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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MW6W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245386**

2. STATE VENDOR OR MEDICAID NO. (L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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 **1/18/2017** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 01/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/26/2017 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245386

January 26, 2017

Ms. Theresa Pridel, Administrator
Golden LivingCenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

Dear Ms. Pridel:

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 January 13, 2017 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 26, 2017

Ms. Theresa Pridel, Administrator
Golden LivingCenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386027

Dear Ms. Pridel:

On December 21, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 26, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on December 8, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, as of January 13, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 13, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the recommended remedies in our letter dated December 21, 2016:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 8, 2016 be rescinded as of January 13, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245386 Y1	A. Building B. Wing Y2	1/18/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0157	Correction	ID Prefix	F0174	Correction	ID Prefix	F0225	Correction
Reg. #	483.10(g)(14)	Completed	Reg. #	483.10(g)(6)(7)(i)	Completed	Reg. #	483.12(a)(3)(4)(c)(1)-(4)	Completed
LSC		01/13/2017	LSC		01/13/2017	LSC		01/13/2017
ID Prefix	F0226	Correction	ID Prefix	F0280	Correction	ID Prefix	F0309	Correction
Reg. #	483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v) (3),483.21(b)(2)	Completed	Reg. #	483.24, 483.25(k)(l)	Completed
LSC		01/13/2017	LSC		01/13/2017	LSC		01/13/2017
ID Prefix	F0312	Correction	ID Prefix	F0318	Correction	ID Prefix	F0323	Correction
Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(c)(2)(3)	Completed	Reg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC		01/13/2017	LSC		01/13/2017	LSC		01/13/2017
ID Prefix	F0520	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		01/13/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	1/26/2017	22113	1/18/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245386 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/23/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	01/13/2017	LSC K0345	01/13/2017	LSC K0346	01/13/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0354	01/13/2017	LSC K0521	01/13/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	1/26/2017	35482	1/23/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/6/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MW6W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245386**

2. STATE VENDOR OR MEDICAID NO. (L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - SLAYTON**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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 **12/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/19/2017 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 21, 2016

Ms. Theresa Pridel, Administrator
Golden LivingCenter - Slayton
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386027

Dear Ms. Pridel:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on March 10, 2016. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 26, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F309 and F318 effective December 8, 2016. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 8, 2017. (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 March 8, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 8, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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 - Slayton is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 8, 2017. This prohibition is not subject to appeal. Further, 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.

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.

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 remedy be imposed:

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

Failure to submit an acceptable PoC 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, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 March 8, 2017 (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 June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		1/13/17

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

Electronically Signed | 12/27/2016

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 1 resident (R48) reviewed who experienced a significant change in medical condition. This resulted in actual harm for R48, who experienced declining oxygen blood levels, altered vital signs and symptoms without ongoing nursing assessments so the appropriate medical intervention could be determined. Findings include:	F 157	It is the policy of Golden Living Center Slayton to notify the physician in a timely manner when there is a significant change in the residents physical, mental, or psychosocial status. Resident R48 is no longer an active resident at the facility. Staff were interviewed and educated regarding updating the MD at the time of incident involving resident R48. Staff will be re-educated on the clinical policy entitled "Notification of Change in	

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F 157	Continued From page 2 During review of R48's medical record the nurses' progress notes indicated R48 was admitted on 11/5/16, from a hospital setting. Documentation indicated R48 had fallen at home on 11/3/16, having been discovered by a home health aide who had arrived to provide home services. R48 was taken to the hospital emergency room. R48's diagnoses at the hospital included atrial fibrillation and hyponatremia (low sodium level). The progress notes further indicated R48 had diagnoses including: congestive heart failure (CHF), hypertension (high blood pressure), pulmonary hypertension, atrial fibrillation (irregular heart beat), edema (extra fluid), prostate cancer, anxiety and weakness. At the time of admission to the nursing home, physician orders for R48 included occupational therapy (OT) and physical therapy (PT) to assist with self care training, gait training, and therapeutic exercise. Document review indicated R48 suffered a significant change in health status and the physician was not notified in a timely manner. A progress note dated 11/17/16, at 3:29 p.m. indicated R48 required supervision and assist with bed mobility, transfers, ambulation and locomotion. In addition, the note indicated R48 required extensive assistance with dressing, toileting, and bathing. Documentation in the progress notes dated 11/18/16, at 12:38 p.m. indicated the attending physician had examined R48, reviewed his medications, and had not prescribed any new orders. A subsequent note dated 11/18/16, at 4:31 p.m. identified R48's vital signs as: temperature (temp)= 96.8 degrees Fahrenheit (F) ; pulse= 75; respirations=18 and oxygen	F 157	Resident Health Status". Staff will also be educated on the appropriate manner to update a physician when a change in condition is noted. Progress notes in PCC will be reviewed daily (Monday-Friday) by DNS or designee. Progress notes from the weekend will be reviewed on Monday by DNS or designee. Notes will be audited for appropriate notification of MD with condition changes. Daily audits will be reviewed at morning clinical standup with management team. Audits of daily notes and changes of condition at the time of change of condition, on current and future residents will be completed for 12 months. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance. Competion date:	

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saturation= 86-90% on room air. That note indicated R48 had denied any shortness of breath, and further that R48 did not use his call light and would ambulate himself into the bathroom with his walker. The documentation also indicated R48 had slightly swollen lower extremities and wore compression stockings (TED hose).

A progress note dated 11/20/16, at 1:00 p.m. indicated R48 was able to complete his own morning cares and used a four wheeled walker to ambulate, and did not use his call light for staff assistance. The note also identified R48 denied shortness of breath, was polite, friendly to staff, had a good appetite and offered no complaints. R48's oxygen saturation was recorded at that time to be 91% on room air.

A progress note dated 11/21/16, at 12:59 p.m. indicated R48's family had voiced concerns about R48's detriorating health condition. The family had reported that R48 appeared more tired and had fallen asleep while the family was visiting. Documentation in the progress note indicated that licensed practical nurse (LPN)-B entered R48's room to assess him and the documentation described R48's hands as appearing dark in color and cold to the touch. In addition, the documentation indicated the nurse had been unable to obtain an oxygen saturation level using R48's fingers and described R48's hands as appearing slightly swollen. The note indicated R48 was not ambulating as well as before and vital signs had been recorded as: blood pressure (B/P)= 112/56; Temp=95.6 F; Pulse=92 and Respirations=20.

There were no nursing progress notes documented from 11/21/16, at 12:59 p.m. until 11/21/16, at 10:29 p.m. (9 1/2 hours later) to indicate any further assessment had been

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conducted for R48. A progress note from 10:29 p.m. on 11/21/16, indicated R48's family had contacted the facility at 9:15 p.m. expressing concerns about R48's declining health condition. According to the documentation, the family member stated R48 had purple hands and seemed tired over the past few days. The note further indicated LPN-C had entered R48's room and checked R48's vital signs which were recorded as: B/P= 81/49; Pulse= 60-70's; Respirations=28; Temp= 96.3 degrees F. and oxygen saturation at 65% on room air. The note described R48 as mouth breathing and unresponsive to touch and sound. In addition, the note indicated oxygen had been initiated for R48 and the family contacted. The family requested R48 be sent to the hospital and R48 had subsequently been transferred to the hospital at 9:30 p.m. by ambulance, after the nurse had obtained a physician order to transport.

When interviewed on 12/6/16, at 12:50 p.m. the director of nursing services (DON) stated she was aware of the incident and that an internal investigation related to the incident had been conducted and that LPN-B had been placed on suspension pending the outcome of the investigation. The DON confirmed LPN-B should have contacted the physician related to R48's declining health status. The DON further explained that LPN-B had sent a fax to the physician which had not been responded to by they physician until the following day after R48 had been hospitalized. The DON stated LPN-B had failed to report R48's condition to the on-coming nurse, or to the day charge nurse prior, to leaving her shift at approximately 5:45 p.m. on 11/21/16.

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F 157	Continued From page 5 When interviewed on 12/6/16, at 2:23 p.m. registered nurse (RN)-E stated she remembered the incident with R48. RN-E said she thought at the time that LPN-B had handled the situation. RN-E recalled she felt R48's condition was such that he required medical intervention. RN-E confirmed she had worked until approximately 6:00-6:30 p.m. and that LPN-B had left the facility around 5:45 p.m. RN-E verified she was unaware of what LPN-B had or hadn't done related to seeking medical intervention, until the facility had initiated the investigation. RN-E stated she figured LPN-B had sent a fax to the doctor but was not aware of the status of the physician's response to the fax. RN-E further stated she had not visualized R48 at anytime throughout the shift on 11/21/16. During interview with RN-D on 12/6/16 at 2:30 p.m., RN-D stated she had been working the floor from 6:00 p.m. to 10:00 p.m. on 11/21/16. RN-D stated the only concern she'd heard from report was that R48 was not walking as well as he had in the past. RN-D stated she was passing medications and really hadn't had a reason to enter R48's room based on what had been reported to her when she'd come on duty. RN-D further stated R48's family member had been at the facility; RN-D said she'd passed by R48's room a couple times where the family member was, but the family member had never approached her with any concerns. RN-D stated she recalled passing medications later that evening and LPN-C entering R48's room because the family member had contacted her via telephone and voiced concern about R48's health status. RN-D stated she was aware LPN-C had been unable to obtain an oxygen saturation level and that R48's hands were cold and discolored.	F 157		

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RN-D further stated R48 was in and out of consciousness and she knew his health had deteriorated. RN-D stated, "I wish I would have known, I would have been right in his room."

During interview on 12/6/16, at 2:49 p.m. family member (F)-A stated F-B had noted a change in R48's health status earlier in the day and had asked the physical therapist (PT) how therapy was progressing. F-A stated the PT had verbalized some concerns about R48's health status, stating R48's condition had demonstrated a decline. F-A stated she had spoken to LPN-B earlier in the day on 11/21/16, and LPN-B had informed her that R48's vitals were okay and that the physician had been notified via fax. F-A stated she was uncomfortable about R48's health status when she left the facility for the day and had decided to call back to speak to staff when she'd arrived home to discuss her concerns.

During interview on 12/7/16, at 7:49 a.m. LPN-C stated when she'd received report at the beginning of the shift on 11/21/16, RN-E had reported that R48 was drowsy and lethargic. LPN-C stated she'd felt there was no reason to go immediately to R48's room based on the shift report. LPN-C further stated she was not assigned to work on the wing where R48 was located and reiterated that she felt from the shift report, there was no urgency related to R48's condition. LPN-C further stated that if she had reviewed the status of R48's condition as documented in the medical record, she would have contacted the physician immediately. LPN-C also explained that if she had faxed the physician and not received a response immediately, she would have called the clinic to speak directly to the physician. LPN-C verified F-A had contacted

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her via telephone on 11/21/16, time uncertain, at which time she had gone to R48's room to check on his condition. LPN-C said she had been unable to obtain an oxygen saturation reading at that time. LPN-C stated R48 was very lethargic and she'd known immediately R48 was in distress. LPN-C stated since the incident related to R48 had occurred, the DON had met with all staff and discussed the expectations regarding notification of the physician. LPN-C said those discussions had included conversation about when to fax versus call a physician.

