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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N8N9

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 **09/08/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (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 :
Lois Boerboom, HFE NE II 09/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245386

September 18, 2015

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 August 24, 2015 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, Program Specialist
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 16, 2015

Ms. Theresa Pridel, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, Minnesota 56172

RE: Project Number S5386025

Dear Ms. Pridel:

On July 31, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 5, 2015. (42 CFR 488.422)

On September 8, 2015, 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 an extended survey, completed on July 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 24, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 17, 2015, as of August 24, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 24, 2015.

However, as we notified you in our letter of July 31, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 17, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245386	A. Building B. Wing	9/8/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/10/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/18/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **08/24/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **08/10/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	09/16/2015	34083	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/17/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245386	01 - MAIN BUILDING 01	8/13/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	08/10/2015	ID Prefix Reg. # NFPA 101 LSC K0154	08/10/2015	ID Prefix Reg. # NFPA 101 LSC K0155	08/10/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/kfd	09/16/2015	34083	08/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
7/14/2015

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: N8N9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

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(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 **07/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 08/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/19/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
July 31, 2015

Ms. Theresa Pridel, Administrator
Golden Livingcenter - Slayton
2957 Redwood Avenue South
Slayton, Minnesota 56172

RE: Project Number S5386025

Dear Ms. Pridel:

On July 17, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic 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.

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 16, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 5, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Golden Livingcenter - Slayton is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 October 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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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. A recertification survey was conducted by the Minnesota Department of Health on 7/13, 7/14, 7/15, 7/16 and 7/17/15. An extended survey was conducted on 7/16 and 7/17/15. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess and effectively implement interventions in order to minimize the risk of serious injury or death from elopements for R55 who had eloped from the facility. The immediate jeopardy that began on 7/15/15, and identified on 7/15/15, at 12:33 p.m. and was removed on 7/16/15, at 3:30 p.m. after the facility implemented a removal plan. However, non-compliance remained at the lower scope and severity level of a D, isolated, with no actual harm with a potential for no more than minimal harm.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164		8/10/15

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

Electronically Signed | 08/10/2015

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F 164	Continued From page 1 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure that confidential medical information was protected during 9 of 9 medication pass observations when staff left the electronic medical administration record (eMAR) open and viewable by residents, staff and/or visitors. Findings include:	F 164	It is Policy and Procedure of Golden Living Center Slayton to provide privacy and confidentiality to our residents. All licensed staff and TMAs have been reeducated on confidentiallly of (EMR) electronic medical records while administering medications. All staff have been reeducated on HIPPA and the	

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F 164	Continued From page 2 On 7/15/15, at 7:28 a.m. trained medication aide (TMA)-B was observed in the process of passing medications to residents when she accessed the computer screen, displaying the electronic medication administration record (eMAR). TMA-B walked away from the cart without locking and/or removing the medical information displayed. This information included resident diagnoses and prescribed medications on the eMAR and allowed visualization by six residents who were seated within visual range of the screen. It was again observed on 7/15/15, at 7:34 a.m. that TMA-B walked away from the displayed eMAR located on the top of the medication cart. TMA-B proceeded to deliver medications to R17 located down the hall in his room. During the time TMA-B administered the medication to R17 in the resident room, confidential information including medical diagnoses, prescribed medications and personal information remained visible on the screen of the computer. The information remained within view and available for staff and residents in the immediate area to have access. During this time, one resident was observed to transport himself around the nurses station and within visual range of the displayed confidential information. No staff were in the area and/or monitoring the access to the computer screen. TMA-B returned to the unattended eMAR information at 7:40 a.m. (6 minutes later) and documented the medications administered. Without locking and/or removing the information, TMA-B left the vicinity and proceeded outside the building to locate some oxygen tanks stored in the shed. TMA-B returned at 7:46 a.m. (6 minutes later) and the eMAR remained unlocked	F 164	expectations of privacy and confidentiality as it relates to all of our residents. Monitoring to ensure conmliance will be performed by the DNS/Designee through random weekly audits during medication pass for privacy and confidentiality. The results of the audits will be reviewed at monthly QAPI.	

