/13/15 mpletion entified-dry, rash, redness, rother-the nurse is to indicate op down boxes, utilizing the ered indicators on the figures g the type of alteration and is identified the licensed nurse the Wound Evaluation Flow each alterations, as well as the d his/her responsible party." ices, Skin Integrity Guideline, tion of Weekly Skin ations read, I be responsible for valuation/observation weekly, Skin Review UDA document weekly on identified d Evaluation Flow Sheet UDA	{2 900}			

Minnesota Department of Health

STATE FORM 6899 M7V212 If continuation sheet 9 of 10

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE	SURVEY PLETED
			B. WING			R
		00941	B. WING		07/2	23/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 HIG	ADDRESS, CITY, S GHWAY 52 NC STER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{2 900}	will be reviewed at	the next onsite visit. Also this will be reviewed for possible	{2 900}		• ,	
İ						

6899

Minnesota Department of Health STATE FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: M7V2 Facility ID: 00941

								•
MEDICARE/MEDICAID PROVIDE (L1) 245306 2.STATE VENDOR OR MEDICAID N		3. NAME AND AL (L3) GOLDEN L (L4) 2215 HIGHV	IVINGCENTI	ER - ROC	HESTER WEST	r	4. TYPE OF AC 1. Initial 3. Termination	TION: <u>2 (</u> L8) 2. Recertification 4. CHOW
(L2) 307113800		(L5) ROCHESTI	ER, MN		(L6)	55901	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF ((L9) 04/01/2006	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other
6. DATE OF SURVEY 05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAR EN	IDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION	Ţ	10 THE EACH ITY	VIC CEDITIEIED	A C.				
From (a):	•	10.THE FACILITY A. In Complia		A5:	And/Or Appro	ved Waivers Of	The Following Requir	rements:
To (b):		Program R	equirements			nical Personnel		Services Limit
12.Total Facility Beds	54 (L18)	•	e Based On: cceptable POC			lour RN 1y RN (Rural SN Safety Code	7. Medical F) 8. Patient F 9. Beds/Ro	Room Size
13.Total Certified Beds	54 (L17)	X B. Not in Con Requireme	npliance with Progents and/or Appli		_	B,5	9. Beds/R0 (L12)	JOIII
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY M	IEETS		
18 SNF 18/19 SNF 54	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM Documentation supporting thapproval.	ARKS (IF APPLICA ne facility's req	BLE SHOW LTC CA	NCELLATION I	DATE): r involvi	ng LSC K67 is	being recor	mmended and f	orwarded to CMS for
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	RVEY AGENCY	APPROVAL	Date:
Lisa Carey (Krebs), HFE 1	NE II	0	6/22/2015	(L19)	K <u>amala Fiske</u>	-Downing, l	Enforcement Sp	<u>pecialis</u> t 06/29/2015 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OF	R SINGLE S'	TATE AGENCY	
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WITH	H CIVIL			ncial Solvency (HCFA-	
1. Facility is Eligible to P	articipate	RIGHTS ACT:		2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)3. Both of the Above :			tmt (HCFA-1513)	
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY	_00	INVO	LUNTARY
01/01/1986					01-Merger, Clos 02-Dissatisfaction			to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involu		n	to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A Suspension	VE SANCTIONS of Admissions:			04-Other Reason	•	OTHE	<u>R</u> vider Status Change
	71. Guspension	or raministions.	(L44)				00-Act	
(L27)	B. Rescind Su	spension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		00454						
	(L28)	00434		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMIN	ATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 9, 2015

Mr. Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

RE: Project Number S5306025

Dear Mr. Richardson:

On May 21, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

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 June 30, 2015, 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 June 30, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (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 August 21, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc_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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 06/19/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245306	B. WING			05/	21/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST		22	TREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHWAY 52 NORTH OCHESTER, MN 55901	•	
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F 000	INITIAL COMMENT The facility's plan of as your allegation of Department's acceen rolled in ePOC, yat the bottom of the form. Your electron be used as verifical Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.20(d), 483.20(l) COMPREHENSIVE A facility must use to develop, review comprehensive plan for each reside objectives and time medical, nursing, an eeds that are idented assessment.	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required if first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with (X)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's n of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial attified in the comprehensive	FC	279		HIAIE	6/30/15
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under a due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.					
I ABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	<u> </u>	TITLE		(X6) DATE