The facility's investigation related to this incident was reviewed. The investigation report indicated that on 11/22/16, RN-E had been interviewed by the DON. RN-E had stated in her report that she was aware that R48 was "different" during the shift and that family had voiced a concern to LPN-B that R48 was sleepy. The investigative report indicated RN-E had further stated that at supper time it had been brought to her attention that R48 was drooling, but RN-E had stated she had not been asked by the nurse working on the East wing (LPN-B) to assess R48 at anytime during the shift. Additionally, the investigation report failed to indicate whether RN-E had been told in report by LPN-B the condition of R48, or whether RN-E was aware of R48's status change.

The investigation report also indicated LPN-C had been interviewed by telephone on 11/21/16 (time not indicated), and LPN-C had reported LPN-B was no longer at the facility when she'd arrived. The report indicated LPN-C had stated she'd been told in report that R48 was acting different than usual. However, LPN-C had stated no nursing assistants (NA's) had reported changes to her. LPN-C had confirmed she was assigned

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as R48's nurse from 6-10 p.m. The report indicated LPN-C had verified she'd received a call from family member (F)-A who had voiced concernes about R48 as his hand had been purple all day. LPN-C stated in the report she'd entered R48's room after the call and had assessed R48. LPN-C stated she had not been able to get answers from R48 at the time of her initial assessment, but that when the ambulance had arrived, R48 had answered limited questions from the ambulance crew. The report also indicated LPN-C had described R48 as phlegmy and drooling from the left side at the time of her initial assessment.

In the investigative report, RN-D had indicated RN-E had given her report and had identified R48 was now in a wheelchair, not using the walker and was not doing well. RN-D stated she did not see R48 prior to 9:00 p.m. as she had started passing medications on the other hall. However, RN-D had stated she'd gone down the hall because the call light had been "on" for awhile and had observed a NA walking R48 to bed. The investigative report indicated RN-D had stated after the call from F-A, LPN-C had assessed R48 and had alerted her (RN-D) of the resident's low oxygen saturation level. RN-D stated when she'd entered R48's room, R48's eyes were closed and mouth open, and that R48 did respond "what" when his name was spoken, and had been able to answer simple questions and follow simple directions. RN-D had reported oxygen had been initiated due to low oxygen saturation reading, and had stated she (RN-D) had stayed by R48's room until the ambulance crew had arrived.

Additional documentation in the report indicated NA-C had stated R48 was very sleepy from the

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time he was awakened for the day. NA-C stated R48's hands were colder and she reported to R48's nurse (LPN-B) that R48 was different. NA-C stated LPN-C told her she would check R48's vitals. NA-C further stated R48 had to to stop three times to walk to dining room which was unusual so R48 was transferred into a wheelchair.

The investigative report indicated LPN-B had been interviewed on 11/22/16. LPN-B had reported at that time that NA-C had verbalized something was not right with R48. LPN-B stated she had looked at R48 but he'd been in therapy at the time. LPN-B verified that around 12:00 noon on 11/21/16, F-A had approached her about R48's condition. At that time, LPN-B stated she'd assessed R48 and has sent a message via fax to the clinic. LPN-B stated R48 had been able to take his pills at the noon meal and hold a glass of water. However, during the evening meal, LPN-B said the nurse had to hold R48's water glass. LPN-B described R48 as having been dusky and drooling, but stated she'd wiped his mouth and he'd answered questions. The investigative report further indicated LPN-B had stated R48 had been using the wheelchair for transportation intermittently during the past couple days.

The summation of the facility's investigative report identified the following: R48 had been declining all shift since a.m. (morning). A fax was sent to the physician but no response came back until 11/22/16 at 1:00 p.m. (the following day). Documentation was lacking in the medical record to indicate a physician notification of status change had been sent via fax to the physician, or that a physician was contacted prior to the time R48 was transferred to the acute hospital setting

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other than the order to transfer via ambulance. In addition, the summation report indicated during a phone interview, LPN-B had stated she would not be returning to work.

Documentation on the investigative report further indicated the DON was conducting shift education, to make a change in resident condition, seen or reported, a priority. And to ensure the physician was notified by fax, or called, if there was a signifiant change in condition which could be quick and ongoing. The report indicated nurses had to sign a sheet to indicate when education was received.

The facility's policy Notification of Change in Resident Health Status revised 10/20/16, had a guideline statement: To ensure proper notifications are made when the resident has a change in health status.
Definitions (As Needed): Immediate: As soon as possible no longer than 24 hours.
The center will consult with the resident's physician, nurse practitioner or physician assistant, and if known notify the residents legal representative or an interested family member when there is: (A.) An accident occurred which resulted in injury and required potential for physician intervention. Notification: Within 24 hours from the time an assessment has been made indicating there may be a potential for physician intervention. (B.) Acute illness or a significant change in the resident's physical, mental, or psychological status (i.e. deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications. Criteria: Life threatening conditions are such things as a heart attack or stroke. Clinical complications are things as development

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of a stage 2 pressure sore when no ulcers were previously present at stage 2 or higher, onset or recurrent periods of delirium, recurrent urinary tract infection, or persistent decline in psycho social status. Appropriate notification time : immediate: (C.) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.
Criteria: A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g. an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g. abnormal laboratory result, the use of any medical procedure, or therapy that has not been used on the resident before.) Notification: Depending on the nursing assessment appropriate notification may be immediate to 24 hours. (D.) A decision to transfer or discharge a resident from the center.
Criteria: Appropriate notification time, immediate. (E.) expected or unexpected deaths. Criteria: Appropriate notification time, immediate.

During interview with Physician (MD)-A on 12/8/16 at 8:47 a.m., MD-A stated she could not recall the incident related to the date but verified she had seen R48 on 11/18/16, and did not note anything significant about his health status. MD-A stated R48 was doing as well as could be expected, sitting up in chair, with no acute concerns when she'd seen him. MD-A further stated the facility had sent a fax however, she wasn't present in the clinic so the fax should have been followed up by the physician on duty. MD-A clarified the facility staff should have followed up on the fax with a call to the MD when the resident's health condition had deteriorated.

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F 157	Continued From page 12 MD-A stated without knowing the exact condition changes assessed by nursing staff, she could not determine whether R48 should have been transferred to the hospital sooner. She verified that staff should attempt to contact the physician if a fax is not responded to in a timely manner. Although the facility investigated the events surrounding the failure to notify the physician in a timely manner, there was a failure of timely nursing assessment which had not been addressed nor had a system been implemented to ensure nursing staff conduct a thorough physical assessment when a change in condition had been identified. Failure to notify the physician in a timely manner and conduct a comprehensive assessment of a resident's condition had been identified during the previous survey and the facility had not implemented an effective system to ensure resident medical needs were met prior to the incident affecting R48.	F 157		
F 174 SS=D	483.10(g)(6)(7)(i) RIGHT TO TELEPHONE ACCESS WITH PRIVACY (g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. (g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services;	F 174		1/13/17

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F 174	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide privacy for telephone use for 1 of 1 resident (R 47) reviewed for privacy practices. Findings include: The most recent quarterly Minimum Data Set (MDS) assessment dated 10/21/16, identified that R47 required extensive assistance with activities of daily living (ADL); bed mobility, transfers, dressing, toilet use and personal hygiene and limited assistance with walking in room/corridor and total dependence for locomotion on/off the unit. R47 was observed being transported via wheelchair by staff to/from meals and to all scheduled activities during the course of the survey from 12/5/16 - 12/8/16. During initial interview with R47 and a family member (F)-A on 12/5/16, at 3:41 p.m. telephone privacy was discussed. The F-A indicated R47 required staff assistance with transportation to access the telephone located at the nursing station as the portable phone, (available for residents who did not have their own phone) did not work in the area of R47's room. During an interview on 12/06/16, at 3:07 p.m. registered nurse (RN)-E confirmed R47 was required to access the phone located at the nurses' station when the portable phone was not working and/or when the phone was outside the range of reception. RN-F who was also in attendance indicated he was aware of R47 being	F 174	It is the policy of Golden Living Center Slayton that all residents have the right to reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard. New cordless phones with signal boosters will be purchased for the residents in the facility. The cordless phones will be available to be used in their room or a private area of their choosing. Until cordless phones arrive residents will be offered a private area to use a phone. Staff will be provided education regarding use of cordless phones and resident's right to have privacy when using phone. Audits will be completed for all residents current and future by the Social Worker on admission and with each quarterly care conference for 1 year. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance.	

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transported to the nursing station to use the telephone, but R47 had not been given the option to speak on the phone in a private area.

When interviewed on 12/7/16, at 8:24 a.m. R47 indicated it bothers her when she has to go to the nursing station to use the telephone and she would prefer to talk in a private area rather than in an "open" area. R47 further stated it was difficult and required a lot of effort for staff to transport her to the nurses' station to respond to a phone call.

The F-A was again interviewed on 12/7/16, at 8:31 a.m. and confirmed when she was not available in the building to let her mom use her personal cell phone, R47 had to be taken to the nursing station and she [F-A] was not pleased with that arrangement. The F-A indicated the range for the portable phone does not work in her mom's room and indicated this concern had been communicated during a staff stand up meeting (did not recall the date, but it had been a couple of weeks previously) in which she was in attendance. The F-A verified that staff response to this issue included, it will be looked into but " it has been a while ago and nothing has been done". The F-A indicated her mom had instructed staff to inform her son that she was already in bed when her son telephoned to talk because it was too hard to be transferred into a wheelchair and talk at the nurses' station.

When interviewed on 12/8/16, at 9:04 a.m. the executive director (ED) indicated a resident who didn't have their own personal phone was able to use the portable phone and/or the phone located at the nurses' desk; if the resident desired privacy a phone located in a private office could be

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F 174	Continued From page 15 utilized. The ED further stated she was not aware of any complaint/grievance related to the lack of privacy with use of the telephone located at the nurses' station. During a subsequent interview with the F-A on 12/8/16, at 10:30 a.m. it was verified the situation with the telephone was restricting R47 from using the phone and the lack of privacy was felt to be an issue. No policy regarding telephone use and privacy practices was provided.	F 174		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		1/13/17

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F 225	Continued From page 16 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the administrator and/or State Agency (SA) of an alleged violation of neglect for 1 of 1 resident (R48) reviewed who experienced a decline in health status without ongoing nursing assessment and subsequently transferred to the hospital. Findings include: During review of R48's medical record the nurses' progress notes indicated R48 was admitted on 11/5/16, from a hospital setting. Documentation indicated R48 had fallen at home on 11/3/16 and discovered by a home health aide who provided services. R48 was taken to the hospital emergency room. R48's diagnoses at the hospital included atrial fibrillation and hyponatremia (low sodium level). The progress notes further indicated R48 had diagnoses including: congestive heart failure (CHF), hypertension (high blood pressure), pulmonary hypertension, atrial fibrillation (irregular heart beat), edema (extra fluid), prostate cancer, anxiety and weakness. At the time of admission to the nursing home, physician orders for R48 included occupational therapy (OT) and physical therapy (PT) to assist with self care training, gait training, and therapeutic exercise. The following progress notes were recorded in R48's medical record: -On 11/17/16, at 3:29 p.m. R48 required supervision and assist with bed mobility, transfers, ambulation and locomotion. R48 required extensive assist with dressing, toileting,	F 225	It is the policy of Golden Living Center Slayton that potential incidents of abuse or neglect be filed in accordance with federal regulation and the facility on the policy abuse prohibition policy. The potential incident of neglect of R48 was filed with MDH on 12/6/16. The incident of potential neglect was immediately investigated starting 11/21/16. Nurse involved in incident was immediately suspended pending the outcome of the investigation. Staff will be educated on the policy "Investigation and Reporting of Alleged Violation of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property." Education given on who to report potential incidents of abuse/neglect to immediately will be included in the education. Staff will also be educated on potential processes or systems that are put in place to prevent further potential abuse, neglect, or mistreatment while an investigation is in progress. Executive Director will monitor/audit weekly for compliance of the abuse prohibition policy and the timely/immediate reporting of abuse and neglect to the state agency. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. Executive Director or designee is	