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and visible to view.

It was again noted that TMA-B left the eMAR open on 7/15/15, at 7:53 a.m. while three residents were seated in the immediate area located next to the medication cart near the nurses' station. The nurses' station is located in the center of the four resident hallways of the facility. No staff were in the area to monitor the medication cart nor the confidential information evident on the display. TMA-B returned at 7:55 a.m. after she walked down the hall to administer additional medications to a resident. TMA-B routinely dished up resident medications, walked away from the eMAR and failed to lock the computer screen to protect confidential resident information. At 8:12 a.m. as TMA-B left the area of the medication cart, the eMAR was left open with medication information displayed and she walked into the central supply room to retrieve needed supplies.

It was noted that when the eMAR was left unattended and visible to view, a resident walked by the medication cart at 8:55 a.m. when TMA-B had left the immediate area and failed to lock the computer screen. TMA-B did not return until 8:59 a.m. (4 minutes later).

The following day, on 7/16/15 TMA-B continued to pass medications from the medication cart which was centrally located at the nurses' station. It was noted that TMA-B dished up medication for each resident after opening the eMAR screen, left the immediate area of the nurses' station and walked down the designated hallway to deliver the resident medications without locking the screen of the eMAR. Confidential resident information remained visible during the timeframe

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TMA-B was not located in the immediate area of the medication cart and eMAR. TMA-B left the cart at 8:25 a.m. and walked down the south hallway to administer medication. She did not return until 8:29 a.m. (4 minutes later).

On 7/16/15, at 10:02 a.m. when TMA-B left the unlocked computer with the displayed eMAR medical information open, three residents were noted to be within visual range of displayed screen. TMA-B left the immediate area to continue with the medication pass. On 7/16, 15, at 10:09 a.m. three residents and one family member were noted to be seated in the immediate area when the eMAR was left unlocked and open to view. One additional family member was observed to walk past the displayed/unattended eMAR screen during the timeframe when TMA-B was not in the immediate area.

On 7/16/15, at 10:28 a.m. TMA-B again left the eMAR screen unlocked as she delivered medications to residents located on the north hallway. One resident was noted to be seated in the immediate area of the nurses' station and within visual range of the displayed eMAR screen. The medication cart was never transported down the hallways during the medication pass by staff. The TMA-B routinely left the screen unlocked on the eMAR located on the medication cart at the nurses' station located in the center of the four resident hallways.

When interviewed on 7/16/15, at 2:27 p.m. the director of nursing (DON) verified when the eMAR screen is left unlocked and confidential information is displayed, this was a privacy issue. The DON indicated she expected staff to

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F 164	Continued From page 5 close/lock the eMAR screen when they left the medication cart unattended to ensure privacy. When the above noted findings were discussed with the DON, she verified the practice was a privacy/confidentiality issue and that staff should be more careful.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 3 of 3 residents (R24, R33, R25) who required supervision and/or assistance with eating and for 4 of 4 residents (R8, R20, R30 & R41) who experienced incontinence related to extended wait times when required toileting assistance. Findings include: R24's quarterly MDS, dated 7/3/15 identified he was totally dependent on one staff for eating, and had short and long-term memory loss. A Brief Interview of Mental Status (BIMS) was unable to be completed. R24's care plan, dated 7/17/15 identified he was dependent with eating and required assistance of one staff member. Additionally, the MDS identified he was totally dependent on staff for all locomotion in the wheelchair as well as for transfers.	F 241	Golden Living Center Slayton promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The care plans for residents 24, 33, 25 related to dining assistance has been reviewed and revised as indicated related to supervision and assistance needs at meal time, and are recieving dining assistance in a dignified manner. The care plans for residents 38, 20, 30 and 41 have been reviewed and revised related to individual toileting assistance needs, and are receieving toileting assistance in a dignified manner. Staff have been re-educated on providing dining and toileting assistance per care plan, in a manner that promotes respect	8/10/15

