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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M7V2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**
2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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

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

6. DATE OF SURVEY **08/14/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 08/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

Please contact me if you have any questions.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

Sincerely,

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245306	A. Building B. Wing	8/14/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**08/14/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GPN/kfd	**Date:** 08/21/2015	**Signature of Surveyor:** 34985	**Date:** 08/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/21/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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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

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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
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	(Y2) Multiple Construction	(Y3) Date of Revisit
00941	A. Building B. Wing	8/14/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. :** LSC	**08/14/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	08/21/2015	34985	08/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/21/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: M7V2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**
2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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

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

6. DATE OF SURVEY **07/23/20155** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 08/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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.

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/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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/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

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245306	A. Building B. Wing	7/23/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	06/30/2015	ID Prefix F0441 Reg. # 483.65 LSC	06/30/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	08/04/2015	34083	07/23/2015
CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/21/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	R 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on July 23, 2015. The certification tags that were corrected can be found on the CMS2567B. Also one tag had not been found to be found corrected at the time of this onsite PCR. The citation will be found on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive weekly skin assessments to	{F 314}	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of	8/11/15

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

Electronically Signed | 08/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 1 determine if current skin interventions are effective to promote healing and prevent further pressure ulcers from developing for 3 of 3 residents (R5, R117, & R150) who currently had pressure ulcers. Findings Include: R5 was admitted to the facility on 11/18/14 with diagnoses to include, but not limited to; chronic pain, multiple sclerosis, and pressure ulcer on the buttock according to the admission sheet. R5's quarterly Minimum Data Set (MDS), dated 4/10/15, indicated R5 was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. This MDS also included an unstageable pressure ulcer with measurements of 2.4 centimeters (cm) x 0.9 cm. Review of R5's physician orders included an orders for weekly skin assessment on Thursday morning. R5's Treatment Administration Record (TAR) revealed the following order: "Right and left gluteal fold: cleanse with NS [normal saline], pat dry, apply moistened Promogran Prisma [medicated dressing] to wound bed, apply barrier product to surrounding wound area, allow to dry. Cover with Nu-Derm [dressing] border. Change every other day. In the morning on odd days related to pressure ulcer buttock." All skin monitoring starting from 6/30/15 through 7/23/15 was requested. The following was provided or found in the electronic medical record.	{F 314}	Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility¿s credible allegation of compliance. F314 -Weekly skin assessments are being completed for R5. Identified alterations in skin integrity are being measured weekly. Wound measurements have been obtained and are being documented on wound consult report for R150. Wound is being measured weekly at wound specialty clinic. Facility staff have been directed by wound clinic to not remove dressing applied at wound clinic unless dressing becomes saturated. R117 has	

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{F 314}	Continued From page 2 R5's weekly skin assessment completed on 7/16/15 indicated R5 had open areas on the right and left buttock. No measurements were included. No other skin assessments were found or provided for R5 upon request. R117 was admitted to the facility on 6/17/15 with diagnoses to include, but not limited to; broken joint prosthetic joint implant found on the admission form. R117's 14 day MDS, dated 7/1/15, indicated R117 was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. This MDS also included an unhealed stage II pressure ulcer which did not include measurements. The State Operations Manual defines a Stage II pressure ulcer as "partial thickness loss of dermis presenting as a shallow open ulcer with red-pink wound bed." Review of R117's physician orders included a weekly skin assessment on Monday morning and orders for Stage 2 ulcer to include Mepilex border (medicated dressing) change every 3 days and as needed (PRN) for skin breakdown. R117's TAR documentation included weekly skin review to be completed. All skin monitoring starting from 6/30/15 through 7/23/15 had been requested and the following was provided and directed to check the electronic medical record.	{F 314}	discharged from the facility. -Residents with altered skin integrity have the potential to be affected if weekly wound assessments are not completed. -Licensed staff responsible for weekly skin assessments and wound monitoring have been educated on requirements for completion and documentation of weekly skin and wound assessments. -Audits will be conducted twice weekly to affirm that weekly skin assessments are being completed and identified areas of concern with skin integrity are being properly measured and documented weekly. Negative outcomes will be addressed immediately. Results will be reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed by 8/11/15.	

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{F 314}	Continued From page 3 R117's Weekly Skin Assessment completed on 7/20/15 indicated R117 had a "1 cm skin tear on left outer calf. Resident states she scratched her leg when it occurred. Skin pulled across and intact. Resident has 2 scratches on right cheek. Reports scratching." However, no measurements or notes of a pressure ulcer were located or provided. R117's Bath Sheet and Skin Assessment CNA[certified nurse assistant]/Nurses, dated 7/20/15, were reviewed and revealed erythema (redness) in the groin and coccyx area, a surgical skin alteration on the left upper leg, and old bruising on the lower left leg. Again a lack of wound measurements were included or provided when requested. No other skin assessments were found or provided for R117 upon request from facility. R150 was admitted to the facility on 7/6/15 with diagnoses to include, but not limited to, delirium, dysthymic disorder, and pneumonia which were located on the admission form. R150's admission MDS, dated 7/13/15, revealed R150 was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. The MDS also indicated R150 had a stage I pressure ulcer and an unhealed stage III or IV pressure ulcer with measurements of 3 cm x 3 cm. The State Operations Manual defines a stage I pressure ulcer "an observable, pressure-related alteration of intact skin", stage III as "full thickness tissue loss." and a stage IV as "full thickness tissue loss with exposed bone, tendon, or muscle."	{F 314}		