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F 225	Continued From page 18 and bathing. -On 11/18/16, at 12:38 p.m. was seen by his attending physician at the facility and R48's medications were reviewed with no new physician orders. -On 11/18/16, at 4:31 p.m. R48's vitals were: temperature-96.8 Fahrenheit (F); pulse=75; respirations=18 and oxygen saturation 86-90% on room air. R48 denied any shortness of breath, did not use his call light and would ambulate himself to the bathroom with his walker. R48 had slightly swollen lower extremities and had compression stockings (TED hose) on. -On 11/20/16, at 1:00 p.m. R48 was able to complete his own AM cares. R48 used a four wheeled walker to ambulate and did not use his call light for staff assistance. R48 denied shortness of breath, was polite, friendly to staff, had a good appetite and offered no complaints. R48's oxygen saturation was recorded as 91% on room air. -On 11/21/16, at 12:59 p.m. R48's family voiced concerns about R48's health condition. The family indicated R48 appeared more tired and fell asleep while visiting. Licensed practical nurse (LPN)-B entered R48's room and documented R48's hands appear dark in color and cold to the touch. Unable to obtain oxygen saturation on the fingers. R48's hands appeared slightly swollen and he was not ambulating as well as before. Vital signs: B/P= 112/56; Temp=95.6; Pulse=92 and Respirations=20. -The next note in the progress notes was dated 11/21/16 at 10:29 p.m. R48's family contacted the facility at 9:15 p.m. expressing concerns about R48's health condition. The family member stated R48 had purple hands and seemed tired the past few days. The note identified LPN-C entered R48's room and checked R48's vital signs and	F 225	responsible for monitoring compliance.	

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recorded: B/P= 81/49; Pulse=60-70's; Respirations= 28; Temp= 96.3 F. and oxygen saturation at 65% on room air. R48 was described as mouth breathing and unresponsive to touch and sound. Oxygen was administered to R48 and family contacted. The family requested R48 be sent to the hospital. R48 was transferred to the hospital at 9:30 p.m. by ambulance after obtaining a physician order to transport.

During interview with the director of nursing services (DON) on 12/6/16, at 12:50 p.m. the DON stated she was aware of the incident and the facility did an internal investigation related to the incident and identified LPN-B was put on suspension pending completion of the investigation. The DON stated LPN-B should have contacted the physician related to R48's health status. The DON stated LPN-B had sent a fax to the physician but the fax was not returned to the facility until the following day, after R48 had been hospitalized. The DON stated LPN-B failed to report R48's condition to the on-coming nurse nor the other day charge nurse at the time she left the facility at approximately 5:45 p.m. The DON and administrator verified there was no report made to the State agency related to the allegation of neglect. The DON further stated the incident should have been reported. The facility conducted an internal investigation but did not immediately report the allegations to outside State agencies as required.

Review of the facility's investigation related to this incident was reviewed. The investigation report indicated that on 11/22/16, RN-E had been interviewed by the DON. RN-E had stated in her report that she was aware that R48 was different during the shift and that family had voiced a

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concern to LPN-B that R48 was sleepy. RN-E further stated that at supper time it had been brought to her attention that R48 was drooling, but stated she had not been asked by the nurse working on the East wing (LPN-B) to assess R48 at anytime during the shift. Additionally, the investigation report failed to indicate RN-E was told in report by LPN-B the condition of R48 or if she was aware of R48's changes.

The investigation report also identified LPN-C was interviewed by telephone on 11/21/16, (time not indicated), and LPN-C stated LPN-B was not at the facility when she arrived. LPN-C stated she was told in report that R48 was acting different than usual. LPN-C stated no nursing assistants (NA's) had reported changes to her and stated she was assigned as R48's nurse from 6-10 p.m. LPN-C identified she received a call from family member (F)-A who voiced concerned about R48 as his hand had been purple all day. LPN-C stated in the report she entered R48's room after the call and assessed R48. LPN-C stated she could not get answers from R48 at time of initial assessment but when the ambulance arrived, R48 answered limited questions from the ambulance crew. LPN-C had described R48 as phlegmy and drooling from the left side at the time of the assessment.

In the investigative report, RN-D stated RN-E gave her report and identified R48 was now in a wheelchair, not using the walker and was not doing well. RN-D stated she did not see R48 prior to 9:00 p.m. as she had started passing medications on the other hall. RN-D stated she went down the hall as the call light had been "on" for awhile and observed an NA walking R48 to bed. RN-D stated after a call from F-A, LPN-C

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assessed R48 and alerted RN-D of the low oxygen saturation level. RN-D stated when she entered R48's room, his eyes were closed and mouth open but did respond "what" when his name was spoken and was able to answer simple questions and follow simple directions. Oxygen had been initiated due to low oxygen saturation reading. RN-D stated she stayed by R48's room until the ambulance crew arrived.

Documentation in the report indicated NA-C stated R48 was very sleepy from the time he was awakened for the day. NA-C stated R48's hands were colder and she reported to R48's nurse (LPN-B) that R48 was different. NA-C stated LPN-C told her she would check R48's vitals. NA-C further stated R48 had to to stop three times to walk to dining room which was unusual so R48 was transferred into a wheelchair.

On 11/22/16 the investigative report indicated LPN-B was interviewed. LPN-B stated NA-C had verbalized something was not right with R48. LPN-B stated she looked at him but he was in therapy at the time. LPN-B stated at around 12:00 noon F-A approached her about R48's condition, he was assessed and a message was sent via fax to the clinic. LPN-B stated R48 was able to take pills at the noon meal and hold glass of water for pills. However, during the evening meal, the nurse had to hold the glass. LPN-B described R48 as dusky and drooling but wiped mouth and he answered questions. LPN-B stated R48 had been using the wheelchair for transportation intermittently during the past couple days.

The summation of the investigative report identified the following: R48 had been declining all shift since a.m. The report identified a fax was

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sent to the physician but no response came back until 11/22/16 at 1:00 p.m. p.m. (next day). Documentation was lacking in the medical record indicating that a physician notification of status change was sent via fax to the physician nor that a physician was contacted prior to the time R48 was transferred to the acute hospital setting. During a phone interview, LPN-B stated she would not be returning to work.

Documentation on the investigative report indicated the DON was conducting shift education to make a change in resident condition seen or reported a priority and ensure a physician is notified by fax or called if condition is a significant change, changes are quick or ongoing. Nurses sign sheet as education is received.

During interview with Physician (MD)-A on 12/8/16, at 8:47 a.m. MD-A stated she could not recall the incident related to the date but verified she had seen R48 on 11/18/16, and did not note anything significant about his health status. MD-A stated R48 was doing as well as could be expected, sitting up in chair, with no acute concerns when she saw him. MD-A further stated the facility sent a fax, she wasn't present in the clinic and the fax should have been followed up by the physician on duty. MD-A further clarified the facility staff should have followed up the fax with a call if the health condition had deteriorated. MD-A stated without knowing the exact condition changes assessed by nursing staff, she could not determine whether R48 should have been transferred to the hospital sooner. She verified that staff should attempt to contact the physician if the fax is not responded to in a timely manner.

The facility abuse prohibition police titled, "Golden

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F 225	Continued From page 23 Living Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Maltreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" identified the following: It is the policy of the company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and ensure they and reported immediately to the executive director (ED) of the center. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The policy further identified it was the responsibility of each individual employee to immediately report any reasonable suspicion of crime, and all allegations of mistreatment, neglect, abuse , injury of unknown source and/or misappropriation of resident property to the designated supervisor in charge at the time. The employee may also report directly to the center/locations ED or DON. For the purposes of reporting "immediately" means as soon as possible but not to exceed two hours in the event of a serious injury or death of patient involved in a report or twenty four hours for all other reports or shorter if State law/regulations require a report within a shorter timeframe. The ED or DON shall also notify the appropriate State agency, in accordance with State law, as well as notify immediate management. .	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement	F 226		1/13/17

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F 226	Continued From page 24 written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse/Neglect policy to ensure immediate reporting of allegations of potential neglect of treatment to the State Agency (SA) for 1 of 1 resident (R48) reviewed who experienced a decline in health status without ongoing nursing assessment and subsequently transferred to the hospital.	F 226	It is the policy of Golden Living Center Slayton that Policies will be implemented that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property. The potential incident of neglect of R48 was filed with MDH on 12/6/16. The incident of potential neglect was	

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F 226	Continued From page 25 Findings include: The facility abuse prohibition police titled, "Golden Living Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Maltreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" identified the following: It is the policy of the company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and ensure they and reported immediately to the executive director (ED) of the center. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The policy further identified it was the responsibility of each individual employee to immediately report any reasonable suspicion of crime, and all allegations of mistreatment, neglect, abuse , injury of unknown source and/or misappropriation of resident property to the designated supervisor in charge at the time. The employee may also report directly to the center/locations ED or DON. For the purposes of reporting "immediately" means as soon as possible but not to exceed two hours in the event of a serious injury or death of patient involved in a report or twenty four hours for all other reports or shorter if State law/regulations require a report within a shorter timeframe. The ED or DON shall also notify the appropriate State agency, in accordance with State law, as well as notify immediate management. . During review of R48's medical record the nurses' progress notes indicated R48 was admitted on 11/5/16, from a hospital setting. Documentation	F 226	immediately investigated starting 11/21/16. Nurse involved in incident was immediately suspended pending the outcome of the investigation. Staff will be educated on the policy entitled "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property". All staff and new hires will receive online education which will train them to recognize the different types of elder abuse and neglect and ways to prevent abuse and what to do if it is suspected. Education will also be provided explaining procedure for reporting incidents, dementia management, and resident abuse prevention. Executive Director (ED) will monitor/audit weekly for compliance of the abuse prohibition policy and the timely/immediate reporting of abuse and neglect to the state agency. ED will complete monthly audits on completion of education for new and current employees. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. Executive Director or designee is responsible for monitoring compliance.	

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indicated R48 had fallen at home on 11/3/16 and discovered by a home health aide who provided services. R48 was taken to the hospital emergency room. R48's diagnoses at the hospital included atrial fibrillation and hyponatremia (low sodium level). The progress notes further indicated R48 had diagnoses including: congestive heart failure (CHF), hypertension (high blood pressure), pulmonary hypertension, atrial fibrillation (irregular heart beat), edema (extra fluid), prostate cancer, anxiety and weakness. At the time of admission to the nursing home, physician orders for R48 included occupational therapy (OT) and physical therapy (PT) to assist with self care training, gait training, and therapeutic exercise.