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F 241	Continued From page 6 During observation on 7/13/15, at 12:29 p.m. R24 was seated at a dining room table with four other residents. Nursing assistant (NA)-R approached R24, pulled him away from his table and set him up at a tray table in the middle of the dining room, stating she needed his place for another resident who required help with eating today. A second aide, NA-J approached R24 who had his eyes closed and began to attempt to feed him potatoes and chocolate milk. R24 was unable to open his eyes and did not eat the food offered. NA-J left R24 at a tray table in the middle of the dining room, in the direct path of the other mobile residents who were attempting to enter and exit the area. During interview on 7/14/15, at 12:13 p.m. NA-A stated R24 was usually fed at a tray table in the middle of the dining area as there was no room for him at the only two assisted tables where NA staff sat in the dining room. R25's significant change MDS, dated 6/12/15 indicated extensive assistance of one staff for eating. The MDS identified a BIMS score of 4 (severe cognitive impairment). A previous quarterly MDS, dated 5/15/15 (1 month prior) revealed R25 had a BIMS of 14 (cognitively intact). A physician's progress note, dated 6/15/15 identified a diagnosis of pain in the joints, shoulder and shoulder region. A nursing assistant care guide, undated indicated R25's ability to feed herself fluctuated and at times she needed to be fed. During observation on 7/13/15, at 12:29 p.m. R25 seated in a wheelchair with her lunch tray in front of her at the dining table. R25 was unable to feed	F 241	and dignity. Monitoring to ensure compliance will be completed through random weekly audits to include all 3 meals by the DNS/Designee, and random weekly audits of direct care observations that toileting needs are being provided per care plan in a dignified and respectful manner. The results of the audits will be reviewed by QAPI monthly.	

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herself. At 12:44 p.m. R25 was being assisted by NA-R to eat her meal. NA-R wheeled away from R25 after offering a few bites to help another resident, stating "I'll be back [R25]." Throughout observation of the dining meal, NA-R was unable to stay with R25 for more than a few bites, assisting four other residents to eat and removing a fifth resident from the dining room after he became ill at the table. At 12:55 stated to R25 "I'm sorry [I can't feed you] I have been running around."

During interview on 7/16/15, at 1:05 p.m. R25 stated she needed help to be fed because of her sore shoulder. R25 stated she did not feel there was enough staff available to help her eat, stating "They are so busy. I just ask for help or wait till they can help me." R25 indicated her food got cold waiting for assistance.

During interview on 7/17/15, at 10:53 a.m. R25 stated when she did not get help with eating it made her feel "Like I am not important, and not worth it [the staff's time]." R25 stated she often did not get help eating her meal and she tried to "Keep my patience. A lot of people need help, but you should get help when you need it."

R33's quarterly MDS, dated 6/26/15 revealed he required supervision for eating with setup help. The MDS identified that a BIMS was unable to be completed, as well as short and long term memory loss. R33's care plan, dated 7/17/15 identified he had a history of gradual weight loss and needed intermittent cueing, prompting and assistance at meals.

During observation on 7/13/15, at 12:06 p.m. R33 was observed at the dining room table awaiting

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lunch. At 12:26 p.m., R33 began to attempt to eat his meal. No staff were in attendance. At 12:29 p.m., R33 spilled ice cream on his lap. A nursing assistant (NA)-R walked up to R33, took his ice cream stating he would need to be moved to another table across the dining room in order to get help with his meal. NA-R proceeded to move R33 to a table at the opposite end of the dining room, pulling another resident away from the table in order to make room for R33. NA-R proceeded to set up R33's tray, sat down on a rolling stool and began assisting four other residents between two tables, attempting to feed or encourage them to eat. NA-R was unable to engage in conversation with the residents she was assisting, and was only able to spend a few minutes at a time in one place. At 12:42 p.m., after several residents had been heard coughing NA-R stated "I feel like everyone is choking right now, all I hear is coughs."