Electronically Signed 06/19/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
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F 279	Continued From p	age 1	F 2	779		
	by: Based on intervie facility failed to de plan after complet assessment and it assistance to mee (R109) identified a were not care plar assessment/s. Findings include: R109 was admitted diagnoses that indicataracts, osteoar degenerative joint fractures of the lur disk protrusion acadmission record. R109's admission dated 5/12/15 indi with a Brief Interviscore of 15, and re MDS revealed R10 of one staff membambulation, toiletin required extensive member for dress indicated balance transitions and wa with staff assistant wheelchair for mo (CAA's) were trigg assessment informitation. The CAA's dated areas were included.	w and document review, the velop a comprehensive care ing a comprehensive dentifying resident needs and at needs for 1 of 3 residents as having assessed needs that need following the initial do to the facility on 5/5/15 with cluded but was not limited to throsis, osteoporosis, disease, and compression mbar and thoracic spine with cording to the facility's Minimum Data Set (MDS) cated no cognitive impairment ew of Mental Status (BIMS) equired corrective lenses. The operacive lenses. The operacive limited assistance are for bed mobility, transfers, and and personal hygiene and assistance of one staffing. The assessment also was not steady during and used a walker and bility. Care Area Assessment ared based off of the MDS mation that required a plan of 5/17/15 indicated the following and had been completed in visual function, pressure ulcer, as of deity living.		Submission of this Respon Correction is not a legal ad deficiency exists or that this Deficiency was correctly cit not to be construed as an a fault by the facility, the Exe or any employees, agents of individuals who draft or main this Response and Plan In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of an or the correctness of any control for the resolution of any appear filed solely because of the under state and federal law submission of a Plan of Cotten (10) days of the survey to participate in Title 18 and programs. This plan of Corsubmitted as the facility allegation of compliance. F279 -Comprehensive care plan developed for R109 to add needs and assistance to mall residents have the pote affected if assessed needs planned.	mission that a significant statement of ted, and is also admission of cutive Director or other by be discussed of Correction. It is submission of so not constitute to fany kind by any facts alleged conclusions set be prepared and ection prior to all which may be requirements by that mandate that mandate the rection within as a condition of Title 19 rection is credible that the press assessed eet needs, ential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245306	B. WING _		05/21/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	
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F 279 F 314 SS=D	5/21/15 failed to incincluded individuality vision, pressure ulder function/rehabilitation CAAs dated 5/17/1 include ADL's of be and personal hygie During an interview registered nurse (Root fully developed comprehensive assinformation. Facility policy was regards to complete plan. 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters	on potential. Tovided by the facility on clude a plan of care that zed goals and interventions for zer, and a complete ADL on focus as indicated by the 5. The care plan did not d mobility, dressing, toilet use, ne. Ton 5/21/15, at 10:04 a.m. TN)-C confirmed care plan was after completing a sessment and CAA requested and not provided in the comprehensive care SENT/SVCS TO TRESSURE SORES Orehensive assessment of a remust ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and the healing, prevent infection and	F 27	-RNAC has been educated on care planning assessed needs and assi to meet needsRandom audits on 50 per cent of radmits for the next 30 days, then 2 cent of new admits for the next six to ensure care plans are developed address assessed needs and assis to meet needs. These audits will be conducted within 72 hours of admis Negative outcomes will be address immediately. Results will be review QAPIDNS/designee will be responsibleCorrective action will be completed 6/30/15.	stance new 5 per months d to stance e ession. eed ved at
	by: Based on observative review the facility facuound assessment	tion, interview and document ailed to complete weekly its for current pressure ulcers (R17, R8) who were reviewed		F314 -Weekly wound assessments have completed for R8 and R17Residents with wounds have the p	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
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F 314	admission diagnos palliative care, with the coccyx. The 5 day admission dated 4/16/15, indintact, had modera care 1-3 days in the required extensive mobility, transfer, of Care Area Assession indicated R17 had did not provide me On 4/2/15, A Wou indicated: suspected sacrum, non blance The facility nursing at 4:31 p.m. indicated pressure ulcer, but measurements. On 4/2/15 weekly so 0.7 sacrum, barrier hours. On 4/2/15 a Wound tissue injury, without the Hospice admissindicate R17 had a his coccyx 2.0 x 7.0	to the facility on 4/2/15, with es of metastatic cancer, on a stage 1 pressure ulcer on on Minimum Data Set (MDS) icated R17 was cognitively te depression, and rejected e look back period. R17 assistance of two staff for bed dressing and toilet use. The ment (CAA) dated 4/8/15, a stage 1 pressure ulcer, but asurements. Ind Assessment was noted and ed deep tissue injury on hable 2.0 x 0.7 sacrum. In admission note dated 4/2/15, ted R17 had a stage one sacral edid not provide Skin check stage 1 redness 2 x of film applied, turn every two decomposition of the dated 4/3/15, a stage one pressure ulcer on	F3	314	to be affected if weekly wound assessments are not completed. -Licensed staff responsible for wou monitoring have been educated on requirements for wound assessment documentation. -Audits of 25 percent of wound assessments and documentation of conducted weekly. Negative outcorn be addressed immediately. Results reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed 6/30/15.	nts and will be nes will will be	

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F 314	On 4-7-15, a stage remains reddened to continues to be nor applied to bottom to Continue with curre and off loaded least breakdown. From 4/7/15 to 4/23 wound assessment provided when required on 4/23/15, a nursi indicated Seasons orders to discontinue pressure ulcer on some continue of the continue o	1 sacral pressure ulcer from admission, area in-blanchable. Protection pad or prevent breakdown. Interpretation of care. Reposition to every 2 hours to prevent as located nor was it uested from facility. In progress note at 10:11 a.m. Hospice visited today: new use dressing, stage [sic] acral area has resolved. In hospice, stage 1 pressure of the provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided. In hospice, stage 1 pressure of the provided or provided or provided. In hospice, stage 1 pressure of the provided or provided or provided. In hospice, stage 1 pressure of the provided or provi	F3	114		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	turns and air mattr Braden score is 14 process of comple in bed and adjustr hours. He was promattress and prescushion. He is end 2 hours to minimiz Licensed nurse co (certified nursing a on checking skin of proper techniquical On 5/19/15 at 2:10 4/2/15) and wound 4/23/15) were revied (RN)-A, and health Weekly wound docomputer, RN-A state aides give bath who should docum Belle stated, Our of the sheets, and I the sheets, and I the check sheets). On 5-19-15, at 2:2 questioned certifies who stated, she did the sheet filled out daily additional dail on 5/19/15 -At 2:3 was unclear about ulcer, so it was obstated, "No open a on coccyx, even of Also the HIC, review."	ess for skin protection. his lating to the stimulation of the session of the stimulation of the stimulation of the session of the stimulation of the session	F 31	4			