The following progress notes were recorded in R48's medical record:
-On 11/17/16, at 3:29 p.m. R48 required supervision and assist with bed mobility, transfers, ambulation and locomotion. R48 required extensive assist with dressing, toileting, and bathing.
-On 11/18/16, at 12:38 p.m. was seen by his attending physician at the facility and R48's medications were reviewed with no new physician orders.
-On 11/18/16, at 4:31 p.m. R48's vitals were: temperature-96.8 Fahrenheit (F); pulse=75; respirations=18 and oxygen saturation 86-90% on room air. R48 denied any shortness of breath, did not use his call light and would ambulate himself to the bathroom with his walker. R48 had slightly swollen lower extremities and had compression stockings (TED hose) on.
-On 11/20/16, at 1:00 p.m. R48 was able to complete his own AM cares. R48 used a four wheeled walker to ambulate and did not use his

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call light for staff assistance. R48 denied shortness of breath, was polite, friendly to staff, had a good appetite and offered no complaints. R48's oxygen saturation was recorded as 91% on room air.
-On 11/21/16, at 12:59 p.m. R48's family voiced concerns about R48's health condition. The family indicated R48 appeared more tired and fell asleep while visiting. Licensed practical nurse (LPN)-B entered R48's room and documented R48's hands appear dark in color and cold to the touch. Unable to obtain oxygen saturation on the fingers. R48's hands appeared slightly swollen and he was not ambulating as well as before. Vital signs: B/P= 112/56; Temp=95.6; Pulse=92 and Respirations=20.
-The next note in the progress notes was dated 11/21/16 at 10:29 p.m. R48's family contacted the facility at 9:15 p.m. expressing concerns about R48's health condition. The family member stated R48 had purple hands and seemed tired the past few days. The note identified LPN-C entered R48's room and checked R48's vital signs and recorded: B/P= 81/49; Pulse=60-70's; Respirations= 28; Temp= 96.3 F. and oxygen saturation at 65% on room air. R48 was described as mouth breathing and unresponsive to touch and sound. Oxygen was administered to R48 and family contacted. The family requested R48 be sent to the hospital. R48 was transferred to the hospital at 9:30 p.m. by ambulance after obtaining a physician order to transport.

During interview with the director of nursing services (DON) on 12/6/16, at 12:50 p.m. the DON stated she was aware of the incident and the facility did an internal investigation related to the incident and identified LPN-B was put on suspension pending completion of the

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investigation. The DON stated LPN-B should have contacted the physician related to R48's health status. The DON stated LPN-B had sent a fax to the physician but the fax was not returned to the facility until the following day, after R48 had been hospitalized. The DON stated LPN-B failed to report R48's condition to the on-coming nurse nor the other day charge nurse at the time she left the facility at approximately 5:45 p.m. The DON and administrator verified there was no report made to the State agency related to the allegation of neglect. The DON further stated the incident should have been reported. The facility conducted an internal investigation but did not immediately report the allegations to outside State agencies as required.

Review of the facility's investigation related to this incident was reviewed. The investigation report indicated that on 11/22/16, RN-E had been interviewed by the DON. RN-E had stated in her report that she was aware that R48 was different during the shift and that family had voiced a concern to LPN-B that R48 was sleepy. RN-E further stated that at supper time it had been brought to her attention that R48 was drooling, but stated she had not been asked by the nurse working on the East wing (LPN-B) to assess R48 at anytime during the shift. Additionally, the investigation report failed to indicate RN-E was told in report by LPN-B the condition of R48 or if she was aware of R48's changes.

The investigation report also identified LPN-C was interviewed by telephone on 11/21/16, (time not indicated), and LPN-C stated LPN-B was not at the facility when she arrived. LPN-C stated she was told in report that R48 was acting different than usual. LPN-C stated no nursing assistants

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(NA's) had reported changes to her and stated she was assigned as R48's nurse from 6-10 p.m. LPN-C identified she received a call from family member (F)-A who voiced concerned about R48 as his hand had been purple all day. LPN-C stated in the report she entered R48's room after the call and assessed R48. LPN-C stated she could not get answers from R48 at time of initial assessment but when the ambulance arrived, R48 answered limited questions from the ambulance crew. LPN-C had described R48 as phlegmy and drooling from the left side at the time of the assessment.

In the investigative report, RN-D stated RN-E gave her report and identified R48 was now in a wheelchair, not using the walker and was not doing well. RN-D stated she did not see R48 prior to 9:00 p.m. as she had started passing medications on the other hall. RN-D stated she went down the hall as the call light had been "on" for awhile and observed an NA walking R48 to bed. RN-D stated after a call from F-A, LPN-C assessed R48 and alerted RN-D of the low oxygen saturation level. RN-D stated when she entered R48's room, his eyes were closed and mouth open but did respond "what" when his name was spoken and was able to answer simple questions and follow simple directions. Oxygen had been initiated due to low oxygen saturation reading. RN-D stated she stayed by R48's room until the ambulance crew arrived.

Documentation in the report indicated NA-C stated R48 was very sleepy from the time he was awakened for the day. NA-C stated R48's hands were colder and she reported to R48's nurse (LPN-B) that R48 was different. NA-C stated LPN-C told her she would check R48's vitals.

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NA-C further stated R48 had to to stop three times to walk to dining room which was unusual so R48 was transferred into a wheelchair.

On 11/22/16 the investigative report indicated LPN-B was interviewed. LPN-B stated NA-C had verbalized something was not right with R48. LPN-B stated she looked at him but he was in therapy at the time. LPN-B stated at around 12:00 noon F-A approached her about R48's condition, he was assessed and a message was sent via fax to the clinic. LPN-B stated R48 was able to take pills at the noon meal and hold glass of water for pills. However, during the evening meal, the nurse had to hold the glass. LPN-B described R48 as dusky and drooling but wiped mouth and he answered questions. LPN-B stated R48 had been using the wheelchair for transportation intermittently during the past couple days.

The summation of the investigative report identified the following: R48 had been declining all shift since a.m. The report identified a fax was sent to the physician but no response came back until 11/22/16 at 1:00 p.m. p.m. (next day). Documentation was lacking in the medical record indicating that a physician notification of status change was sent via fax to the physician nor that a physician was contacted prior to the time R48 was transferred to the acute hospital setting. During a phone interview, LPN-B stated she would not be returning to work.

Documentation on the investigative report indicated the DON was conducting shift education to make a change in resident condition seen or reported a priority and ensure a physician is notified by fax or called if condition is a significant change, changes are quick or ongoing. Nurses

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F 226	Continued From page 31 sign sheet as education is received. During interview with Physician (MD)-A on 12/8/16, at 8:47 a.m. MD-A stated she could not recall the incident (referenced) but verified she had seen R48 on 11/18/16, and did not note anything significant about his health status. MD-A stated R48 was doing as well as could be expected, sitting up in chair, with no acute concerns when she saw him. MD-A further stated the facility sent a fax, she wasn't present in the clinic and the fax should have been followed up by the physician on duty. MD-A further clarified the facility staff should have followed up the fax with a call if the health condition had deteriorated. MD-A stated without knowing the exact condition changes assessed by nursing staff, she could not determine whether R48 should have been transferred to the hospital sooner. She verified that staff should attempt to contact the physician if the fax is not responded to in a timely manner.	F 226		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 280		1/13/17

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F 280	Continued From page 32 other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 280		

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F 280	Continued From page 33 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include range of motion (ROM) exercises for 2 of 2 residents (R7, R3) reviewed with limited ROM. Findings include: Review of R7's quarterly Minimum Data Set (MDS) dated 9/30/16 identified a limitation in ROM on one side. The MDS also identified R7 as severely cognitively impaired, requiring extensive assistance of staff with bed mobility and transfers and being totally dependent in dressing, toileting, eating and grooming.	F 280	It is the policy of Golden Living Center Slayton that each resident has a comprehensive care plan that is prepared by the interdisciplinary team and is reviewed and revised after each assessment. The care plans for residents R7 and R3 have been updated and revised to include range of motion exercise due to residents limited ROM. ROM exercises will be completed by facility staff per therapy recommendations. Other residents with limited mobility or ROM have the potential to be affected.	

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F 280	Continued From page 34 During initial observation of R7 on 12/5/16, at 3:22 p.m. R7 was noted to have a contracted left hand with no splint in place. R7's right hand was noted to be clenched and when asked whether she was able to open the right hand, R7 demonstrated she could only partially extend her fingers. On 12/5/16, at 5:00 p.m. R7 was observed with a cloth cone in her left hand and her right hand remained clenched. On 12/6/16, at 2:00 p.m. R7 was again observed to have a cloth splint in her left hand and R7's right hand was clenched shut. On 12/7/16, at 8:30 a.m. R7 was observed to have a cone in her left hand and her right hand remained clinched with no devices in place. During observation of R7's hand in the presence of the occupational therapist (OT) on 12/7/16, at 2:24 p.m. the OT stated there was now a 10-15 degree loss of motion to the left hand from the last time (9/2015) OT worked with R7. OT also stated R7's left thumb was now adducted. She stated since the completion of OT therapy, ROM had worsened. The OT further stated she would identify R7 as having a contracted right hand and felt a splint would be an appropriate intervention to prevent the ongoing contracture. The OT confirmed that a restorative plan should have been implemented after R7 had completed her therapy program on 9/1/16. OT stated she was unaware of the reason the restorative program had not been implemented after OT discharge. The OT was not sure whether the the recommendation had been communicated with	F 280	Residents with limited ROM will be identified and the care plans will be reviewed and updated to ensure ROM exercises are included. Nurses and NARs will be educated in regards to the completion and documentation of ROM programs. Care plans will be reviewed and revised when programs are recommended from therapy. Care plans will also be reviewed and revised quarterly, with changes of condition, and with acute incidents. DNS and/or designee will complete weekly audit of care plans to ensure they are current and have the necessary interventions to maintain the residents highest practicable level. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance.	

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nursing staff.

During review of R7's OT progress and discharge summary note, dated 9/1/16, it was noted OT had developed a restorative plan for R7 and staff were trained on the objectives of the plan. Staff were trained on application of splint, the splint use schedule to decrease further risk of contracture, PROM/AAROM/ (active assistive range of motion) gentle massage to left wrist/digits and heat application to R7's left hand with continuous warm water prior to stretching.

The care plan revised on 10/2/16, identified left hand contracture with intervention to place cone splint on left hand in morning (AM) and remove at bedtime (HS). No intervention for PROM was present on the care plan. Review of the nursing assistant worksheet undated, did not identify a PROM plan nor splint/cone for R7.

When interviewed on 12/7/16, at 1:20 p.m. nursing assistant (NA) B stated R7 is totally dependent in all cares and does not have currently have a ROM program implemented. She stated she tries to clean and open R7's hands to clean them when she does cares. She further stated if you rub it very slowly you can sometimes get it to open up. She can't feed herself or hold food anymore, she is a total assist.