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{F 314}	Continued From page 4 Review of R150's physician orders included a weekly skin assessment on Monday morning and Isodosorb Gel 0.9% [wound cleanser] apply to right heel ulcer, cleanse with saline apply 50:50 Isodosorb and curisol to wound, cover with tegaderm silicone foam dressing and change daily. All skin monitoring starting from admission date until 7/23/15 was requested. The following was provided or found in the electronic medical record. Weekly Skin Assessments dated: 7/22/15 in progress was the computer message but no information completed. 7/20/15 "Previously documented pressure ulcer to right heel." No measurements included. 7/13/15 "Open areas on abdomen, knee, calf, shin and heel of rle [right lower extremity]. Dressings being completed as ordered. No irritation around pej tube. Open area to coccyx." Again no measurements were completed. 7/6/15 read, "Unstageable pressure ulcer [stage IV], Isodosorb/hydrogel mepiborder. 3.5 x 1.8 cm. Full thick serosanguineous [blood/serum mix] dressing 85% granulating with 15% fibrinous. Aquacel AG covered with mepiborder 2.5 x .3 cm. Right lower extremity scab. 4 x 1.8 cm right upper 2/5 x 3 cm. Mepilite border." No other skin assessments were found or provided for R150 upon requesting them from the facility. On 7/23/15 at 12:13 p.m. the director of nursing (DON) was asked where weekly skin assessments are located especially for R5, R117,	{F 314}		

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{F 314}	Continued From page 5 & R150. The DON stated, "It is a new system to do them electronically. We are doing them once a week with a shower sheet. The nurses would notify higher level management of concerns." The DON verified weekly skin assessments were not completed for R5, R117, & R150. The DON reviewed the electronic medical record (Point Click Care) with surveyors then said, "I will have to dig through the paperwork in my office to find the shower sheets." The DON stated she knew they were not in compliance with their written plan of correction in regards to F314 which had been issued on the survey exited 5/21/15. DON said, "A wound should be monitored weekly with measurements to see if it is healing." Again the DON verified the current weekly skin assessments did not contain measurements and healing status for R5, R117, & R150. On 7/23/15 at 12:30 p.m. the DON delivered Bath Sheet and Skin Assessment CNA/Nurses form that was completed on the resident's shower days. The DON verified there were no wound measurements or assessed status of wounds located on these forms. DON then said to surveyor, "I know that is not good enough [in reference to meeting the minimum requirement for F314]." On 7/23/15 at 12:59 p.m. registered nurse (RN)-A, charge nurse, was asked who is responsible for completing the weekly skin assessments and what does the weekly skin assessment consist of, and who would be notified of changes. RN-A said, "Should be nurses when the resident is given a bath. The CNA [certified nursing assistant] will give the nurses the bath sheet and the nurse will go do a complete head to toe skin check. Checking all over, if there is a	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 6 new skin issue to notify me [RN-A] or DON and to document in the PCC (Point Click Care). As of plan of correction we expect to measure wounds when they are completing weekly skin assessment." RN-A then stated the DON receives the completed forms to review. On 7/23/15 at 1:25 p.m. the DON was asked who reviews skin assessments. DON stated, "They go to the ADON (assistant director of nursing), who is absent right now. Currently they come to me and I review the next day. We have the skin assessment sheet, double check if it has been transcribed in PCC as the weekly skin review, if it has not then we track down the nurse and have them complete." The DON was asked how they are ensuring the plan of correction is being followed and stated, "The ADON was completing audits because I was out. The weekly skin assessment is how we are making sure the plan of correction is being followed. Pressure ulcers I have been following, I have been relearning residents due to being absent for a bit." On 7/23/15 at 1:48 p.m. RN-B was asked who is responsible for completing the weekly skin assessments, what does the weekly skin assessment consist of, and who would be notified of changes. RN-B stated, "Skin assessments are scheduled on shower days, they [CNAs] pop in and tell me when the resident is in the shower or I will do it when they are back in their room. I give the bath sheet to the aide and add my stuff to it. I enter it into the computer and then I recycle the sheets." RN-B was asked about [reference to wound/s especially pressure ulcer/s] measurements. If it is a new open area I will. There is a process with old areas that the DON or ADON that they will be reviewing the old wounds,	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 7 they will be completing the measuring of existing ones. I measure the new ones and they follow up after. It's an ongoing process we are just trying to figure who does what." Policy/Document #CLIN513 Weekly Skin Review UDA(user defined assessments), dated 5/13/15 read, "Steps for completion... If an alteration is identified-dry, rash, redness, skin tear, blisters or other-the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each alteration identified. MD[medical doctor]/NP[nurse practitioner] are to be notified of any skin alterations, as well as the resident/patient and his/her responsible party." Golden Living Services, Skin Integrity Guideline, undated. Page 2 Documentation of Weekly Skin Evaluation/Observations read, "Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review UDA Licensed nurse to document weekly on identified wound using Wound Evaluation Flow Sheet UDA (one UDA per wound identified)"	{F 314}		

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

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

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
00941	A. Building B. Wing	7/23/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **06/30/2015**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **06/30/2015**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **06/30/2015**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **06/30/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/21/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	R 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****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 the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on July 23, 2015. During this onsite visit it was determined that the following corrections orders/s # 0900 had not been corrected. This uncorrected order will remain in effect and will be reviewed at the next onsite visit and will be reviewed for possible penalty assessment.	{2 000}	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 | 08/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	R 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	{2 900}		8/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	R 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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{2 900}	Continued From page 2 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview, and document review the facility failed to complete comprehensive weekly skin assessments to determine if current skin interventions are effective to promote healing and prevent further pressure ulcers from developing for 3 of 3 residents (R5, R117, & R150) who currently had pressure ulcers. Findings Include: R5 was admitted to the facility on 11/18/14 with diagnoses to include, but not limited to; chronic pain, multiple sclerosis, and pressure ulcer on the buttock according to the admission sheet. R5's quarterly Minimum Data Set (MDS), dated 4/10/15, indicated R5 was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. This MDS also included an unstageable pressure ulcer with measurements of 2.4 centimeters (cm) x 0.9 cm. Review of R5's physician orders included an orders for weekly skin assessment on Thursday morning. R5's Treatment Administration Record (TAR)	{2 900}	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility¿s credible allegation of compliance. F314	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	R 07/23/2015