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F 314	nursing services (C weekly wound door for residents, and wadditional document was the expectation documentation for R8's document revieweekly skin evaluated R8 was admitted to a.m. with primary or respiratory failure at metastatic adenocates a type of cancerous several parts of the included a prior gluand new abrasions secondary to proloc (Comprehensive R). Comprehensive R: Comprehensive Skindicated R8 had the tissue tolerance obtoined of pressure ulcer, the disease with addition chooses not to coorditive impairment extremity, and skindicated R8 had skindic	p.m. the consultant director of CDNS), was not aware that umentation had not been done was not able to provide any nation. The CDNS verified it in to have weekly skin all residents. iew revealed the facility lacked tion. The facility on 4/9/15 at 11:15 liagnoses of acute hypoxic and newly diagnosed arcinoma [Adenocarcinoma is stumor that can occur in a body] additional diagnoses iteal pressure ulcer, stage II, wareas of breakdown	F 31	4				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245306	B. WING		05	5/21/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER WEST				STREET ADDRESS, CITY, STATE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
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F 314	tendon, or muscle i present but does no loss. May include u Dimensions of unhacm. [length x width indicated two stage upon admission. R8's dressing chan at 12:22 p.m. Pressimeasured by RN-Adepth 0.1 cm. Presimeasured length 0. stated both were a Wound Evaluation Right gluteal pressure with measing width 0.8 cm, depth identified 4/9/15. W (pre-admission). 5/11/15 Wound Evaluation Right gluteal pressure with measing width 0.2 cm. 5/15/15 Wound Evaluation Right gluteal pressure with measing width 0.2 cm. 5/15/15 Wound Evaluation Right gluteal pressure with measing width 1 cm. Signature with measing width 1 cm, and de was identified 4/9/1 (pre-admission). 5/11/15 Wound Evaluation). 5/11/15 Wound Evaluation Right	s not exposed. Slough may be of obscure the depth of tissue indermining or tunneling."] ealed: 1.0 cm x 0.8 cm x 0.2 x depth] 14 day MDS Ill pressure ulcers present ge was observed on 5/21/15 sure ulcer on the right gluteal, length 2.4 cm, width 1.3 cm, sure ulcer on the left gluteal 3 cm, width 0.4 cm. RN-A stage III. Flow Sheet Multiple Weeks: ure ulcer, uation Week 1: right buttock surements of length 1 cm, in 0.2 cm stage III. Wound was found type: pressure ulcer aluation Week 2: Details and gth 1.2 cm, width 2.6 cm, aluation Week 3: Details and gth 2.0 cm, width 0.9 cm,	F3	14		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	cm. Current treatm Treatment Administ May 2015 revealed gluteal pressure ul documentation of sites. On 5/21/15 at 11:1 dressing changes [treatment administ measurements RN of Nursing Service On 5/21/15 at 3:03 wound documentation bet 5/11/15. "It's probation available. I informed month ago but the On 5/21/15 at 3:33 was asked about the Skin/wound documentation bet 5/11/15. "It's probation available. I informed month ago but the On 5/21/15 at 3:33 was asked about the Skin/wound documentation will be responsible skin integrity Guid Page 1: "DNS [director of will be responsible skin integrity progron a weekly basis. Page 2: "Documentation of Evaluation/Observ responsible for per	nigth 0 cm, width 0 cm, depth 0 ment resolved. Stration Record for April and different to right and left cers as ordered, but no monitoring the pressure ulcer 1 a.m. RN-B was asked where are documented, "In the TAR stration record]" regarding I-B stated, "The DNS [Director s] had been going that weekly." 5 p.m. RN-A verified that the tion provided to surveyor was ation available with no sween the dates of 4/9/15 and ably the only information that is ed them that is was missing a y did not do anything about it." 5 p.m. RN-C, facility consultant, the expectation of how often inentation occurred. RN-C peckly." The eline, undated: The provided to surveyor was ation available with no sween the dates of 4/9/15 and ably the only information that is ed them that is was missing a provided to anything about it." The p.m. RN-C, facility consultant, the expectation of how often inentation occurred. RN-C peckly." The provided to surveyor was missing a provided to anything about it." The p.m. RN-C, facility consultant, the expectation of how often inentation occurred. RN-C peckly." The p.m. RN-C is a surveyor was missing a provided to surveyor was ation available with no surveyor was at the p.m. and the p.m. at the p.	F 31	4				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901	·	
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F 314	assessment]. Licen weekly on identified Evaluation Flow Shidentified)." Page 3: "Monitoring Complare in place to dem compliance with gu UDA's are in place, evaluates/observes 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and to help prevent the of disease and infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pushould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreading Spreadi	w UDA [user defined sed nurse to document I wounds using the Wound eet UDA (one UDA per wound iance. The following elements onstrate satisfactory ideline: Weekly Skin Review DNS or designee wounds on a weekly basis." I CONTROL, PREVENT I CONTROL, PREVENT I CONTROL, PREVENT I Tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, on an individual resident; and ord of incidents and corrective if ections. The add of Infection ion Control Program esident needs isolation to of infection, the facility must	F 4			6/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245306	B. WING _	••••	05/	21/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER WEST				STREET ADDRESS, CITY, STATE, ZIP CO 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	direct contact will to (3) The facility must hands after each do hand washing is in professional practic. (c) Linens Personnel must had transport linens so infection. This REQUIREME by:	ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 4	41 F441		
	use glucometers w for 3 of 3 residents blood glucose more Findings include: On 5/21/15, at 11:4 nurse (LPN)-A was (BG) test and BG completing the BG medication cart (whand set the used B medication cart, LF medication cart an into the carrier and started to put the country the bottom drawer, surveyor to ask about PN-A stated, "When we use alcohol packilled hepatitis C or surveyor to ask about the carrier and started to put the country to ask about the carrier and started to put the country to ask about the carrier and started to put the carrier and st	ailed to ensure multi-resident ere disinfected between uses (R1, R46, R21) reviewed for itoring. 22 a.m. The licensed practical observed for a blood glucose meter disinfection. After test, LPN-A returned to the nere BG meter was stored), G meter directly on top of the PN-A then opened the d put the used (soiled) meter removed her gloves. LPN-A arrier with the used meter into but was interrupted by the out disinfecting the BG Meter. en we don't have the cleaner ds." When asked if alcohol other contagious disease, it does not." LPN-A further		-Multi use glucometers have disinfected with appropriate water prevent spread of infection. Wipes have been placed on representation and the potential to be affect glucometers are not properly successed staff have been exproper disinfection of glucometers are not properly successed staff have been exproper disinfection of glucometer disinfection audits glucometer disinfection will be weekly. Negative outcomes water at QAPI. -DNS/designee will be resposited to the proper disinfection will be confective action will be confective action will be confective.	wipes to Disinfecting med carts. monitoring sted if shared disinfected. ducated in meters and applies. of proper se conducted will be sults will be nsible.	