During interview on 12/8/16, at 11:29 a.m. NA-A stated we wash out her left hand and then try to get the cone back in. You have to pry her hand open to get it in. We just wash the hand, we don't do any ROM program for her.

When interviewed on 12/7/16, at 11:42 a.m. the registered nurse (RN)-A confirmed that R7's right

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hand was becoming tighter. She stated R7 has a cone for the contracted left hand that she sometimes removes. RN-A stated the last OT evaluation recommended the cone but R7 had not been seen by OT since. RN-A verified that R7 should be receiving ROM to her left hand; the hand should be massaged and soaked in warm water and gently opened with cares. RN-A stated ROM used to be documented but they no longer sign off. She stated it should be in the kiosk for the aides to chart but it was not in the kiosk. She stated "I'm not going to lie, we aren't doing it, it wasn't care planned". She verified the care plan had not been revised to reflect the program for ROM for R7.
R3's care plan dated 12/7/16 identified R3 with a diagnosis of paraplegia, and a cerebrovascular accident (CVA) with resulting left sided weakness and contracture of the left shoulder/arm. The care area assessment (CAA), indicated R3 as being at risk for functional decline. The care plan did not have an intervention related to passive range of motion (PROM) twice daily as recommended by the occupational therapist-registered (OTR).

The quarterly Minimum Data Set (MDS) assessment dated 10/14/16, identified a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive decline) and R3 required extensive assistance with activities of daily living (ADL) and had impairments in range of motion (ROM) for one upper extremity. The CAA (care area assessment) indicated R3 had little to no voluntary movement in bilateral lower extremities.

Review of the occupational therapy (OT) therapy report dated 10/6/16 revealed R3's OT discharge date as 10/6/16. The goal identified that nursing

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staff implement PROM to prevent deformity and/or skin breakdown by placing a washcloth in R3's left palm. The nursing care plan did not have a intervention related to ROM two times per day and placement of a washcloth, as ordered by the occupational therapist.

On 12/6/16, at 9:10 a.m. R3 was using his right hand to eat; it was noted that the left hand and fingers were tightly contracted into the palm of his hand. No washcloth was noted in the left hand.

On 12/6/16, at 9:45 a.m. during observation of cares R3 was assisted into bed by nursing assistant (NA)-A with the use of the mechanical lift. No attempt was made to place a washcloth into the palm of his hand nor complete ROM exercises.

On 12/7/16, at 7:26 a.m. R3 was again observed eating in the dining room, the fingers of R3's left hand were curled tightly, with his nails digging into the palm of his hand; no washcloth placed in his hand. At 9:33 a.m., R3 was transferred into bed for a morning nap. No ROM nor placement of a washcloth in his left hand was noted.

When interviewed on 12/7/16, at 8:49 a.m. NA-A stated she was familiar with R3's plan of care and sometimes during care R3 winces or resists care and cleaning of his arm and hand. NA-A stated R3 was not on the restorative care list, and "myself and a few others will try to move his hand with cares."

When interviewed on 12/7/16, at 1:22 p.m. the licensed practical nurse (LPN)-A denied knowledge of a PROM training session being provided related to services for R3.

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F 280	Continued From page 38 During a observation and interview on 12/7/16, at 1:40 p.m. the OT confirmed it was the expectation that PROM would be implemented to the wrist and hand morning and evening. The OT confirmed that she had demonstrated the PROM exercise program to a group of 2-3 aides. During interview on 12/7/16, at 10:10 a.m. the director of nursing (DON) stated the NA's completed ROM exercises with cares. The DON confirmed there was no documentation to verify ROM exercises were implemented. At 11:50 a.m. the DON presented an updated NA worksheet. The DON confirmed she revised the plan of care to include "ROM to be completed to left upper extremely, and right lower extremely with a.m. and p.m., cares." to the NA assignment work sheet for R3.	F 280		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		1/13/17

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F 309	Continued From page 39 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate nursing assessment and services for 1 of 1 resident (R48) reviewed who experienced declining health status. This resulted in actual harm for R48, who experienced declining oxygen blood levels, altered vital signs and physical symptoms without ongoing nursing assessment so the appropriate medical intervention could be determined with the deterioration of condition. R48 was transferred to the hospital and expired within 24 hours after hospital admission. Findings include: During review of R48's medical record the nurses' progress notes indicated R48 was admitted on 11/5/16, from a hospital setting. Documentation indicated R48 had fallen at home on 11/3/16, having been discovered by a home health aide who had arrived to provide home services. R48 was taken to the hospital emergency room. R48's diagnoses at the hospital included atrial fibrillation and hyponatremia (low sodium level). The progress notes further indicated R48 had diagnoses including: congestive heart failure (CHF), hypertension (high blood pressure), pulmonary hypertension, atrial fibrillation (irregular heart beat), edema (extra fluid),	F 309	It is the policy of Golden Living Center Slayton that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Resident R48 is no longer a resident at the facility. At the time of the noted incident, staff was educated on appropriate actions to be completed in the future with a noted change in resident condition. Staff will be re-educated on the clinical policy entitled "Notification of Change in Resident Health Status". Education will also be provided to licensed staff regarding the appropriate, timely, and thorough physical assessment needed when a change in condition is noted. Staff will also be educated on the appropriate manner to update a physician when a change in condition is noted. Progress notes in PCC will be reviewed daily (Monday-Friday) by DNS or designee. Progress notes from the weekend will be reviewed on Monday by	

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F 309	Continued From page 40 prostate cancer, anxiety and weakness. At the time of admission to the nursing home, physician orders for R48 included occupational therapy (OT) and physical therapy (PT) to assist with self care training, gait training, and therapeutic exercise. A progress note dated 11/17/16, at 3:29 p.m. indicated R48 required supervision and assist with bed mobility, transfers, ambulation and locomotion. In addition, the note indicated R48 required extensive assistance with dressing, toileting, and bathing. Documentation in the progress notes dated 11/18/16, at 12:38 p.m. indicated the attending physician had examined R48, reviewed his medications, and had not prescribed any new orders. A subsequent note dated 11/18/16, at 4:31 p.m. identified R48's vital signs as: temperature (temp)= 96.8 degrees Fahrenheit (F) ; pulse= 75; respirations=18 and oxygen saturation= 86-90% on room air. That note indicated R48 had denied any shortness of breath, and further that R48 did not use his call light and would ambulate himself into the bathroom with his walker. The documentation also indicated R48 had slightly swollen lower extremities and wore compression stockings (TED hose). A progress note dated 11/20/16, at 1:00 p.m. indicated R48 was able to complete his own morning cares and used a four wheeled walker to ambulate, and did not use his call light for staff assistance. The note also identified R48 denied shortness of breath, was polite, friendly to staff, had a good appetite and offered no complaints. R48's oxygen saturation was recorded at that time to be 91% on room air.	F 309	DNS or designee. Notes will be audited for appropriate notification of MD with condition changes. Daily audits will be reviewed at morning clinical standup with management team. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance.	

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F 309	Continued From page 41 A progress note dated 11/21/16, at 12:59 p.m. indicated R48's family had voiced concerns about R48's detriorating health condition. The family had reported that R48 appeared more tired and had fallen asleep while the family was visiting. Documentation in the progress note indicated that licensed practical nurse (LPN)-B entered R48's room to assess him and the documentation described R48's hands as appearing dark in color and cold to the touch. In addition, the documentation indicated the nurse had been unable to obtain an oxygen saturation level using R48's fingers and described R48's hands as appearing slightly swollen. The note indicated R48 was not ambulating as well as before and vital signs had been recorded as: blood pressure (B/P)= 112/56; Temp=95.6 F; Pulse=92 and Respirations=20. There were no nursing progress notes documented from 11/21/16, at 12:59 p.m. until 11/21/16, at 10:29 p.m. (9 1/2 hours later) to indicate any further assessment had been conducted for R48. A progress note from 10:29 p.m. on 11/21/16, indicated R48's family had contacted the facility at 9:15 p.m. expressing concerns about R48's declining health condition. According to the documentation, the family member stated R48 had purple hands and seemed tired over the past few days. The note further indicated LPN-C had entered R48's room and checked R48's vital signs which were recorded as: B/P= 81/49; Pulse= 60-70's; Respirations=28; Temp= 96.3 degrees F. and oxygen saturation at 65% on room air. The note described R48 as mouth breathing and unresponsive to touch and sound. In addition, the note indicated oxygen had been initiated for R48 and the family contacted. The family requested R48 be sent to the hospital and R48 had	F 309		

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subsequently been transferred to the hospital at 9:30 p.m. by ambulance, after the nurse had obtained a physician order to transport.

When interviewed on 12/6/16, at 12:50 p.m. the director of nursing services (DON) stated she was aware of the incident and that an internal investigation related to the incident had been conducted and that LPN-B had been placed on suspension pending the outcome of the investigation. The DON confirmed LPN-B should have contacted the physician related to R48's declining health status. The DON further explained that LPN-B had sent a fax to the physician which had not been responded to by they physician until the following day after R48 had been hospitalized. The DON stated LPN-B had failed to report R48's condition to the on-coming nurse, or to the day charge nurse prior, to leaving her shift at approximately 5:45 p.m. on 11/21/16.

When interviewed on 12/6/16, at 2:23 p.m. registered nurse (RN)-E stated she remembered the incident with R48. RN-E said she thought at the time that LPN-B had handled the situation. RN-E recalled she felt R48's condition was such that he required medical intervention. RN-E confirmed she had worked until approximately 6:00-6:30 p.m. and that LPN-B had left the facility around 5:45 p.m. RN-E verified she was unaware of what LPN-B had or hadn't done related to seeking medical intervention, until the facility had initiated the investigation. RN-E stated she figured LPN-B had sent a fax to the doctor but was not aware of the status of the physician's response to the fax. RN-E further stated she had not visualized R48 at anytime throughout the shift on 11/21/16.

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F 309	Continued From page 43 During interview with RN-D on 12/6/16 at 2:30 p.m., RN-D stated she had been working the floor from 6:00 p.m. to 10:00 p.m. on 11/21/16. RN-D stated the only concern she'd heard from report was that R48 was not walking as well as he had in the past. RN-D stated she was passing medications and really hadn't had a reason to enter R48's room based on what had been reported to her when she'd come on duty. RN-D further stated R48's family member had been at the facility; RN-D said she'd passed by R48's room a couple times where the family member was, but the family member had never approached her with any concerns. RN-D stated she recalled passing medications later that evening and LPN-C entering R48's room because the family member had contacted her via telephone and voiced concern about R48's health status. RN-D stated she was aware LPN-C had been unable to obtain an oxygen saturation level and that R48's hands were cold and discolored. RN-D further stated R48 was in and out of consciousness and she knew his health had deteriorated. RN-D stated, "I wish I would have known, I would have been right in his room." During interview on 12/6/16, at 2:49 p.m. family member (F)-A stated F-B had noted a change in R48's health status earlier in the day and had asked the physical therapist (PT) how therapy was progressing. F-A stated the PT had verbalized some concerns about R48's health status, stating R48's condition had demonstrated a decline. F-A stated she had spoken to LPN-B earlier in the day on 11/21/16, and LPN-B had informed her that R48's vitals were okay and that the physician had been notified via fax. F-A stated she was uncomfortable about R48's health status	F 309		

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when she left the facility for the day and had decided to call back to speak to staff when she'd arrived home to discuss her concerns.