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{2 900}	Continued From page 3 revealed the following order: "Right and left gluteal fold: cleanse with NS [normal saline], pat dry, apply moistened Promogran Prisma [medicated dressing] to wound bed, apply barrier product to surrounding wound area, allow to dry. Cover with Nu-Derm [dressing] border. Change every other day. In the morning on odd days related to pressure ulcer buttock." All skin monitoring starting from 6/30/15 through 7/23/15 was requested. The following was provided or found in the electronic medical record. R5's weekly skin assessment completed on 7/16/15 indicated R5 had open areas on the right and left buttock. No measurements were included. No other skin assessments were found or provided for R5 upon request. R117 was admitted to the facility on 6/17/15 with diagnoses to include, but not limited to; broken joint prosthetic joint implant found on the admission form. R117's 14 day MDS, dated 7/1/15, indicated R117 was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. This MDS also included an unhealed stage II pressure ulcer which did not include measurements. The State Operations Manual defines a Stage II pressure ulcer as "partial thickness loss of dermis presenting as a shallow open ulcer with red-pink wound bed." Review of R117's physician orders included a weekly skin assessment on Monday morning and	{2 900}	-Weekly skin assessments are being completed for R5. Identified alterations in skin integrity are being measured weekly. Wound measurements have been obtained and are being documented on wound consult report for R150. Wound is being measured weekly at wound specialty clinic. Facility staff have been directed by wound clinic to not remove dressing applied at wound clinic unless dressing becomes saturated. R117 has discharged from the facility. -Residents with altered skin integrity have the potential to be affected if weekly wound assessments are not completed. -Licensed staff responsible for weekly skin assessments and wound monitoring have been educated on requirements for completion and documentation of weekly skin and wound assessments. -Audits will be conducted twice weekly to affirm that weekly skin assessments are being completed and identified areas of concern with skin integrity are being properly measured and documented weekly. Negative outcomes will be addressed immediately. Results will be reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed by 8/11/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 900}	Continued From page 4 orders for Stage 2 ulcer to include Mepilex border (medicated dressing) change every 3 days and as needed (PRN) for skin breakdown. R117's TAR documentation included weekly skin review to be completed. All skin monitoring starting from 6/30/15 through 7/23/15 had been requested and the following was provided and directed to check the electronic medical record. R117's Weekly Skin Assessment completed on 7/20/15 indicated R117 had a "1 cm skin tear on left outer calf. Resident states she scratched her leg when it occurred. Skin pulled across and intact. Resident has 2 scratches on right cheek. Reports scratching." However, no measurements or notes of a pressure ulcer were located or provided. R117's Bath Sheet and Skin Assessment CNA[certified nurse assistant]/Nurses, dated 7/20/15, were reviewed and revealed erythema (redness) in the groin and coccyx area, a surgical skin alteration on the left upper leg, and old bruising on the lower left leg. Again a lack of wound measurements were included or provided when requested. No other skin assessments were found or provided for R117 upon request from facility. R150 was admitted to the facility on 7/6/15 with diagnoses to include, but not limited to, delirium, dysthymic disorder, and pneumonia which were located on the admission form. R150's admission MDS, dated 7/13/15, revealed R150 was cognitively intact and required	{2 900}		

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{2 900}	Continued From page 5 extensive assistance of two staff for bed mobility, transfer, dressing, and toilet use. The MDS also indicated R150 had a stage I pressure ulcer and an unhealed stage III or IV pressure ulcer with measurements of 3 cm x 3 cm. The State Operations Manual defines a stage I pressure ulcer "an observable, pressure-related alteration of intact skin", stage III as "full thickness tissue loss." and a stage IV as "full thickness tissue loss with exposed bone, tendon, or muscle." Review of R150's physician orders included a weekly skin assessment on Monday morning and Isodosorb Gel 0.9% [wound cleanser] apply to right heel ulcer, cleanse with saline apply 50:50 Isodosorb and curisol to wound, cover with tegaderm silicone foam dressing and change daily. All skin monitoring starting from admission date until 7/23/15 was requested. The following was provided or found in the electronic medical record. Weekly Skin Assessments dated: 7/22/15 in progress was the computer message but no information completed. 7/20/15 "Previously documented pressure ulcer to right heel." No measurements included. 7/13/15 "Open areas on abdomen, knee, calf, shin and heel of rle [right lower extremity]. Dressings being completed as ordered. No irritation around pej tube. Open area to coccyx." Again no measurements were completed. 7/6/15 read, "Unstageable pressure ulcer [stage IV], Isodosorb/hydrogel mepiborder. 3.5 x 1.8 cm. Full thick serosanguineous [blood/serum mix] dressing 85% granulating with 15% fibrinous. Aquacel AG covered with mepiborder 2.5 x .3 cm. Right lower extremity scab. 4 x 1.8 cm right upper	{2 900}		

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{2 900}	Continued From page 6 2/5 x 3 cm. Mepilite border." No other skin assessments were found or provided for R150 upon requesting them from the facility. On 7/23/15 at 12:13 p.m. the director of nursing (DON) was asked where weekly skin assessments are located especially for R5, R117, & R150. The DON stated, "It is a new system to do them electronically. We are doing them once a week with a shower sheet. The nurses would notify higher level management of concerns." The DON verified weekly skin assessments were not completed for R5, R117, & R150. The DON reviewed the electronic medical record (Point Click Care) with surveyors then said, "I will have to dig through the paperwork in my office to find the shower sheets." The DON stated she knew they were not in compliance with their written plan of correction in regards to F314 which had been issued on the survey exited 5/21/15. DON said, "A wound should be monitored weekly with measurements to see if it is healing." Again the DON verified the current weekly skin assessments did not contain measurements and healing status for R5, R117, & R150. On 7/23/15 at 12:30 p.m. the DON delivered Bath Sheet and Skin Assessment CNA/Nurses form that was completed on the resident's shower days. The DON verified there were no wound measurements or assessed status of wounds located on these forms. DON then said to surveyor, "I know that is not good enough [in reference to meeting the minimum requirement for F314]." On 7/23/15 at 12:59 p.m. registered nurse (RN)-A, charge nurse, was asked who is	{2 900}		

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{2 900}	Continued From page 7	{2 900}		

responsible for completing the weekly skin assessments and what does the weekly skin assessment consist of, and who would be notified of changes. RN-A said, "Should be nurses when the resident is given a bath. The CNA [certified nursing assistant] will give the nurses the bath sheet and the nurse will go do a complete head to toe skin check. Checking all over, if there is a new skin issue to notify me [RN-A] or DON and to document in the PCC (Point Click Care). As of plan of correction we expect to measure wounds when they are completing weekly skin assessment." RN-A then stated the DON receives the completed forms to review.