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER WEST SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 11 stated the facility had been "out of the (disinfecting) wipes since last week." LPN-A was asked how she would access wipes or supplies when out, LPN-A stated the South BG meter, was shared between three residents, R1, R21, and R46. Charts were reviewed for R1, R21, and R46, no contagious diseases were listed in the admission diagnoses. On 5/21/15 at 11:50, the health information coordinator (HIC) stated she usually orders, and she was not aware the disinfecting wipes were out of stook. The registered nurse/charge nurse (RN)-A stated she had "ordered supplies on Tuesday, and the supplies should be in today." At 11:58 staff went and found supplies, the facility used Mediline micro (bacterioidal, virialidal, etc) disinfecting wipes. The disinfecting gipse were in supply within the facility, but had not been put on the medication cart. The RN-A stated she had not been told the cart lacked bleach (disinfecting) wipes. At 12:10 The Consultant DNS stated she expected the glucometers to be cleaned with bleach wipes R1 was admitted to the facility on 12:8/14 with admission diagnoses of paranoid schizophrenia and diabetes mellitus type II (DMI). R1 had physician orders dated 5/1/15, for BG test before meals and at befulting (four times a day), when the BG meter was not properly disinfected.		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 225 HIGHWAY 28 NORTH ROCHESTER, MR 55901 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG F 441 Continued From page 11 Stated the facility had been "out of the (disinfecting) wipes since last week." LPN-A was asked how she would access wipes or supplies when out, LPN-A stated the nurse would "give supply orders to charge nurse, and she does the ordering." LPN-A stated the South BG meter, was shared between three residents, R1, R21, and R46. Charts were reviewed for R1, R21, and R46, no contagious diseases were listed in the admission diagnoses. On 5/21/15 at 11:50, the health information coordinator (HIC) stated she usually orders, and she was not aware the disinfecting wipes were out of stock. The registered nurse/charge nurse (RN)-A stated she had "ordered supplies on Tuesday, and the supplies should be in today." At 11:58 staff went and found supplies, the facility used Medline micro (bacteriodal, viralsidal, etc) disinfecting wipes. The disinfecting wipes were in supply within the facility, but had not been put on the medication cart. The RN-A stated she had not been told the cart lacked bleach (disinfecting) wipes. At 12:10 The Consultant DNS stated she expected the glucometers to be cleaned with bleach wipes R1 was admitted to the facility on 12/8/14 with admission diagnoses of paranoid schizophrenia and diabetes mellitus type II (DMII). R1 had physician orders dated 51/15, for BG test before meals and at bedtime (four times at day), and was potentially at risk for transferred contagious disease four times at day), and was potentially at risk for transferred contagious diseases four times at day.			245306	B. WING			05/2	21/2015
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 11 stated the facility had been "out of the (disinfecting) wipes since last week." LPN-A was asked how she would access wipes or supplies when out, LPN-A stated the nurse would "give supply orders to charge nurse, and she does the ordering." LPN-A stated the South BG meter, was shared between three residents, R1, R21, and R46. Charts were reviewed for R1, R21, and R46, no contagious diseases were listed in the admission diagnoses. On 5/21/15 at 11:50, the health information coordinator (HIC) stated she usually orders, and she was not aware the disinfecting wipes were out of stock. The registered nurse/charge nurse (RN)-A stated she had "ordered supplies on Tuesday, and the supplies should be in today." At 11:58 staff went and found supplies, the facility used Medline micro (bactericidal, viratsidal,et) disinfecting wipes. The disinfecting wipes were in supply within the facility, but had not been put on the medication cant. The RN-A stated she had not been told the cart lacked bleach (disinfecting) wipes. At 12:10 The Consultant DNS stated she expected the glucometers to be cleaned with bleach wipes R1 was admitted to the facility on 12/8/14 with admission diagnoses of paranoid schizophrenia and diabetes mellitus type II (DMII). R1 had physician orders dated 5/1/15, for BG test before meals and at bedtime (four times a day,) and was potentially at risk for transferred contagious disease four times a day, when the BG meter was					2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901			
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R21 was admitted to the facility 11/8/12, with	F 441	stated the facility had (disinfecting) wipes asked how she wou when out, LPN-A st supply orders to chrordering." LPN-A st was shared between and R46. Charts were review contagious diseased diagnoses. On 5/21/15 at 11:50 coordinator (HIC) she was not aware out of stock. The result of stock. The result of stock. The result of stock is the result of stock. The result of stock is the result of stock. The result of stock is the result of stock is the result of stock. The result of stock is the result of	ad been "out of the since last week." LPN-A was ald access wipes or supplies ated the nurse would "give arge nurse, and she does the ated the South BG meter, in three residents, R1, R21, and R46, no s were listed in the admission by the health information tated she usually orders, and the disinfecting wipes were gistered nurse/charge nurse and "ordered supplies on upplies should be in today." At a found supplies, the facility of (bactericidal, viralsidal, etc). The disinfecting wipes were in cility, but had not been put on acked bleach (disinfecting) to Consultant DNS stated she meters to be cleaned with the facility on 12/8/14 with the sof paranoid schizophrenia aus type II (DMII). R1 had ted 5/1/15, for BG test before the (four times a day), and was in transferred contagious a day, when the BG meter was cted.	F 4	41			

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245306	B. WING			05/:	21/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ROCHESTER WEST				22	REET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHWAY 52 NORTH DCHESTER, MN 55901	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	intestines, protein of mitochondria me R21 had physician four times a day, ar transferred contagion when the BG meter R46 was admitted the admission diagnose pulmonary disease R46 had physician test twice a day, an transferred contagion the BG meter was a The Blood Glucose policy dated 12/1/14 that is EPA register against HIV, HBV, a bacteria. The Equipment and Medications Policy directed the charge equipment and sup administration are contage nurse is not or equipment fails to	es of epilepsy, disorder of the calorie malnutrition, disorders cated 5/1/15, for for BG and was potentially at risk for ous disease four times a day, was not properly disinfected. To the facility 8/8/14 with es of chronic obstructive (COPD), dementia and DMII. orders dated 5/1/15, for BG d was potentially at risk for ous disease twice a day, when not properly disinfected. Monitor Decontamination 4, directed staff to use a wipe ed as tuberculocidal, effective and a broad spectrum of discontamination dated November 2011, a nurse on duty ensures that plies relating to medication clean and orderlyThe ified if supplies are inadequate o work properly. The charge oment and supply deficiencies	F 4	41			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/22/2015 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245306 05/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 HIGHWAY 52 NORTH **GOLDEN LIVINGCENTER - ROCHESTER WEST** ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Rochester West was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), **EPOC** Chapter 19 Existing Health Care.

445 Minnesota St., Suite 145

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

Health Care Fire Inspections State Fire Marshal Division

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY

TITLE

(X6) DATE

Electronically Signed

06/19/2015

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

DEFICIENCIES (K-TAGS) TO:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING	I` 'a	ATE SURVEY OMPLETED
		245306	B. WING			5/21/2015
	ROVIDER OR SUPPLIER	OCHESTER WEST		STREET ADDRESS, CITY 2215 HIGHWAY 52 NO ROCHESTER, MN 5	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000	St Paul, MN 55101 By email to: Marian.Whitney@s	-5145, or tate.mn.us and	К0	00		
		RRECTION FOR EACH ST INCLUDE ALL OF THE				
	1. A description of to correct the defici	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.				
	1-story building, wif	center - Rochester West is a th a partial basement. The 1963 and was determined to construction				
	alarm system with and spaces open to	sprinkled. The facility has a fire full corridor smoke detection the corridor that is monitored epartment notification.				
		apacity of 54 beds and had a at the time of the survey.				
K 067 SS=F	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD	K	67		6/18/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245306	B. WING		05	/21/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST		STREET ADDRESS, CITY, STATE, ZIP C 2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901		
(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 067	with the provisions in accordance with	age 2 g, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K 0	67		
	Based on observa could not be verified ventilating and air of installed and tested Section 19.5.2.1 are	is not met as evidenced by: itions and staff interviews, it ed that the facility's general conditioning system (HVAC) is d in accordance with the LSC, and NFPA 90A, Section 3-4.7. A C system could affect all 40		A waiver for this deficiency requested. Please see atta form and documentation.		
	05/21/2015, observentilation system the supply air for the building construction balance report available.	ween 1:00 PM and 3:30 PM on vation revealed, that the utilizes the egress corridor as he resident rooms. Date of on is 1963. There was no ilable.				
	This deficient pract	tice was confirmed by the nance at the time of discovery.	*			
	TEAM COMPOSI Gary Schroeder, Li	TION ife Safety Code Spc.				