During interview on 12/7/16, at 7:49 a.m. LPN-C stated when she'd received report at the beginning of the shift on 11/21/16, RN-E had reported that R48 was drowsy and lethargic. LPN-C stated she'd felt there was no reason to go immediately to R48's room based on the shift report. LPN-C further stated she was not assigned to work on the wing where R48 was located and reiterated that she felt from the shift report, there was no urgency related to R48's condition. LPN-C further stated that if she had reviewed the status of R48's condition as documented in the medical record, she would have contacted the physician immediately. LPN-C also explained that if she had faxed the physician and not received a response immediately, she would have called the clinic to speak directly to the physician. LPN-C verified F-A had contacted her via telephone on 11/21/16, time uncertain, at which time she had gone to R48's room to check on his condition. LPN-C said she had been unable to obtain an oxygen saturation reading at that time. LPN-C stated R48 was very lethargic and she'd known immediately R48 was in distress. LPN-C stated since the incident related to R48 had occurred, the DON had met with all staff and discussed the expectations regarding notification of the physician. LPN-C said those discussions had included conversation about when to fax versus call a physician.

The facility's investigation related to this incident was reviewed. The investigation report indicated that on 11/22/16, RN-E had been interviewed by the DON. RN-E had stated in her report that she

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was aware that R48 was "different" during the shift and that family had voiced a concern to LPN-B that R48 was sleepy. The investigative report indicated RN-E had further stated that at supper time it had been brought to her attention that R48 was drooling, but RN-E had stated she had not been asked by the nurse working on the East wing (LPN-B) to assess R48 at anytime during the shift. Additionally, the investigation report failed to indicate whether RN-E had been told in report by LPN-B the condition of R48, or whether RN-E was aware of R48's status change.

The investigation report also indicated LPN-C had been interviewed by telephone on 11/21/16 (time not indicated), and LPN-C had reported LPN-B was no longer at the facility when she'd arrived. The report indicated LPN-C had stated she'd been told in report that R48 was acting different than usual. However, LPN-C had stated no nursing assistants (NA's) had reported changes to her. LPN-C had confirmed she was assigned as R48's nurse from 6-10 p.m. The report indicated LPN-C had verified she'd received a call from family member (F)-A who had voiced concernes about R48 as his hand had been purple all day. LPN-C stated in the report she'd entered R48's room after the call and had assessed R48. LPN-C stated she had not been able to get answers from R48 at the time of her initial assessment, but that when the ambulance had arrived, R48 had answered limited questions from the ambulance crew. The report also indicated LPN-C had described R48 as phlegmy and drooling from the left side at the time of her initial assessment.

In the investigative report, RN-D had indicated RN-E had given her report and had identified R48

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was now in a wheelchair, not using the walker and was not doing well. RN-D stated she did not see R48 prior to 9:00 p.m. as she had started passing medications on the other hall. However, RN-D had stated she'd gone down the hall because the call light had been "on" for awhile and had observed a NA walking R48 to bed. The investigative report indicated RN-D had stated after the call from F-A, LPN-C had assessed R48 and had alerted her (RN-D) of the resident's low oxygen saturation level. RN-D stated when she'd entered R48's room, R48's eyes were closed and mouth open, and that R48 did respond "what" when his name was spoken, and had been able to answer simple questions and follow simple directions. RN-D had reported oxygen had been initiated due to low oxygen saturation reading, and had stated she (RN-D) had stayed by R48's room until the ambulance crew had arrived.

Additional documentation in the report indicated NA-C had stated R48 was very sleepy from the time he was awakened for the day. NA-C stated R48's hands were colder and she reported to R48's nurse (LPN-B) that R48 was different. NA-C stated LPN-C told her she would check R48's vitals. NA-C further stated R48 had to to stop three times to walk to dining room which was unusual so R48 was transferred into a wheelchair.

The investigative report indicated LPN-B had been interviewed on 11/22/16. LPN-B had reported at that time that NA-C had verbalized something was not right with R48. LPN-B stated she had looked at R48 but he'd been in therapy at the time. LPN-B verified that around 12:00 noon on 11/21/16, F-A had approached her about R48's condition. At that time, LPN-B stated she'd

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assessed R48 and has sent a message via fax to the clinic. LPN-B stated R48 had been able to take his pills at the noon meal and hold a glass of water. However, during the evening meal, LPN-B said the nurse had to hold R48's water glass. LPN-B described R48 as having been dusky and drooling, but stated she'd wiped his mouth and he'd answered questions. The investigative report further indicated LPN-B had stated R48 had been using the wheelchair for transportation intermittently during the past couple days.

The summation of the facility's investigative report identified the following: R48 had been declining all shift since a.m. (morning). A fax was sent to the physician but no response came back until 11/22/16 at 1:00 p.m. (the following day). Documentation was lacking in the medical record to indicate a physician notification of status change had been sent via fax to the physician, or that a physician was contacted prior to the time R48 was transferred to the acute hospital setting other than the order to transfer via ambulance. In addition, the summation report indicated during a phone interview, LPN-B had stated she would not be returning to work.

Documentation on the investigative report further indicated the DON was conducting shift education, to make a change in resident condition, seen or reported, a priority. And to ensure the physician was notified by fax, or called if a signifiant change in condition, changes are quick or ongoing. Nurses sign sheet as education is received. Documentation was lacking to indicate the lack of nursing assessment had been addressed to ensure resident medical needs were met.

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F 309	Continued From page 48 During interview with Physician (MD)-A on 12/8/16 at 8:47 a.m., MD-A stated she could not recall the incident related to the date but verified she had seen R48 on 11/18/16, and did not note anything significant about his health status. MD-A stated R48 was doing as well as could be expected, sitting up in chair, with no acute concerns when she'd seen him. MD-A further stated the facility had sent a fax however, she wasn't present in the clinic so the fax should have been followed up by the physician on duty. MD-A clarified the facility staff should have followed up on the fax with a call to the MD when the resident's health condition had deteriorated. MD-A stated without knowing the exact condition changes assessed by nursing staff, she could not determine whether R48 should have been transferred to the hospital sooner. She verified that staff should attempt to contact the physician if a fax is not responded to in a timely manner. Although the facility investigated the events surrounding R48's condition decline and the staff failure to promptly notify the physician, there was a failure of timely nursing assessment which had not been addressed nor had a system been implemented to ensure nursing staff conduct a thorough physical assessment when a change in condition had been identified.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		1/13/17

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F 312	Continued From page 49 Based on observation, interview and document review the facility failed to provide personal hygiene for 1 of 1 resident (R3) dependent upon staff assistance for all activities of daily living (ADL). Findings include: R3's care plan dated 12/7/16, identified R3 with a diagnosis of paraplegia, and a cerebrovascular accident (CVA) with resulting left sided weakness and contracture of the left shoulder/arm and hand. The quarterly Minimum Data Set (MDS) assessment dated 10/14/16, identified that R3 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive decline). The MDS also identified R3 as requiring extensive staff assistance with activities of daily living (ADL). Review of the occupational therapy (OT) therapy report dated 10/6/16 revealed R3's OT discharge date as 10/6/16. The goal identified was for the nursing staff to follow positioning protocol for passive range of motion (PROM) to prevent skin breakdown by placing a washcloth in R3's left palm. According to the nursing assistant assignment document, R3 had a regularly scheduled shower weekly on Tuesday (12/5/16). On 12/6/16, at 9:10 a.m. R3 was using his right hand to eat; it was noted that the left hand and fingers were tightly contracted into the palm of his hand. No washcloth was noted in the left hand. On 12/6/16, at 9:45 a.m. during observation of cares R3 was assisted into bed by nursing assistant (NA)-A with the use of the mechanical	F 312	It is the policy of Golden Living Center Slayton to provide hygiene care to all residents with contractors to promote hygiene and prevent skin breakdown. Resident R3 has orders requested to have new evaluation from OT. Staff is providing care with AM and PM cares to hand and arm. Lidocaine cream to be applied before cares to fingers and has been ordered to attempt to provide comfort and allow staff to provide cares to hand. Staff will be educated on care of contracted limbs and use of splints/wash clothes if ordered by OT. Grooming audits will be randomly done weekly to ensure all residents are being provided proper hygiene. Audits will be done weekly by DNS and/or designee. Audits will be reviewed at monthly QAPI meeting. QAPI Committee will provide direction or change when necessary. QAPI Committee will dictate the continuation or completion of this monitoring process based on audit results/notes. DNA and/or designee are responsible for monitoring compliance.	

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F 312	Continued From page 50	F 312		

lift. No attempt was made to do hand hygiene or place a washcloth into the palm of his hand.

On 12/7/16, at 7:26 a.m. R3 was again observed eating in the dining room. The fingers of R3's left hand were curled tightly, with his nails digging into the palm of his hand and no washcloth had been placed into the contracted hand. At 9:33 a.m., R3 was transferred into bed for a morning nap. No hand hygiene nor placement of a washcloth into his left contracted hand was noted.

When interviewed on 12/7/16, at 8:49 a.m. nursing assistant (NA)-A stated she was familiar with R3's plan of care and explained that sometimes during care R3 winces or resists care and cleaning of his arm and hand.

When interviewed on 12/7/16, at 1:22 p.m. LPN-A revealed that last week she remembered the condition of the hand was reported to the RN and it was LPN-A's understanding the RN was going to get an order for Nystatin cream application to the hand. Document review in the medical record for the past 3 weeks lacked evidence that Nystatin cream had been ordered and/or applied.

On 12/7/16, at 1:40 p.m. the OTR and the surveyor observed the condition of R3's hand together. It was noted that R3 covered his left hand with his right hand as he remained seated in his chair. There was no washcloth noted in the left contracted hand and the OT confirmed the fingers (#2-#3-#4) were digging into the palm of the hand, especially without a wash cloth applied to the left hand. Upon gently moving and coaxing of the fingers, the skin underneath was noted to be a deep red color and the hand had a strong pungent yeast odor when the fingers were

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F 312	Continued From page 51 opened from the palm of the hand. The odor of the hand was confirmed with the presence of the OT. When interviewed on 12/8/16 at 10:10 a.m. the director of nursing (DON) requested a skin assessment of the left hand be conducted.	F 312		
F 318 SS=G	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a plan of care recommended by the occupational therapist upon discharge from therapy to prevent further decrease in range of motion (ROM) for 2 of 2 residents (R7, R3) reviewed who had limited ROM. This resulted in harm for R7 and R3 who both experienced a decrease in range of motion when restorative services were not provided as recommended. Findings include: Review of R7's quarterly Minimum Data Set	F 318	It is the policy of Golden Living Center Slayton to provide residents treatment and care in mobility (Range of Motion) in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Residents R3 and R7 care plans and care sheets and nursing TAR/MAR have been updated with daily ROM by CNA or Nurse staff. A ROM sign off sheet has been placed for staff to sign daily after providing care. Other residents with limited or decreased	1/13/17

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F 318	Continued From page 52 (MDS) assessment dated 9/30/16, identified a limitation in ROM on one side. The MDS also identified R7 as severely cognitively impaired, requiring extensive assistance of staff with bed mobility and transfers, and as being totally dependent in dressing, toileting, eating and grooming. The record indicated R7 received OT (occupational therapy) services in 2015 related to a a decline in functional ROM to the left hand. At that time a restorative plan for R7 was developed and staff were trained on the objectives of the plan. Staff were trained on application of a splint, the splint-use schedule to decrease further risk of contracture, PROM/AAROM/ (active assistive range of motion), gentle massage to left wrist/digits and heat application to R7's left hand with continuous warm water prior to stretching. During initial observation on 12/5/16, at 3:22 p.m. it was noted that R7 had a contracted left hand with no splint in place. R7's right hand was noted to be clenched and when asked whether she was able open the right hand, R7 demonstrated she could only partially extend her fingers. On 12/5/16, at 5:00 p.m. R7 was observed with a cloth cone in her left hand and her right hand remained clenched. On 12/6/16, at 2:00 p.m. R7 was again observed to have a cloth splint in her left hand and R7's right hand was clenched shut. On 12/7/16, at 8:30 a.m. R7 was observed to have a cone in her left hand and her right hand remained clinched with no devices in place.	F 318	ROM will be assessed for need for ROM program. Staff will be provided education as to the individual program for each resident and where to document that the program was completed. Therapy will also be providing basic ROM education to the nursing staff. ROM sign off sheet will be audited for completeness weekly. Residents with decline in motion or contractors will have an order request sent to primary MD to have therapy evaluation. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance.	