During interview on 7/17/15, at 11:00 a.m. the director of nursing (DON) stated she would not expect residents to be placed in the middle of the dining room at a table, they should be assisted at their usual place. The DON confirmed there were usually only two aides in the dining room at the lunch meal, however was not able to state if this was enough assistance for the number of residents needing help. She stated ideally an aide should only help two or three people at most.

The facility policy, entitled Eating Support, last reviewed 1/26/15 directed staff to never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention.
R8's quarterly MDS, dated 4/23/15 revealed a BIMS of 3 (severely impaired) and was frequently

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incontinent of bowel and bladder. A urinary tract infection within the last 30 days was check marked as present. The MDS identified R8 was total assistance of two staff members for toileting.

During observation on 7/15/15, at 12:31 p.m. R8 was observed sitting in her wheelchair in the hall across from the nursing station. R8 was repeatedly stating she needed to use the toilet and asking for assistance. Staff (unidentified) were observed to pass by R8, telling her someone would be right back. Family member (FM)-D entered the facility and walked up to R8 at 12:35 p.m. R8 again expressed the need to toilet, "Right now". FM-D indicated that this is the usual occurrence on a daily basis and stated, "No one is available when [R8] needs to go to the bathroom." Three nursing assistants were on duty with two staff in the dining room and a third was taking a meal cart down the hall past R8. NA-J spoke with R8 and told her she would take her to the toilet once she passed the meal trays. R8 responded, "I need to go now". FM-D indicated this was upsetting to her as she was not able to assist R8 as she required a lift for transfers from the wheelchair to the toilet.
During interview on 7/15/15, at 12:33 p.m. FM-D indicated she had concerns related to not having enough staff available especially during the noon meal time from 11:45 a.m. until about 1-1:30 p.m., when residents are done eating and needing to toilet. FM-D further indicated if there was someone available from another wing to assist, then there was not a lift available. FM-D indicated there was only one nursing assistant (NA) available to help residents during this time and multiple residents require two persons to assist. FM-D indicated when she comes to visit every day, her mother frequently states she

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needs to go to the toilet. FM-D further stated that it is her mother's pattern to need to toilet either during the meal or immediately after and she felt staff were aware of this. FM-D voiced her concern and indicated she had informed the director of nursing (DON) and administrator. FM-D further indicated she was upset about this and didn't feel staff recognized R8's potential for recurrent urinary tract infections. FM-D stated the NAs were busy, and not able to pay attention to individual resident needs.
R20's annual MDS, dated 5/30/15 revealed a BIMS score of 9 (moderate cognitive impairment). The MDS further identified that R20 was frequently incontinent of bowel and bladder, and was extensive assistance of one staff for transfers and toileting.

During interview on 7/14/15, at 1:55 p.m. R20 stated she did not feel there was enough staff and she had to wait a long time to have her call light answered. R20 further stated she had accidents as a result of having to wait for the toilet and it didn't make her feel "Very good." R20 stated when they got her into the bathroom they made her wait so long after she was finished that she felt "Sick."

R30's most recent quarterly MDS, dated 6/19/15 indicated a BIMS of 9/15 which indicated moderate cognitive impairment. R30 was occasionally incontinent of bladder and continent of bowel and required extensive assistance with toileting. R30's care plan, dated 7/22/15 indicated she required one person assistance for transfers, required assistance of one staff with toileting, and did not need a toileting plan related to her strengths. The care plan further indicated R30 had isolated dribbling/incontinence of