Sheehan, Pat (DPS)

From:

Sheehan, Pat (DPS)

Sent:

Monday, June 22, 2015 11:59 AM

To:

rochi lsc@cms.hhs.gov

Cc:

gary.schroeder@state.mn.us; 'jon.richardson@goldenliving.com'; Dehler, Robert;

Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston,

Kate'; Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)

Subject:

Golden Livingcneter Rochester West (246024) K67 Annual Waiver Request - Previously

Approved - No Changes

This is to notify you that GLC Rochester West is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-21-15.

I am recommending that CMS approve the waiver request.

Patrick Sheehan, Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416 Health Care & Corrections Fire Inspections

Minnesota State Fire Marshal Division 445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525 Web: fire.state.mn.us

Name of Facility

Golden Living Rochester West - 2215 Hwy 52 North, Rochester, MN 55901 - (507) 288-1818

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

A waiver is requested for the following reasons: 1. There are no adverse effects on the health or safety of residents or staff a. The building is equipped with an approved full-corridor smoke detection system b. The facility is fully protected by an automatic sprinkler system c. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building's fire alarm and/or sprinkler systems d. Annual service and maintenance contracts are in place to ensure proper service of all the facility's fire protection systems (fire alarm, sprinkler system, portable extinguishers) e. The building's fire alarm system is monitored to provide automatic notification to the fire department f. Fire safety training is provided for all new hires during orientation and for all employees annually g. Fire drills are conducted at least quarterly on each shift. 2. Compliance with this provision would impose an unreasonable hardship on the facility: a. Compliance would cost an estimated \$126,200 to upgrade the facility's HVAC system to comply with NFPA 90a b. The required work would lead to infection control issues. b. The required work would lead to infection control issues.
Title
2 3 8 3 4 8 5 8 5 8 5 8 6

Fire Safety Supervisor Title Fire Authority Official (Signature) Form CMS-2786H F02/2019)/U

Page 27

Date

State Fire Marshai

Office



1400 7th Street NV/ Rochester, MN 55901 Phone: (507) 280-7713 Fax: (507) 284-5206

www.himec.com

April 15, 2014

Golden Living Center West 2215 HWY 52 N Rochester, MN 55901

RE: Ducting Both Wings

- · Fabricate all Return air ducting for both north and south wing
- Take down ceiling after hours and reinstall after work has been completed
- · Provide and install all return air duct in hallway
- · Provide and Install return air for each room
- Provide and install supply air registers to the middle of each room
- Test and balance both rooftops/duct work and provide a copy to the owner and city as required
- Provide and install fire smoke dampers in each wall for supply and return
- Install balancing dampers in each run
- Provide moving of all pipes and electrical in the way above the ceiling
- Provide and install a fire rated wall in each corridor above the ceiling and all the
 way up to the deck with 5/8 gyp board and all fire caulking. This needs to be
 done through both wings above the ceiling
- Provide coned off work areas everyday with plastic enclosures
- Labor/Materials
- Start-up
- Permit
- Test and balance
- Engineered cost for plans are included in this price Total.....\$126,200.00

Please let me know if I can be of further assistance to you, or should you have any questions regarding this, please feel free to contact me at (507) 288-7713.

Sincerely,	
Bryce Beckel	
Project Manager Service Division	
Acceptance	Date:

Proposal Guaranteed For 30 Days





Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted June 9, 2015

Mr. Jon Richardson, Administrator Golden Livingcenter - Rochester West 2215 Highway 52 North Rochester, Minnesota 55901

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5306025

Dear Mr. Richardson:

The above facility was surveyed on May 18, 2015 through May 21, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 06/19/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00941 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2215 HIGHWAY 52 NORTH **GOLDEN LIVINGCENTER - ROCHESTER WES1** ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

> Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

06/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/21/2015	
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 HIG	DRESS, CITY, HWAY 52 NO TER, MN 55	*****		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
2 000	you electronically, is necessary for State enter the word "corn text. You must then State licensure procompletion date, the corrected prior to elements of the Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of computer of the Statement of the Statem	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. & 21, 2015 surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting correction Orders using an umbers have been nota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute of the surveyors findings method of Correction and trection. ARD THE HEADING OF THE	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction This column also includes the find which are in violation of the state after the statement, "This Rule is as evidence by." Following the surfindings are the Suggested Metho Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." liance is of sthe "To order. lings statute not met rection. DING OF TO THIS O DN FOR	