On 7/23/15 at 1:25 p.m. the DON was asked who reviews skin assessments. DON stated, "They go to the ADON (assistant director of nursing), who is absent right now. Currently they come to me and I review the next day. We have the skin assessment sheet, double check if it has been transcribed in PCC as the weekly skin review, if it has not then we track down the nurse and have them complete." The DON was asked how they are ensuring the plan of correction is being followed and stated, "The ADON was completing audits because I was out. The weekly skin assessment is how we are making sure the plan of correction is being followed. Pressure ulcers I have been following, I have been relearning residents due to being absent for a bit."

On 7/23/15 at 1:48 p.m. RN-B was asked who is responsible for completing the weekly skin assessments, what does the weekly skin assessment consist of, and who would be notified of changes. RN-B stated, "Skin assessments are scheduled on shower days, they [CNAs] pop in and tell me when the resident is in the shower or I will do it when they are back in their room. I give

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{2 900}	Continued From page 8 the bath sheet to the aide and add my stuff to it. I enter it into the computer and then I recycle the sheets." RN-B was asked about [reference to wound/s especially pressure ulcer/s] measurements. If it is a new open area I will. There is a process with old areas that the DON or ADON that they will be reviewing the old wounds, they will be completing the measuring of existing ones. I measure the new ones and they follow up after. It's an ongoing process we are just trying to figure who does what." Policy/Document #CLIN513 Weekly Skin Review UDA(user defined assessments), dated 5/13/15 read, "Steps for completion... If an alteration is identified-dry, rash, redness, skin tear, blisters or other-the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each alteration identified. MD[medical doctor]/NP[nurse practitioner] are to be notified of any skin alterations, as well as the resident/patient and his/her responsible party." Golden Living Services, Skin Integrity Guideline, undated. Page 2 Documentation of Weekly Skin Evaluation/Observations read, "Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review UDA Licensed nurse to document weekly on identified wound using Wound Evaluation Flow Sheet UDA (one UDA per wound identified)" This uncorrected order will remain in effect and	{2 900}		

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{2 900}	Continued From page 9 will be reviewed at the next onsite visit. Also this uncorrected order will be reviewed for possible penalty assessment.	{2 900}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: M7V2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245306**
2.STATE VENDOR OR MEDICAID NO.
(L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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

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

6. DATE OF SURVEY **05/21/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 06/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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/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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/30/15

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

Electronically Signed | 06/19/2015

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan after completing a comprehensive assessment and identifying resident needs and assistance to meet needs for 1 of 3 residents (R109) identified as having assessed needs that were not care planed following the initial assessment/s. Findings include: R109 was admitted to the facility on 5/5/15 with diagnoses that included but was not limited to cataracts, osteoarthrosis, osteoporosis, degenerative joint disease, and compression fractures of the lumbar and thoracic spine with disk protrusion according to the facility's admission record. R109's admission Minimum Data Set (MDS) dated 5/12/15 indicated no cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 15, and required corrective lenses. The MDS revealed R109 required limited assistance of one staff member for bed mobility, transfers, ambulation, toileting and personal hygiene and required extensive assistance of one staff member for dressing. The assessment also indicated balance was not steady during transitions and walking, and only able to stabilize with staff assistance and used a walker and wheelchair for mobility. Care Area Assessment (CAA's) were triggered based off of the MDS assessment information that required a plan of care. The CAA's dated 5/17/15 indicated the following areas were included and had been completed in R109's care plan: visual function, pressure ulcer, and ADL (activities of daily living)	F 279	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility¿s credible allegation of compliance. F279 -Comprehensive care plan has been developed for R109 to address assessed needs and assistance to meet needs. -All residents have the potential to be affected if assessed needs are not care planned.	

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F 279	Continued From page 2 function/rehabilitation potential. R109's care plan provided by the facility on 5/21/15 failed to include a plan of care that included individualized goals and interventions for vision, pressure ulcer, and a complete ADL function/rehabilitation focus as indicated by the CAAs dated 5/17/15. The care plan did not include ADL's of bed mobility, dressing, toilet use, and personal hygiene. During an interview on 5/21/15, at 10:04 a.m. registered nurse (RN)-C confirmed care plan was not fully developed after completing a comprehensive assessment and CAA information. Facility policy was requested and not provided in regards to completing the comprehensive care plan.	F 279	-RNAC has been educated on care planning assessed needs and assistance to meet needs. -Random audits on 50 per cent of new admits for the next 30 days, then 25 per cent of new admits for the next six months to ensure care plans are developed to address assessed needs and assistance to meet needs. These audits will be conducted within 72 hours of admission. Negative outcomes will be addressed immediately. Results will be reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed by 6/30/15.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete weekly wound assessments for current pressure ulcers for 2 of 3 residents (R17, R8) who were reviewed for pressure ulcer.	F 314	F314 -Weekly wound assessments have been completed for R8 and R17. -Residents with wounds have the potential	6/30/15