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F 318	Continued From page 53 On 12/7/16, at 11:50 a.m. the surveyor entered R7's room with registered nurse (RN)-A and observed R7 with a cone in her left hand which had slid out of position. RN-A attempted to extend R7's right hand but was unable to fully extend R7's fingers. RN-A stated R7's right hand/fingers [ROM] exhibited more stiffness. RN-A verified R7's right hand was contracted and R7 was unable to fully extend the fingers to an open position. RN-A then removed the ill-positioned cone from R7's left hand and attempted to place it back into the appropriate position in the hand. It was observed that R7 exhibited some facial grimacing when RN-A attempted to place the cone back into R7's left hand. The left hand was noted to be tightly contracted and it took some effort for RN-A to open the left hand adequately to place the cone. During the observation, RN-A stated she did not think there had been any change in the contracture noted on R7's left hand. During observation of R7's hand in the presence of the occupational therapist-registered(OTR) on 12/7/16, at 2:24 p.m. the OTR stated there was now a 10-15 degree loss of motion to the left hand from the last time OT had evaluated and provided services to R7 (9/2015). The OTR also stated R7's left thumb was now adducted. She reiterated R7's ROM had declined since discharge from therapy (9/2015). The OTR stated she could identify through assessment that R7 had a contracted right hand and felt a splint would be an appropriate intervention for the contracture to prevent ongoing contraction. The OTR also stated a restorative plan should have been in place after R7 had completed the therapy program in 9/1/15. The OTR stated she was unaware why a restorative program had not been	F 318		

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established, and didn't know whether or not this had been communicated to nursing staff. The OTR stated a request would be submitted for an OT evaluation for R7.

Review of the OT plan of care dated 12/8/16 (developed during the survey), identified that R7 had been dependent for all self cares for several months and now presented with a decline in functional ROM of right hand due to often clenching fist closed. R7 was identified as having had a decline in ROM of the right hand which resulted in R7 requiring significantly more assistance with ROM tasks of the right hand. The plan of care identified that due to an increased risk of skin breakdown and flexion pattern of the right hand, and no updated ROM plan for both hands, R7 required skilled OT services to determine appropriate ROM plans and orthotic use of both hands and to provide proper training of nursing staff to implement upon OT discharge. Documentation identified that R7 had marked increase in tightness in right hand as she often clenched fist closed, and R7 had a cone splint for use of left hand but did not have an orthotic or ROM program for right hand.

The current care plan revised on 10/2/16, identified a left hand contracture with intervention to place cone splint on left hand in morning (AM) and remove at bedtime (HS). No intervention related to ROM exercises had been identified on the care plan. Review of the undated nursing assistant (NA) worksheet provided by the facility, lacked any mention of a ROM plan or splint/cone use for the hand.

When interviewed on 12/7/16, at 1:20 p.m. NA-B stated R7 was totally dependent in all personal

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cares and does not currently have a ROM program. She explained that she attempts to clean/open R7's hands during cares and further stated that if you gently rub her fingers, they sometimes open up. NA-B verified R7 is no longer able to feed herself and/or hold food as she requires total staff assistance.

During interview on 12/8/16, at 11:29 NA-A stated staff wash R7's left hand and then try to place the cone back in the hand. NA-A stated they have to pry her hand open to replace the cone. NA-A confirmed staff wash the hand but have not been providing ROM exercises.

During interview on 12/7/16, at 11:42 a.m. registered nurse (RN)-A (the facility's restorative nurse) confirmed that R7's right hand was becoming tighter. RN-A stated R7 has a cone placed in the contracted left hand, but that R7 sometimes removes it. RN-A stated the last OT evaluation had occurred when the cone was placed and that no OT had been provided since that occurrence. RN-A agreed that R7 should be receiving ROM to her left hand; stating the hand should be massaged, soaked in warm water and gently opened with cares. RN-A verified she was unaware of any ROM plan implemented for the right hand. RN-A confirmed, "we did not have a ROM program in place and we should have."

R3's care plan dated 12/7/16, identified R3 as having diagnoses of paraplegia, cerebrovascular accident (CVA) with resulting left sided weakness, and a contracture of the left shoulder/arm and hand. Upon discharge from OT on 10/16/16, the OTR had recommended that nursing staff implement passive range of motion (PROM) twice daily. However this was not evident on the plan of

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F 318	Continued From page 56 care. The quarterly Minimum Data Set (MDS) assessment dated 10/14/16, identified a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive decline). The MDS also identified R3 as requiring extensive assistance with activities of daily living (ADL) and having impairments in ROM on one side of the upper extremity. The CAA documentation indicated R3 had little to no voluntary movement in bilateral lower extremities. Review of the occupational therapy (OT) discharge summary for R3 dated 10/6/16, indicated a goal that nursing staff were to follow a positioning protocol for implementation of PROM to prevent deformity. According to the OT discharge summary, at the time of discharge, R3's left wrist had a resting range of motion of 45 degrees flexion. The nursing care plan failed to identify the OT recommendation/intervention related to PROM. During observation on 12/6/16, at 9:10 a.m. R3 was using his right hand to eat; it was noted the left hand and fingers were tightly contracted into the palm of his hand. There was no splint in place in the contracted left hand. When cares were observed on 12/6/16, at 9:45 a.m. R3 was assisted into bed by NA-A with the use of the mechanical lift. No attempt was made to complete PROM exercises. On 12/7/16, at 7:26 a.m. R3 was again observed eating in the dining room. The fingers of R3's left hand were curled tightly, with his nails digging into the palm of his hand. At 9:33 a.m. R3 was	F 318		

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F 318	Continued From page 57 observed to be transferred into bed for a morning nap. Staff did not perform PROM to the contracted left hand. When interviewed on 12/7/16, at 8:49 a.m. NA-A stated she was familiar with R3's plan of care and indicated that R3 sometimes winces or resists care. NA-A stated R3 was not identified on the restorative care list, but "myself and a few others will try to move his hand with cares." NA-A denied receiving instructions related to PROM exercises for R3. When interviewed on 12/7/16, at 1:22 p.m. licensed practical nurse (LPN)-A denied knowledge of a PROM training session having been provided by OT to instruct staff how to perform PROM to R3's left hand. During observation and interview on 12/7/16, at 1:40 p.m. the OTR confirmed it had been the expectation for PROM exercises to be performed to R3's wrist and hand in the morning and evening. The OTR confirmed she had demonstrated the PROM exercise program to a group of 2-3 aides in the facility. At that time, the OTR examined R3's hand. R3 was seated in his chair with the right hand placed on top of the left contracted hand. The OTR gently examined the left hand, indicating it had definitely deteriorated since R3 had been discharged from OT in October 2016. The OTR stated an expectation that PROM and placement of a washcloth into the palm of R3's hand had been implemented since discharge from therapy. The OTR stated, "I could get his fingers open to 90 degrees and put his splint on. Now I can get very little movement." Review of the OTR discharge summary identified this position had been accomplished at rest. The	F 318		

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OTR explained that utilization of a warm pack to the left hand prior to PROM "would certainly help."

The OTR then proceeded to prepare a towel with warm water from the sink and wrapped the left contracted hand for 2 minutes. With gentle coaxing of the fingers, the OTR was able to move the little finger 1/2 inch. It was noted that fingers (#2, #3 and #4) were digging into the palm of the resident's left hand. When the fingers were moved away from the palm of the hand, the skin underneath was a deep red color. The OTR stated, "it has gotten a lot worse." R3 began to resist any further movement of the left contracted hand and fingers; the OTR verified she would definitely resume OT.

When interviewed on 12/7/16, at 10:10 a.m. the DON stated the NA's were expected to complete ROM exercises with personal cares. The DON confirmed there was no documentation to verify the PROM exercises had been performed for R3. On 12/7/16, at 11:50 a.m. the DON presented an updated NA work sheet. The DON confirmed she just added "ROM to be completed to left upper extremity and right lower extremity with a.m. and p.m. cares." to the assignment sheet for R3.

Review of the facility's policy Mobility/Range of Motion last reviewed 11/28/16, included: The facility must ensure that a resident who enters the facility without a limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease

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F 318	Continued From page 59 in range of motion. Upon assessment, if a resident is identified as having a change in ROM, the DNS (director of nursing services)/designee may seek a referral to therapy for further evaluation.	F 318		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess a lap belt to promote safe care for 1 of 1 resident (R23)	F 323	It is the policy of Golden Living Center Slayton that the resident's environment remains as free from accident hazards as	1/13/17

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F 323	Continued From page 60 reviewed who utilized a lap belt. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 11/18/16, identified R23 required extensive assistance of two staff to transfer, toilet and move in bed. The assessment further identified R23 had a Brief Interview for Mental Status (BIMS) score of one (1) indicating severe cognition impairment. R23's quarterly MDS also identified R23 as unsteady with standing and transfers and had a history of falls, indicating R23 had sustained two or more falls since last assessment (8/25/16) with no injuries as a result of the falls. During initial observation on 12/6/16, at 8:48 a.m. R23 was in her room seated in the wheelchair with a lap belt across her lap. The lap belt was loosely applied, with several inches noted between R23's lap and the placement of the cloth belt. The cloth belt had a plastic seat belt clip and Velcro to hold the ends of the belt together. Documentation in R23's medical record identified that R23 had sustained multiple falls as noted: (1) Progress note dated 9/29/16, at 7:09 a.m. identified R23 was found lying on the floor on her right side in her in front of the bathroom door. No apparent injury noted (2) Progress note dated 10/8/16, at 2:29 a.m. identified R23 was in her wheelchair going to her room and staff went to wheel her back to the nurses station and while the nursing assistant (NA) was pulling her back with her wheelchair R23 attempted to stand up and as she was sitting back on wheelchair, sat on the edge of wheelchair and slid to the floor. No apparent	F 323	is possible. Resident R23 utilizes an alarming Velcro seatbelt when in wheelchair as a fall intervention. An assessment has been completed for the safe use and placement of the seatbelt. The seatbelt has been discontinued at this time. Residents who are using seatbelts will also have an assessment completed for the safe use and placement of safety. Staff will be education on the appropriate placement and assessment of lap belt devices prior to placement of device. DNS and/or designee will complete weekly audits of residents with lap belt devices to ensure assessments have been completed and devices are applied safely. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS and/or designee are responsible for monitoring compliance.	