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
		00941	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		-
GOLDEN	LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 302	2 MN State Statute 144.6503 Alzheimer's disease or related disorder train		2 302			6/29/15
	ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503					
	(a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.					
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	This MN Requirements	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION a:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215 H	ADDRESS, CITY, IGHWAY 52 NO ESTER, MN 58			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	facility failed to prov to 4 of 5 employees since April 2014 tha	and document review, the vide required dementia training (E-A, E-B, E-C, E-D) hired at continued to work in the e potential to affect all 40 in the facility.	ng	Corrected		
	Findings Include:					
	employees hired be 2015. E-A (nursing (Registered nurse-I employees' files we training upon hire the facility. However, in training of these for and no information	e manager provided a list of etween April 2014 and May assistant-NA), E-B (NA), E-RN), E-D (RN) new ere reviewed for Dementia nat are still employed by the formation as to Dementia ur employees was requested was provided by facility in a training was received.				
	(SS)-stated demen- an annual basis and stated the annual fa on 10/10/14 and the completed upon hir	p.m. social services tia training was completed or d upon hire at the facility. SS acility training was completed e dementia training that was e was done at Golden Living ast as a component of new on.	- A			
	no documentation i	p.m. SS-A verified there was n the employee files to show received dementia training ility or since then.				
	director of nursing of direct care staff and work with persons of This should at a mi	THOD OF CORRECTION: The designee could in-service their supervisors on how to with dementia type behavior. In the include explanation of and related disorders,	all			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED	
		00941	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S HWAY 52 NC	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	CHESTER WEST	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ige 4	2 302			
	assistance with activities of daily living, problem solving with challenging behaviors and communication skills.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			6/29/15
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to develop plan after completing assessment and ideassistance to meet (R109) identified assessment/s. Findings include: R109 was admitted diagnoses that included aracts, osteoarth degenerative joint of fractures of the lum	and document review, the elop a comprehensive care ng a comprehensive entifying resident needs and needs for 1 of 3 residents shaving assessed needs that ed following the initial I to the facility on 5/5/15 with uded but was not limited to prosis, osteoporosis, disease, and compression abar and thoracic spine with ording to the facility's		Corrected		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO TER, MN 559			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 560	Continued From pa	age 5	2 560			
	R109's admission of dated 5/12/15 indic with a Brief Intervie score of 15, and rem MDS revealed R10 of one staff member ambulation, toileting required extensive member for dressing indicated balance with the transitions and wall with staff assistance wheelchair for mober (CAA's) were triggeneassessment inform care. The CAA's dated 5 areas were included R109's care plan: wheelchair for mober of the triggeneasses were included R109's care plan: wheelchair for mober of the triggeneasses were included R109's care plan: wheelchair for mober of the triggeneasses were included R109's care plan problem of the triggeneasses for the triggeneasses of triggeneasses of the triggeneass	Minimum Data Set (MDS) ated no cognitive impairment ow of Mental Status (BIMS) quired corrective lenses. The 9 required limited assistance or for bed mobility, transfers, g and personal hygiene and assistance of one staffing. The assessment also was not steady during king, and only able to stabilize e and used a walker and sility. Care Area Assessment or dealy living. Care Area Assessment or dealy living and had been completed in risual function, pressure ulcer, of daily living on potential. The rovided by the facility on clude a plan of care that or a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set, and a complete ADL on focus as indicated by the set on 5/21/15, at 10:04 a.m. and the completing a sessment and CAA or equested and not provided in the comprehensive care				
	plan. SUGGESTED MET	THOD OF CORRECTION: The or designee could provide				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED	
				B. WING		
		00941			05/2	21/2015
	PROVIDER OR SUPPLIER	2215 HIGI	HWAY 52 NC	STATE, ZIP CODE DRTH		
GOLDEN	LIVINGCENTER - RO	OCHESTER WEST	ΓER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	tool or checklist for the care plan, and compliance.	olan development, develop a the required components of then perform audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			6/29/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	tho has pressure sores by treatment and services to revent infection, and prevent reloping.				
	by: Based on observation review the facility factor wound assessment for 2 of 3 residents for pressure ulcer.	ent is not met as evidenced on, interview and document alled to complete weekly as for current pressure ulcers (R17, R8) who were reviewed		Corrected		
	Findings include:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 50.25.1.10.1			
		00941	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO FER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 900	Continued From pa	ge 7	2 900			
	admission diagnose	to the facility on 4/2/15, with es of metastatic cancer, on a stage 1 pressure ulcer on				
	dated 4/16/15, indi intact, had moderat care 1-3 days in the required extensive mobility, transfer, d Care Area Assessm	on Minimum Data Set (MDS) cated R17 was cognitively the depression, and rejected to look back period. R17 assistance of two staff for bed ressing and toilet use. The ment (CAA) dated 4/8/15, a stage 1 pressure ulcer, but asurements.				
	indicated: suspecte	nd Assessment was noted and deep tissue injury on hable 2.0 x 0.7 sacrum.				
		admission note dated 4/2/15, ed R17 had a stage one sacral did not provide				
	0.7 sacrum, barrier hours.	kin check stage 1 redness 2 x film applied, turn every two d Assessment indicated a deep at measurements.				
	indicate R17 had a his coccyx 2.0 x 7.0	ssion notes dated 4/3/15, stage one pressure ulcer on centimeters (cm) does have an air mattress on				
	remains reddened continues to be nor	1 sacral pressure ulcer from admission, area n-blanchable. Protection pad prevent breakdown.				