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F 314	Continued From page 3 Findings include: R17 was admitted to the facility on 4/2/15, with admission diagnoses of metastatic cancer, on palliative care, with a stage 1 pressure ulcer on the coccyx. The 5 day admission Minimum Data Set (MDS) dated 4/16/15, indicated R17 was cognitively intact, had moderate depression, and rejected care 1-3 days in the look back period. R17 required extensive assistance of two staff for bed mobility, transfer, dressing and toilet use. The Care Area Assessment (CAA) dated 4/8/15, indicated R17 had a stage 1 pressure ulcer, but did not provide measurements. On 4/2/15, A Wound Assessment was noted and indicated: suspected deep tissue injury on sacrum, non blanchable 2.0 x 0.7 sacrum. The facility nursing admission note dated 4/2/15, at 4:31 p.m. indicated R17 had a stage one sacral pressure ulcer, but did not provide measurements. On 4/2/15 weekly skin check stage 1 redness 2 x 0.7 sacrum, barrier film applied, turn every two hours. On 4/2/15 a Wound Assessment indicated a deep tissue injury, without measurements. The Hospice admission notes dated 4/3/15, indicate R17 had a stage one pressure ulcer on his coccyx 2.0 x 7.0 centimeters (cm) non-blanchable. He does have an air mattress on his bed.	F 314	to be affected if weekly wound assessments are not completed. -Licensed staff responsible for wound monitoring have been educated on requirements for wound assessments and documentation. -Audits of 25 percent of wound assessments and documentation will be conducted weekly. Negative outcomes will be addressed immediately. Results will be reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed by 6/30/15.	

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F 314	Continued From page 4 On 4-7-15, a stage 1 sacral pressure ulcer remains reddened from admission, area continues to be non-blanchable. Protection pad applied to bottom to prevent breakdown. Continue with current plan of care. Reposition and off loaded least every 2 hours to prevent breakdown. From 4/7/15 to 4/23/15 no documentation of wound assessment was located nor was it provided when requested 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 hospice, stage 1 pressure ulcer, dress with optifoam. From 4/23/15 to 5/7/15 again no would assessment located 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. On 5/8/15, the hospice comprehensive nursing visit indicated Skin: sin intact. Stage 1 pressure ulcer on sacrum is healed. Registered nurse (RN) noted some redness on the bottom, which was blanchable. R17 did not have and Optifoam dressing in place. On 5/13/15, a nursing progress note, Comprehensive Review: indicated ....Skin: R17 had a pink, non-blanchable and fragile skin.	F 314		

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F 314	Continued From page 5 Diligent peri-care is performed with incontinence, turns and air mattress for skin protection. his Braden score is 14, tissue tolerance is in the process of completion. He need assist with turns in bed and adjustments in wheelchair every 2 hours. He was provided a pressure reduction mattress and pressure reduction wheelchair cushion. He is encouraged to repositioned every 2 hours to minimize risk of skin impairments. Licensed nurse completes the skin check. CNA's (certified nursing assistants) have been educated on checking skin daily and reminds the resident of proper technique to prevent friction and shear. On 5/19/15 at 2:10 p.m. weekly wound (dated 4/2/15) and wound documentation (4/2/15, 4/23/15) were reviewed with registered nurse (RN)-A, and health information coordinator (HIC). Weekly wound documentation was not present in computer, RN-A stated, it should be documented, the aides give bath, then give a paper to nurse who should document in the computer. Belle stated, Our director of nursing (DON) gets the sheets, and I think she puts them in a book. (The facility was unable to produce weekly skin check sheets). On 5-19-15, at 2:22 p.m. RN-A stated she had questioned certified nursing assistant (CNA)-A who stated, she did not know she should have the sheet filled out. RN-A was unable to locate daily additional daily skin check sheets. On 5/19/15 -At 2:30 p.m. the chart documentation was unclear about the presence of a pressure ulcer, so it was observed with RN-A. RN-A stated, "No open area currently, but it remains red on coccyx, even on air bed." Also the HIC, reviewed hospice notes, because hospice was doing all the baths for R17, since	F 314		

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F 314	Continued From page 6 admitted to hospice on 5/3/15. On 5/21/15, at 3:30 p.m. the consultant director of nursing services (CDNS), was not aware that weekly wound documentation had not been done for residents, and was not able to provide any additional documentation. The CDNS verified it was the expectation to have weekly skin documentation for all residents. R8's document review revealed the facility lacked weekly skin evaluation. 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. Admission Minimum Data Set (MDS) dated 4/16/15 indicated two unhealed Stage III pressure ulcers.[Stage III pressure ulcer defined in The State Operations Manual as "Full thickness tissue loss. Subcutaneous fat may be visible but bone,	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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F 314	Continued From page 7 tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling."] Dimensions of unhealed: 1.0 cm x 0.8 cm x 0.2 cm. [length x width x depth] 14 day MDS indicated two stage III pressure ulcers present upon admission. R8's dressing change was observed on 5/21/15 at 12:22 p.m. Pressure ulcer on the right gluteal measured by RN-A, length 2.4 cm, width 1.3 cm, depth 0.1 cm. Pressure ulcer on the left gluteal measured length 0.3 cm , width 0.4 cm. RN-A stated both were a stage III. Wound Evaluation Flow Sheet Multiple Weeks: Right gluteal pressure ulcer, 4/9/15 Wound Evaluation Week 1: right buttock pressure with measurements of length 1 cm, width 0.8 cm, depth 0.2 cm stage III. Wound was identified 4/9/15. Wound type: pressure ulcer (pre-admission). 5/11/15 Wound Evaluation Week 2: Details and Measurements; length 1.2 cm, width 2.6 cm, depth 0.2 cm. 5/15/15 Wound Evaluation Week 3: Details and Measurements; length 2.0 cm, width 0.9 cm, depth 0.2 cm. Left gluteal pressure ulcer, 4/9/15 Wound Evaluation Week 1: left buttock pressure with measurements of length 0.5 cm, width 1 cm, and depth 0.1 cm stage III. Wound was identified 4/9/15. Wound type: pressure ulcer (pre-admission). 5/11/15 Wound Evaluation Week 2: Details and Measurements; length 0.7 cm, width 0.9 cm, depth 0.3 cm. 5/15/15 Wound Evaluation Week 3: Details and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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F 314	Continued From page 8 Measurements; length 0 cm, width 0 cm, depth 0 cm. Current treatment resolved. Treatment Administration Record for April and May 2015 revealed treatments to right and left gluteal pressure ulcers as ordered, but no documentation of monitoring the pressure ulcer sites. On 5/21/15 at 11:11 a.m. RN-B was asked where dressing changes are documented, "In the TAR [treatment administration record]" regarding measurements RN-B stated, "The DNS [Director of Nursing Services] had been going that weekly." On 5/21/15 at 3:03 p.m. RN-A verified that the wound documentation provided to surveyor was the only documentation available with no documentation between the dates of 4/9/15 and 5/11/15. "It's probably the only information that is available. I informed them that is was missing a month ago but they did not do anything about it." On 5/21/15 at 3:33 p.m. RN-C, facility consultant, was asked about the expectation of how often skin/wound documentation occurred. RN-C stated, "At least weekly." Skin Integrity Guideline, undated: Page 1: "DNS [director of nursing services] or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis." Page 2: "Documentation of Weekly Skin Evaluation/Observations: Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the	F 314		