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F 323	Continued From page 61 injury noted. will continue to monitor. (3) Progress note dated 10/10/16, at 10:39 p.m. identified staff heard R23's floor alarm sounding and found R23 sitting on her buttocks leaning to the right side. The note identified R23 was attempting to get herself up. No injuries noted. (4) Progress note dated 10/20/16, at 10:15 p.m. identified R23 was found kneeling on a mat next to her bed, with her buttocks still on body pillow on side of bed. Staff unable to get lift sling on resident effectively, so staff used a 2 person transfer with gait belt applied. While R23 was standing up with staff assist, R23 became dead weight and began to kneel on the ground, attempting to get to ground. Staff lowered R23 to knees and lying position on the floor and utilized the Hoyer lift to assist into geri-chair. No injuries noted. (5) Progress note dated 10/24/16, at 10:34 p.m. identified R23 was found sitting on floor on buttocks at the head of her bed. (6) Progress note dated 10/25/16, at 10:05 a.m. identified the interdisciplinary team (IDT) discussed R23's on-going falls and placed a call to the hospice case manager to discuss falls. Plan is for hospice aide to come in late afternoon and evening when R23 was restless rather than in the morning when R23 exhibits sleeping and/or calmer. (7) Progress note dated 10/26/16, at 2:43 p.m. identified R23's alarm was heard sounding at 1:50 p.m. and was found sitting halfway on the foot rest of the recliner, and halfway on the floor; the recliner was tipped forward. (8) Progress note dated 11/23/16, at 3:27 a.m. R23 was found sitting on floor about 4 feet in front of her fully reclined geri-chair. R23 was observed scooting around on the floor and laughed at staff when they discovered her on floor. R23 had been	F 323		

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F 323	Continued From page 62 observed sleeping in geri-chair a few minutes before the incident occurred. No injuries noted. R23's care plan for Mobility/Falls, dated 11/21/16, identified R23 had risk for falling related to dementia, confusion, cardiovascular disease, psychotropic med therapy, balance deficit, non-ambulatory status, Right foot drag, diabetic neuropathy, lumbago, multi-level anterior vertebral body, soundless, history of acute lower back pain, hip pain and fall history. The care plan identified a goal for R23 to be free of falls or injury through interventions that included: (1.) Alarming Velcro seat belt use when in wheelchair- belt is not a restraint as resident is able to release belt per self . (2.) Assist of 1-2 to pivot transfer, and/or assist of 1 and stand lift to transfer. (3.) Body pillow for positioning & noodle under bottom sheet on outside of bed. (4.) Bring back from meals and toilet. (5.) Do not leave resident alone in room unless in bed. (6.) Floor mat with alarm to be placed next to bed on floor any time bed is occupied. (7.) Grip strips placed on floor in front of bed-grip strips placed on floor in front of lounge chair (8.) Keep call light in reach and remind resident to use call light to get up with each interaction. When interviewed on 12/7/16, at 8:02 a.m. the director of nursing (DON) stated she could not find an assessment for the use of the lap belt and stated the facility probably did not assess the belt because it was not a restraint. The DON was interviewed about R23's safety with the use of the	F 323		

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F 323	Continued From page 63 loose lap belt as R23 had a history of sliding out of her chair and bed. The DON verified the lap belt had not been assessed for safe use and verified it should be assessed to determine whether it was too loose. It was confirmed there had been no assessment conducted for safe use of the lap belt device. During interview with the DON on 12/8/16 at 8:30 a.m. the DON stated staff had looked at belt and it was tightened to R2's lap and marked so staff would know how it should be placed on R23. During observation of R23 during the breakfast meal in the dining room on 12/8/16, at 8:40 a.m. R23 was observed seated in her w/c with the lap belt firmly placed on her lap.	F 323		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		1/13/17

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F 520	Continued From page 64 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to develop a quality assessment and assurance (QAA) committee that established appropriate plans of action for identified quality deficiencies related to timely notification of physician, comprehensive assessment of resident condition, immediate reporting of potential abuse/neglect incidents and follow up by nursing staff with therapy recommendations to prevent decline in range of motion. This practice had the potential to affect all 37 residents who currently reside in the facility. Findings include: The facility's quality assessment and assurance	F 520	Action plans will be established for timely notification of physician, comprehensive assessment of resident condition, immediate reporting of potential abuse/neglect incidents and follow up by nursing staff with therapy recommendation to prevent further decline in range of motion. The QAPI program will focus on quality care and quality of life for the residents. These action plans will be aimed at performance improvement and will measure the success with auditing. The performance will be tracked to ensure that improvements are sustained. Management team will discuss action	

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F 520	Continued From page 65 (QAA) committee met monthly and discussed potential quality concerns. However, the program lacked action plans that corrected quality deficiencies and failed to monitor/sustain identified areas which lacked current quality of care standards. The facility failed to meet resident needs, including timely physician notification when a resident health needs required medical intervention and/or additional intervention from another health care setting. In addition, the facility failed to provide a comprehensive and ongoing nursing assessment of a resident's health needs to monitor the need for timely physician intervention and treatment related to deteriorating health. Furthermore, the facility failed to report the incident of potential neglect of care to the State Agency as required by law. Although the facility investigated the events surrounding R48's condition decline and the staff failure to promptly notify the physician, there was a failure of timely nursing assessment which had not been addressed nor had a system been implemented to ensure nursing staff conduct a thorough physical assessment when a change in condition had been identified. The QAA committee could not demonstrate that when evidence of non-compliance related to standards of practice was investigated, a root cause analysis was not conducted to determine what system failed in meeting resident needs and to develop and implement an action plan to prevent a repeat event. The director of nursing (DON) and administrator were interviewed on 12/8/16, at 9:50 a.m. The DON stated the facility had addressed concerns	F 520	plans daily in IDT meeting. Daily updates will be documented on the standup/SCOOP form and brought monthly to QAPI meeting. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. ED is responsible for compliance.	

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F 520	Continued From page 66	F 520		

with the notification of the physician for changes in resident health status for about three months after the deficiency was cited during the March 2016 survey but had not maintained any system to evaluate/re-evaluate the ongoing response after the initial 3 months to ensure compliance had been sustained. The DON stated the QAA meeting has many topics discussed but there had been no root cause analysis and/or real analytical response to the identified quality of care/practice issues.

The facility failed to put systems in place to prevent identified quality of care problems. These were related to provision of care and services for a resident experiencing acute deteriorating health, prompt notification of the physician during such an episode and timely reporting of potential neglect to State agencies as required by law. In addition, a system to ensure the appropriate therapy recommendations were followed thru by nursing staff had not been identified to prevent loss of range of motion.

See F157- Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 1 resident (R48) reviewed who experienced a significant change in medical condition. This resulted in actual harm for R48, who experienced declining oxygen blood levels, altered vital signs and physical symptoms without ongoing nursing assessments so the appropriate medical intervention could be implemented while the deterioration of condition occurred.

See F225-Based on interview and document review, the facility failed to immediately notify the administrator and/or State Agency (SA) of an

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F 520	Continued From page 67 alleged violation of neglect for 1 of 1 resident (R48) reviewed who experienced a decline in health status without ongoing nursing assessment and subsequently transferred to the hospital. See F226- Based on interview and document review, the facility failed to implement their Abuse/Neglect policy to ensure immediate reporting of allegations of potential neglect of treatment to the State Agency (SA) for 1 of 1 resident (R48) reviewed who experienced a decline in health status without ongoing nursing assessment and subsequently transferred to the hospital. See F309-Based on interview and document review, the facility failed to provide adequate nursing assessment and services for 1 of 1 resident (R48) reviewed who experienced declining health status. This resulted in actual harm for R48, who experienced declining oxygen blood levels, altered vital signs and physical symptoms without ongoing nursing assessment so the appropriate medical intervention could be determined with the deterioration of condition. R48 was transferred to the hospital and expired within 24 hours after hospital admission. See F318- Based on observation, interview and document review the facility failed to implement the plan of care recommended by the occupational therapist upon discharge from therapy to prevent further decrease in range of motion (ROM) for 2 of 2 residents (R7, R3) reviewed with limited ROM. This resulted in harm for R7 and R3 who experienced a decrease in range of motion when restorative services were not provided as recommended.	F 520		

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 6, 2016. At the time of this survey, Golden LivingCenter Slayton was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter Slayton was constructed as follows: The original building was constructed in 1965, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control	K 324		1/13/17

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K 324	Continued From page 2 and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		
	This STANDARD is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.This deficient practice could affect 37 of the 37 residents, visitors and staff. Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2		It is the practice of Golden Living Center Slayton to obtain Kitchen Fire Suppression system inspection on a semi-annual schedule. Documentation was retrieved by our inspection company, Hometown Fire, stating this was completed in April 2016. Maintenance will review his records randomly to ensure all inspections are completed and documentation within his records.	

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K 324	Continued From page 3 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/06/2016, documentation reviewed could not show that the Kitchen Fire Suppression System was inspected on a semi-annual schedule. Documentation was reviewed for the inspection on October 18, 2016, but could not be located for the inspection that should have occurred in April, 2016. This deficient practice was verified by the Facility Maintenance Director.	K 324		
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 345		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

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K 345	Continued From page 4 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 37 out of 37 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/06/2016, documentation reviewed revealed that the DACT System was not tested during the 2015/2016 fire drills conducted on the night shift. This deficient practice was verified by the Facility Maintenance Director.	K 345	It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. All residents have the potential to be effected; however, there was no actual harm. Maintenance man has been educated to complete silent alarm test during the day from 11am to 6 pm to ensure bells and chimes are received monthly by Fire Protection Company. ED will monitor on an ongoing basis with results brought to QAPI	
K 346 SS=D	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the	K 346		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

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K 346	Continued From page 5 fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 37 out of 37 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/06/2016, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current staff contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	It is the practice of Golden Living Center contact staff names and phone numbers in the Fire Alarm Out of Service Plan. This has been completed by maintenance, signed by ED and placed in the proper area.	
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		1/13/17

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	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

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K 354	Continued From page 6 sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 37 out of 37 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/06/2016, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current staff contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	It is the practice of Golden Living Center Slayton to state current contact staff names and phone numbers in the Fire Sprinkler Out of Service Plan. This has been completed by maintenance, signed by ED, and placed in the proper area.	

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	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

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K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 37 out of 37 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/06/2016, documentation could not be provided that indicated the fire/smoke damper test had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	It is the practice of the facility to ensure that fire/smoke damper test occur every 4 years. No residents were affected by this. Mike's Plumbing and Heating along with the facility maintenance man inspected dampers. It was decided to replace all dampers. Completion date will be January 13, 2017 and testing ongoing.	1/13/17