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00941	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO TER, MN 559			
(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) COMPLETE DATE
2 900	Continued From pa	age 8	2 900			
		ent plan of care. Reposition t every 2 hours to prevent				
		3/15 no documentation of twas located nor was it uested from facility.				
	On 4/23/15, a nursing progress note at 10:11 a.m. indicated Seasons Hospice visited today: new orders to discontinue dressing, stage [sic] pressure ulcer on sacral area has resolved.					
	On 4/23/15, note by ulcer, dress with op	y hospice, stage 1 pressure otifoam.				
	From 4/23/15 to 5/7 assessment located	7/15 again no would d or provided.				
	On 5/7/15, a nursing progress note: administration indicated apply optifoam dressing to sacral area, ulcer stage 1, change every 7 days and PRN every day shift every Thursday. Stated get out of my room.					
	visit indicated Skin: ulcer on sacrum is noted some rednes	pice comprehensive nursing s sin intact. Stage 1 pressure healed. Registered nurse (RN) as on the bottom, which was id not have and Optifoam				
	had a pink, non-bla Diligent peri-care is turns and air mattre Braden score is 14 process of complet	ing progress note, eview: indicatedSkin: R17 inchable and fragile skin. is performed with incontinence, ess for skin protection. his , tissue tolerance is in the ion. He need assist with turns ents in wheelchair every 2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/	21/2015
	PROVIDER OR SUPPLIER	OCHESTER WEST 2215	T ADDRESS, CITY, S HIGHWAY 52 NO IESTER, MN 559	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	hours. He was proving mattress and press cushion. He is ence 2 hours to minimize Licensed nurse correctly for the correctly of the sheets, and health who should docume Belle stated, Our ditthe sheets, and I th (The facility was uncheck sheets). On 5-19-15, at 2:22 questioned certified who stated, she did the sheet filled out. daily additional daily. On 5/19/15 -At 2:30 was unclear about ulcer, so it was obs stated, "No open are on coccyx, even on Also the HIC, review hospice was doing admitted to hospice. On 5/21/15, at 3:30 nursing services (Compared to minimize the control of the sheets).	rided a pressure reduction ure reduction wheelchair buraged to repositioned everal risk of skin impairments. Impletes the skin check. CNA sistants) have been educated and reminds the resider to prevent friction and sheel to prevent in the cordinator (HI umentation was not present ated, it should be document to the give a paper to nurse the prevent in the computer. The cordinator (DON) geink she puts them in a book able to produce weekly sking the prevent of the prevent of a pressure that the presence of a pressure that the prevent with RN-A. RN-A area currently, but it remains air bed." Wed hospice notes, because all the baths for R17, since the prevent with the prevent of the prevent o	A's red at ar. C). in ed, ts			
	weekly wound docu	mentation had not been do vas not able to provide any	ne			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	2215 HIGI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 10	2 900			
	additional documentation. The CDNS verified it was the expectation to have weekly skin documentation for all residents.					
	R8's document revi weekly skin evaluat	ew revealed the facility lacked ion.				
	R8 was admitted to the facility on 4/9/15 at 11:15 a.m. with primary diagnoses of acute hypoxic respiratory failure and newly diagnosed metastatic adenocarcinoma [Adenocarcinoma is a type of cancerous tumor that can occur in several parts of the body] additional diagnoses included a prior gluteal pressure ulcer, stage II, and new abrasions/areas of breakdown secondary to prolonged down time. (Comprehensive Review Note dated 4/28/15)					
	Comprehensive Skin Assessment dated 4/9/15 indicated R8 had the following risk factors with a tissue tolerance observation: current ulcer,/history of pressure ulcer, terminal cancer, pulmonary disease with additional risk factors of; resident chooses not to cooperate with repositioning, cognitive impairment, edema of the right upper extremity, and skin issue present on admit. Overall risk for pressure ulcer was rated as high risk.					
	4/16/15 indicated to ulcers. [Stage III present loss. Subcutaneous tendon, or muscle i present but does no loss. May include u Dimensions of unhorm. [length x width]	m Data Set (MDS) dated wo unhealed Stage III pressure essure ulcer defined in The lanual as "Full thickness tissue is fat may be visible but bone, is not exposed. Slough may be of obscure the depth of tissue indermining or tunneling."] ealed: 1.0 cm x 0.8 cm x 0.2 x depth] 14 day MDS				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		00941	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER		l .	STATE, ZIP CODE	1 00/2	1/2010
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NC			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	TER, MN 55	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 11	2 900			
	upon admission.					
	at 12:22 p.m. Press measured by RN-A depth 0.1 cm. Pres measured length 0. stated both were a Wound Evaluation Right gluteal press 4/9/15 Wound Eval pressure with meas width 0.8 cm, depth identified 4/9/15. W (pre-admission). 5/11/15 Wound Eval	Flow Sheet Multiple Weeks: ure ulcer, uation Week 1: right buttock surements of length 1 cm, n 0.2 cm stage III. Wound was found type: pressure ulcer aluation Week 2: Details and				
	depth 0.2 cm. 5/15/15 Wound Eva	gth 1.2 cm, width 2.6 cm, aluation Week 3: Details and gth 2.0 cm, width 0.9 cm,				
	pressure with meas width 1 cm, and de was identified 4/9/1 (pre-admission). 5/11/15 Wound Eva Measurements; len depth 0.3 cm. 5/15/15 Wound Eva	uation Week 1: left buttock surements of length 0.5 cm, pth 0.1 cm stage III. Wound 5. Wound type: pressure ulcer aluation Week 2: Details and 19th 0.7 cm, width 0.9 cm, aluation Week 3: Details and 19th 0 cm, width 0 cm, depth 0				
	May 2015 revealed gluteal pressure uld	tration Record for April and treatments to right and left cers as ordered, but no nonitoring the pressure ulcer				