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F 314	Continued From page 9 Weekly Skin Review UDA [user defined assessment]. Licensed nurse to document weekly on identified wounds using the Wound Evaluation Flow Sheet UDA (one UDA per wound identified)." Page 3: "Monitoring Compliance. The following elements are in place to demonstrate satisfactory compliance with guideline: Weekly Skin Review UDA's are in place, DNS or designee evaluates/observes wounds on a weekly basis."	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		6/30/15

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	245306	A. BUILDING _____ B. WING _____	05/21/2015

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F 441	Continued From page 10 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure multi-resident use glucometers were disinfected between uses for 3 of 3 residents (R1, R46, R21) reviewed for blood glucose monitoring. 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	F 441	F441 -Multi use glucometers have been disinfected with appropriate wipes to prevent spread of infection. Disinfecting wipes have been placed on med carts. -Residents requiring glucose monitoring have the potential to be affected if shared glucometers are not properly disinfected. -Licensed staff have been educated in proper disinfection of glucometers and procurement of necessary supplies. -Random observation audits of proper glucometer disinfection will be conducted weekly. Negative outcomes will be addressed immediately. Results will be reviewed at QAPI. -DNS/designee will be responsible. -Corrective action will be completed by 6/30/15.	

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F 441	Continued From page 11	F 441		

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, 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

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	245306	A. BUILDING _____ B. WING _____	05/21/2015

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F 441	Continued From page 12 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. R46 was admitted to the facility 8/8/14 with admission diagnoses of chronic obstructive pulmonary disease (COPD), dementia and DMII. R46 had physician orders dated 5/1/15, for BG test twice a day, and was potentially at risk for transferred contagious disease twice a day, when the BG meter was not properly disinfected. The Blood Glucose Monitor Decontamination policy dated 12/1/14, directed staff to use a wipe that is EPA registered as tuberculocidal, effective against HIV, HBV, and a broad spectrum of bacteria. 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 orderly.....The 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.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

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GOLDEN LIVINGCENTER - ROCHESTER WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - 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), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester West is a 1-story building, with a partial basement. The facility was built in 1963 and was determined to be of Type II(111) construction The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 40 beds at the time of the survey.	K 000		
K 067 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	K 067		6/18/15

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K 067	Continued From page 2 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed and tested in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 40 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 05/21/2015, observation revealed, that the ventilation system utilizes the egress corridor as the supply air for the resident rooms. Date of building construction is 1963. There was no balance report available. HVAC system shut down upon activation of the fire alarm system. This deficient practice was confirmed by the Director of Maintenance at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	A waiver for this deficiency has been requested. Please see attached waiver form and documentation.	

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 Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility | **2000 CODE**

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).

PROVISION NUMBER(S)	JUSTIFICATION
K067 HVAC system shall comply with section 9.2 and NFPA 90A	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 be a hardship as residents would need to be relocated and the associated dust from this work could lead to infection control issues.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 6-22-15

HiMEC
MECHANICAL

1400 7th Street NW
Rochester, MN 55901
Phone: (507) 288-7713
Fax: (507) 281-5206
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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	05/21/2015

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GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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2 000	Initial Comments *****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 the Department within 15 days of receipt of a notice of assessment for non-compliance. 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	05/21/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On May 18, 19 20 & 21, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train 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. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		6/29/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to provide required dementia training to 4 of 5 employees (E-A, E-B, E-C, E-D) hired since April 2014 that continued to work in the facility. This had the potential to affect all 40 residents residing in the facility. Findings Include: The business office manager provided a list of employees hired between April 2014 and May 2015. E-A (nursing assistant-NA), E-B (NA), E-C (Registered nurse-RN), E-D (RN) new employees' files were reviewed for Dementia training upon hire that are still employed by the facility. However, information as to Dementia training of these four employees was requested and no information was provided by facility in regards to Dementia training was received. On 5/21/15 at 2:33 p.m. social services (SS)-stated dementia training was completed on an annual basis and upon hire at the facility. SS-A stated the annual facility training was completed on 10/10/14 and the dementia training that was completed upon hire was done at Golden Living Center Rochester East as a component of new employee orientation. On 5/21/15 at 3:11 p.m. SS-A verified there was no documentation in the employee files to show E-A, E-B, E-C, E-D received dementia training upon hire at the facility or since then. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all direct care staff and their supervisors on how to work with persons with dementia type behavior. This should at a minimum include explanation of Alzheimer's disease and related disorders,	2 302	Corrected	