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AND DIAN OF CODDECTION IN IDENTIFICATION NUMBER.		, ,	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN	J		
		00941	B. WING		05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY	, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HIGHWAY 52 N HESTER, MN 5			
(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 ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	age 12	2 900			
	sites.					
	dressing changes a [treatment administ measurements RN of Nursing Services On 5/21/15 at 3:03 wound documentate the only documentate documentation betwo 5/11/15. "It's probate available. I informe month ago but they On 5/21/15 at 3:33 was asked about the service of the servic	1 a.m. RN-B was asked whare documented, "In the Tatration record]" regarding -B stated, "The DNS [Directs] had been going that wee p.m. RN-A verified that the tion provided to surveyor wation available with no ween the dates of 4/9/15 at ably the only information that d them that is was missing a did not do anything about p.m. RN-C, facility consult the expectation of how ofter contation accurred.	AR stor kly." as ad at is a it."			
	stated, "At least we Skin Integrity Guide	·				
	Page 1: "DNS [director of rwill be responsible skin integrity progration a weekly basis." Page 2: "Documentation of Evaluation/Observaresponsible for perevaluation/observa Weekly Skin Reviet assessment]. Licer weekly on identified Evaluation Flow Shidentified)." Page 3: "Monitoring Complete Skin Reviet assessment].	nursing services] or designer to implement and monitor am. Wound status is monite f Weekly Skin ations: Licensed nurse will	the bred be und			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00941	B. WING		05/2	21/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - RO	CHESTER WEST	HWAY 52 NO			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 13	2 900			
	UDA's are in place,	ideline: Weekly Skin Review DNS or designee wounds on a weekly basis."				
	The Director of Nur the facility's current to pressure ulcer m Nursing or designe	THOD OF CORRECTION: sing or designee could review policy and procedure related onitoring. The Director of e could develop a system to with pressure ulcer				
	TIME OF PERIOD one (21) days.	FOR CORRECTION: Twenty				
21390	MN Rule 4658.080	Subp. 4 A-I Infection Control	21390			6/29/15
	control program mu procedures which p A. surveillance	and procedures. The infection ust include policies and provide for the following: based on systematic data or nosocomial infections in				
	control of outbreaks C. isolation and reduce risk of trans	detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection				
	E. a resident himmunization progridefined in part 465 procedures of residing the prevention and F. the development of the practices, including defined in part 4656	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815;				
	G. a system fo	r reviewing antibiotic use;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2)			(X3) DATE SURVEY COMPLETED				
		00941		B. WING		05/2	21/2015		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u>,ı </u>			
	2215 HIGHWAY 52 NORTH								
GOLDEN	N LIVINGCENTER - RO	CHESTER WEST	ROCHEST	TER, MN 559	901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21390	Continued From pa	ge 14		21390					
	H. a system for products which affe disinfectants, antise incontinence product. I. methods for its distance of the system of th	review and evaluatio ect infection control, su eptics, gloves, and	uch as ss of						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure multi-resident use glucometers were disinfected between uses for 3 of 3 residents (R1, R46, R21) reviewed for blood glucose monitoring.			Corrected					
	Findings include:								
	On 5/21/15, at 11:42 a.m. The licensed practical nurse (LPN)-A was observed for a blood glucose (BG) test and BG meter disinfection. After completing the BG test, LPN-A returned to the medication cart (where BG meter was stored), and set the used BG meter directly on top of the medication cart, LPN-A then opened the medication cart and put the used (soiled) meter into the carrier and removed her gloves. LPN-A started to put the carrier with the used meter into the bottom drawer, but was interrupted by the surveyor to ask about disinfecting the BG Meter. LPN-A stated, "When we don't have the cleaner we use alcohol pads." When asked if alcohol killed hepatitis C or other contagious disease, LPN-A replied "No it does not." LPN-A further stated the facility had been "out of the (disinfecting) wipes since last week." LPN-A was asked how she would access wipes or supplies when out, LPN-A stated the nurse would "give supply orders to charge nurse, and she does the ordering." LPN-A stated the South BG meter,								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00941		B. WING		05/21/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	_	
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO TER, MN 559			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 15	21390			
	was shared betwee and R46.	n three residents, R1, R21,				
		ed for R1, R21, and R46, no s were listed in the admission				
	On 5/21/15 at 11:50, the health information coordinator (HIC) stated she usually orders, and she was not aware the disinfecting wipes were out of stock. The registered nurse/charge nurse (RN)-A stated she had "ordered supplies on Tuesday, and the supplies should be in today." At 11:58 staff went and found supplies, the facility used Medline micro (bactericidal, viralsidal,etc) disinfecting wipes. The disinfecting wipes were in supply within the facility, but had not been put on the medication cart. The RN-A stated she had not been told the cart lacked bleach (disinfecting) wipes. At 12:10 The Consultant DNS stated she expected the glucometers to be cleaned with bleach wipes R1 was admitted to the facility on 12/8/14 with admission diagnoses of paranoid schizophrenia and diabetes mellitus type II (DMII). R1 had physician orders dated 5/1/15, for BG test before meals and at bedtime (four times a day), and was potentially at risk for transferred contagious disease four times a day, when the BG meter was not properly disinfected.					
	R21 was admitted to the facility 11/8/12, with admission diagnoses of epilepsy, disorder of the intestines, protein calorie malnutrition, disorders of mitochondria metabolism, and DMII. R21 had physician orders dated 5/1/15, for for BG four times a day, and was potentially at risk for transferred contagious disease four times a day, when the BG meter was not properly disinfected.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
		7. BOLDING.				
00941		B. WING		05/2	21/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	HWAY 52 NO TER, MN 559			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
21390	Continued From pa	ige 16	21390			
	admission diagnose pulmonary disease R46 had physician test twice a day, and transferred contaginate BG meter was a The Blood Glucose policy dated 12/1/14 that is EPA register	to the facility 8/8/14 with es of chronic obstructive (COPD), dementia and DMII. orders dated 5/1/15, for BG and was potentially at risk for ous disease twice a day, when not properly disinfected. Monitor Decontamination 4, directed staff to use a wipe ed as tuberculocidal, effective and a broad spectrum of				
	The Equipment and Supplies for Administering Medications Policy dated November 2011, directed the charge nurse on duty ensures that equipment and supplies relating to medication administration are clean and orderlyThe charge nurse is notified if supplies are inadequate or equipment fails to work properly. The charge nurse reports equipment and supply deficiencies to the director of nursing.					
	SUGGESTED METHOD OF CORRECTION: The nursing director could inservice all staff responsible for glucose monitoring on the steps to sanitize the glucometer after each use according to the policy.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			6/29/15
		e provider must establish and nensive tuberculosis				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00941		B. WING		05/21/2015		
	PROVIDER OR SUPPLIER	2215 HIGH	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	TER, MN 55			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	ogram according to the most infection control guidelines distates Centers for Disease attion (CDC), Division of the pattern attion, as published in CDC's ality Weekly Report (MMWR). Include a tuberculosis and that covers all paid and contractors, students, interest. The Department of the technical assistance and the guidelines.	21426			
	by: Based on interview facility failed to ens test (TST) was com (R17) who was new to ensure 1 of 6 resinterpretation was in Tuberculosis Scree Findings included: R17 was admitted the medical record reversements of the screening Tool for addition it was reverse tep TST on 4/2/15 millimeters (mm) won 4/4/15. During for revealed the medical record reverse terms on the screening to the screening t	and document review, the ure a two step tuberculin skin apleted for 1 of 6 residents by admitted. In addition failed sidents (R61) TST induration acclude reviewed for ning State regulations. To the facility on 4/2/15. The ealed the Baseline TB Residents on the same day. In aled R17 had received the first, and results were read as 0 ith a "Negative" interpretation arther document review, it was all record lacked evidence R17 econd step TST as the column		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00941	B. WING		05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	•	
GOLDEN	I LIVINGCENTER - RO	OCHESTER WEST	GHWAY 52 NC STER, MN 55			
(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)	JLD BE	(X5) COMPLETE DATE
21426	Continued From pa	age 18	21426			
	was left blank.					
	medical record indi of her TST on 4/4/1 as 0 mm with a "Ne reading - on 4/6/15 second step TST o	to the facility on 4/4/15. R61's cted she received the first stells, and the results were read egative" interpretation of . R61 then received the in 4/20/15, results were read m but lacked documentation of .	q			
	On 5/20/15, at 12:16 p.m. the consultant registered nurse provided the original Baseline TB Screening Tool for Nursing Home and Boarding Care Home Resident which only indicated R17 had only received the first step TST. At 12:28 p.m. the consultant registered nurse stated R17 had not received the second step TST.					
	On 5/20/15, at 12:50 p.m. the director of nursing (DON) stated, "Looks like it was missed. I have to go through hospice to find out if they have other records." When asked who was responsible to ensure the records were complete, accurate and had received required TB screening DON stated "Me."		o I			
	reviewed 12/01/201 documented negation determine if TB present within the previous baseline (two step) upon admission. If follow-up TST will bafter the initial test	ening Resident for policy 14, read, "Any resident without ive TST, BAMT [another test esent] or CXR [chest ex ray] 12 months will receive a TST or (one-step) BAMT the first TST is negative, a be administered 1 to 3 weeks is read" THOD OF CORRECTION: The	10			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND I EAN OF CONNECTION IDENTIFICATION NOWIDEN.		A. BUILDING:		OOWII L		
		00941	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER - RO	K HESTER WEST	HWAY 52 NO ΓER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 19	21426			
	responsible for TB of MDH.	control on the protocol from				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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