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2 302	Continued From page 4 assistance with activities of daily living, problem solving with challenging behaviors and communication skills. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan after completing a comprehensive assessment and identifying resident needs and assistance to meet needs for 1 of 3 residents (R109) identified as having assessed needs that were not care planed following the initial assessment/s. Findings include: R109 was admitted to the facility on 5/5/15 with diagnoses that included but was not limited to cataracts, osteoarthrosis, osteoporosis, degenerative joint disease, and compression fractures of the lumbar and thoracic spine with disk protrusion according to the facility's admission record.	2 560	Corrected	6/29/15

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2 560	Continued From page 5 R109's admission Minimum Data Set (MDS) dated 5/12/15 indicated no cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 15, and required corrective lenses. The MDS revealed R109 required limited assistance of one staff member for bed mobility, transfers, ambulation, toileting and personal hygiene and required extensive assistance of one staff member for dressing. The assessment also indicated balance was not steady during transitions and walking, and only able to stabilize with staff assistance and used a walker and wheelchair for mobility. Care Area Assessment (CAA's) were triggered based off of the MDS assessment information that required a plan of care. The CAA's dated 5/17/15 indicated the following areas were included and had been completed in R109's care plan: visual function, pressure ulcer, and ADL (activities of daily living) function/rehabilitation potential. R109's care plan provided by the facility on 5/21/15 failed to include a plan of care that included individualized goals and interventions for vision, pressure ulcer, and a complete ADL function/rehabilitation focus as indicated by the CAAs dated 5/17/15. The care plan did not include ADL's of bed mobility, dressing, toilet use, and personal hygiene. During an interview on 5/21/15, at 10:04 a.m. registered nurse (RN)-C confirmed care plan was not fully developed after completing a comprehensive assessment and CAA information. Facility policy was requested and not provided in regards to completing the comprehensive care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could provide	2 560		

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2 560	Continued From page 6 education on care plan development, develop a tool or checklist for the required components of the care plan, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to complete weekly wound assessments for current pressure ulcers for 2 of 3 residents (R17, R8) who were reviewed for pressure ulcer. Findings include:	2 900	Corrected	6/29/15

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2 900	Continued From page 7 R17 was admitted to the facility on 4/2/15, with admission diagnoses of metastatic cancer, on palliative care, with a stage 1 pressure ulcer on the coccyx. The 5 day admission Minimum Data Set (MDS) dated 4/16/15, indicated R17 was cognitively intact, had moderate depression, and rejected care 1-3 days in the look back period. R17 required extensive assistance of two staff for bed mobility, transfer, dressing and toilet use. The Care Area Assessment (CAA) dated 4/8/15, indicated R17 had a stage 1 pressure ulcer, but did not provide measurements. On 4/2/15, A Wound Assessment was noted and indicated: suspected deep tissue injury on sacrum, non blanchable 2.0 x 0.7 sacrum. The facility nursing admission note dated 4/2/15, at 4:31 p.m. indicated R17 had a stage one sacral pressure ulcer, but did not provide measurements. On 4/2/15 weekly skin check stage 1 redness 2 x 0.7 sacrum, barrier film applied, turn every two hours. On 4/2/15 a Wound Assessment indicated a deep tissue injury, without measurements. The Hospice admission notes dated 4/3/15, indicate R17 had a stage one pressure ulcer on his coccyx 2.0 x 7.0 centimeters (cm) non-blanchable. He does have an air mattress on his bed. On 4-7-15, a stage 1 sacral pressure ulcer remains reddened from admission, area continues to be non-blanchable. Protection pad applied to bottom to prevent breakdown.	2 900		

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2 900	Continued From page 8 Continue with current plan of care. Reposition and off loaded least every 2 hours to prevent breakdown. From 4/7/15 to 4/23/15 no documentation of wound assessment was located nor was it provided when requested 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 hospice, stage 1 pressure ulcer, dress with optifoam. From 4/23/15 to 5/7/15 again no would assessment located 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. On 5/8/15, the hospice comprehensive nursing visit indicated Skin: sin intact. Stage 1 pressure ulcer on sacrum is healed. Registered nurse (RN) noted some redness on the bottom, which was blanchable. R17 did not have and Optifoam dressing in place. On 5/13/15, a nursing progress note, Comprehensive Review: indicated ....Skin: R17 had a pink, non-blanchable and fragile skin. Diligent peri-care is performed with incontinence, turns and air mattress for skin protection. his Braden score is 14, tissue tolerance is in the process of completion. He need assist with turns in bed and adjustments in wheelchair every 2	2 900		

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2 900	Continued From page 9 hours. He was provided a pressure reduction mattress and pressure reduction wheelchair cushion. He is encouraged to repositioned every 2 hours to minimize risk of skin impairments. Licensed nurse completes the skin check. CNA's (certified nursing assistants) have been educated on checking skin daily and reminds the resident of proper technique to prevent friction and shear. On 5/19/15 at 2:10 p.m. weekly wound (dated 4/2/15) and wound documentation (4/2/15, 4/23/15) were reviewed with registered nurse (RN)-A, and health information coordinator (HIC). Weekly wound documentation was not present in computer, RN-A stated, it should be documented, the aides give bath, then give a paper to nurse who should document in the computer. Belle stated, Our director of nursing (DON) gets the sheets, and I think she puts them in a book. (The facility was unable to produce weekly skin check sheets). On 5-19-15, at 2:22 p.m. RN-A stated she had questioned certified nursing assistant (CNA)-A who stated, she did not know she should have the sheet filled out. RN-A was unable to locate daily additional daily skin check sheets. On 5/19/15 -At 2:30 p.m. the chart documentation was unclear about the presence of a pressure ulcer, so it was observed with RN-A. RN-A stated, "No open area currently, but it remains red on coccyx, even on air bed." Also the HIC, reviewed hospice notes, because hospice was doing all the baths for R17, since admitted to hospice on 5/3/15. On 5/21/15, at 3:30 p.m. the consultant director of nursing services (CDNS), was not aware that weekly wound documentation had not been done for residents, and was not able to provide any	2 900		

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2 900	Continued From page 10 additional documentation. The CDNS verified it was the expectation to have weekly skin documentation for all residents. R8's document review revealed the facility lacked weekly skin evaluation. 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. Admission Minimum Data Set (MDS) dated 4/16/15 indicated two unhealed Stage III pressure ulcers.[Stage III pressure ulcer defined in The State Operations Manual as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling."] Dimensions of unhealed: 1.0 cm x 0.8 cm x 0.2 cm. [length x width x depth] 14 day MDS indicated two stage III pressure ulcers present	2 900		

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2 900	Continued From page 11 upon admission. R8's dressing change was observed on 5/21/15 at 12:22 p.m. Pressure ulcer on the right gluteal measured by RN-A, length 2.4 cm, width 1.3 cm, depth 0.1 cm. Pressure ulcer on the left gluteal measured length 0.3 cm , width 0.4 cm. RN-A stated both were a stage III. Wound Evaluation Flow Sheet Multiple Weeks: Right gluteal pressure ulcer, 4/9/15 Wound Evaluation Week 1: right buttock pressure with measurements of length 1 cm, width 0.8 cm, depth 0.2 cm stage III. Wound was identified 4/9/15. Wound type: pressure ulcer (pre-admission). 5/11/15 Wound Evaluation Week 2: Details and Measurements; length 1.2 cm, width 2.6 cm, depth 0.2 cm. 5/15/15 Wound Evaluation Week 3: Details and Measurements; length 2.0 cm, width 0.9 cm, depth 0.2 cm. Left gluteal pressure ulcer, 4/9/15 Wound Evaluation Week 1: left buttock pressure with measurements of length 0.5 cm, width 1 cm, and depth 0.1 cm stage III. Wound was identified 4/9/15. Wound type: pressure ulcer (pre-admission). 5/11/15 Wound Evaluation Week 2: Details and Measurements; length 0.7 cm, width 0.9 cm, depth 0.3 cm. 5/15/15 Wound Evaluation Week 3: Details and Measurements; length 0 cm, width 0 cm, depth 0 cm. Current treatment resolved. Treatment Administration Record for April and May 2015 revealed treatments to right and left gluteal pressure ulcers as ordered, but no documentation of monitoring the pressure ulcer	2 900		

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2 900	Continued From page 12 sites. On 5/21/15 at 11:11 a.m. RN-B was asked where dressing changes are documented, "In the TAR [treatment administration record]" regarding measurements RN-B stated, "The DNS [Director of Nursing Services] had been going that weekly." On 5/21/15 at 3:03 p.m. RN-A verified that the wound documentation provided to surveyor was the only documentation available with no documentation between the dates of 4/9/15 and 5/11/15. "It's probably the only information that is available. I informed them that is was missing a month ago but they did not do anything about it." On 5/21/15 at 3:33 p.m. RN-C, facility consultant, was asked about the expectation of how often skin/wound documentation occurred. RN-C stated, "At least weekly." Skin Integrity Guideline, undated: Page 1: "DNS [director of nursing services] or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis." Page 2: "Documentation of Weekly Skin Evaluation/Observations: Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review UDA [user defined assessment]. Licensed nurse to document weekly on identified wounds using the Wound Evaluation Flow Sheet UDA (one UDA per wound identified)." Page 3: "Monitoring Compliance. The following elements are in place to demonstrate satisfactory	2 900		

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2 900	Continued From page 13 compliance with guideline: Weekly Skin Review UDA's are in place, DNS or designee evaluates/observes wounds on a weekly basis." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review the facility's current policy and procedure related to pressure ulcer monitoring. The Director of Nursing or designee could develop a system to ensure compliance with pressure ulcer monitoring. TIME OF PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use;	21390		6/29/15

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	00941	A. BUILDING: _____ B. WING _____	05/21/2015

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GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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21390	Continued From page 14 H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. 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. 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,	21390	Corrected	

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21390	Continued From page 15 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, 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.	21390		

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21390	Continued From page 16 R46 was admitted to the facility 8/8/14 with admission diagnoses of chronic obstructive pulmonary disease (COPD), dementia and DMII. R46 had physician orders dated 5/1/15, for BG test twice a day, and was potentially at risk for transferred contagious disease twice a day, when the BG meter was not properly disinfected. The Blood Glucose Monitor Decontamination policy dated 12/1/14, directed staff to use a wipe that is EPA registered as tuberculocidal, effective against HIV, HBV, and a broad spectrum of bacteria. 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 orderly.....The 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 FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		6/29/15

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21426	Continued From page 17 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a two step tuberculin skin test (TST) was completed for 1 of 6 residents (R17) who was newly admitted. In addition failed to ensure 1 of 6 residents (R61) TST induration interpretation was include reviewed for Tuberculosis Screening State regulations. Findings included: R17 was admitted to the facility on 4/2/15. The medical record revealed the Baseline TB Screening Tool for Residents on the same day. In addition it was revealed R17 had received the first step TST on 4/2/15, and results were read as 0 millimeters (mm) with a "Negative" interpretation on 4/4/15. During further document review, it was revealed the medical record lacked evidence R17 had received the second step TST as the column	21426	Corrected	

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21426	Continued From page 18 was left blank. R61 was admitted to the facility on 4/4/15. R61's medical record indicted she received the first step of her TST on 4/4/15, and the results were read as 0 mm with a "Negative" interpretation of reading - on 4/6/15. R61 then received the second step TST on 4/20/15, results were read on 4/22/15, as 0 mm but lacked documentation of interpretation. 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." Tuberculosis, Screening Resident for policy reviewed 12/01/2014, read, "Any resident without documented negative TST, BAMT [another test to determine if TB present] or CXR [chest ex ray] within the previous 12 months will receive a baseline (two step) TST or (one-step) BAMT upon admission. If the first TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read..." SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff	21426		

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21426	Continued From page 19 responsible for TB control on the protocol from MDH. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		