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F 241	Continued From page 11 bladder. During interview on 7/14/15, at 1:45 p.m. R30 indicated, "Staff are kinda mean and rough," when they provided personal care following toileting. R30 stated staff told her she asked too many times to go to the bathroom. R30 further stated staff didn't always answer the call light and she had "Many times gone in my pants," because staff didn't respond to the call light. R30 stated this happened more after 3:00 p.m.. She told staff when she puts her light on she needed to go, however "Sometimes they just don't come." During a subsequent interview on 7/17/15, at 10:38 a.m. R30 stated she, "Had to poop in my pants at least twice because staff never came to help me". R30 then stated she felt "Awful [about having accidents]." She stated, "I felt terrible about it, but then thought if they don't care enough to come help me than I'm just going to poop in my pants and they will have to clean me up. I didn't like doing that but I had to go. Sometimes I just can't hold it for very long." R41's admission MDS, dated 6/22/15, revealed a BIMS score of 15 (cognitively intact). R41's bowel and bladder continence status were listed as frequently incontinent and extensive assistance for toileting and transfers. R41's care plan, dated 6/22/15 indicated he required assistance of one staff for toileting upon request. During interview on 7/13/15, at 3:00 p.m. R41 stated, "It feels short staffed all the time and it is worse from 4:00 p.m. to midnight." R41 stated he had an incontinence episode of bowel, "I shit my pants because I couldn't hold it anymore waiting for staff." R41 indicated this incident occurred at	F 241		

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F 241	Continued From page 12 2:30-3:00 p.m., and stated he was embarrassed about it. R30 stated sometimes he waited 45 minutes for staff to assist him to the bathroom. During interview on 7/17/15, at 11:00 a.m. the DON stated she was unaware of residents complaining about not being toileted, or extensive wait times for toileting. The DON further stated that she had not completed any audits of call lights or response times.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to communicate any decisions and/or actions taken related to the ongoing complaints of untimely call light response times expressed by the resident group over the past 6 months. This has the potential to affect all of the 42 residents who reside in the facility. Findings include: The Resident Council Minutes were reviewed for the previous 10 months and revealed ongoing resident complaints with long call light response times, first reported at the council meeting in January 2015 (6 months earlier). The resident	F 244	It is the standard of Golden Living Center Slayton to listen to the views and act upon the grievances and recommendations of residents and families. The living center system for addressing grievances has been reviewed. Staff have been educated, that the answering of call lights is the responsibility of all disciplines, and on the living center grievance process. Monitoring to ensure compliance will be completed by the ED/Designee, through random weekly call light audits/resident	8/10/15

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F 244	Continued From page 13 council minutes, dated 2/15 revealed the director of nursing (DON) and administrator had been in attendance related to call light concerns. The resident council minutes, dated 5/15 and 7/15 reflected continued resident complaints related to timely responses to the call lights. Documentation failed to indicate the actions taken by the facility to address the ongoing complaints. The Resident Council Department Response Forms were reviewed for the previous 10 months and included the following entries: -1/6/15 - Concern from 6 of 6 residents attending Resident Council related to call lights not being answered in a timely manner. The department response section, to include dates of proposed or completed actions was blank. -5/5/15 - Concern from 1 of 10 residents related to his call light being on too long for assistance. The departmental response included education given to staff to monitor down west [wing] more often, will follow up with resident. The form was signed by the DON and administrator and indicated a response was provided to the resident council on 5/18/15, with resident response listed at this time as: "Continues to be a problem, often depends upon who is working." -7/14/15 - Concern from 1 of 11 residents attending resident council related to call lights continue to not be answered timely. The response to the resident concern was listed as: "Other residents stated they do not have a problem depending upon who is working." During interview on 7/17/15, at 11:00 a.m. the DON stated she "Randomly," observed call light	F 244	interviews, 5x per week review of any grievances identified, and monthly Resident Council Minutes. The results of the audits will be reviewed at QAPI.	

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F 244	Continued From page 14 response times, however, had not completed any formalized audits to ensure timely responses were occurring. During interview on 7/17/15, at 12:30 p.m. the administrator stated the facility "Had a full schedule," and felt there were adequate staff on to meet resident needs. No further documentation was evident to indicate that facility staff had communicated the actions taken to remedy the continued complaints of untimely call light response.	F 244		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R11 & R25) who were dependent on staff for eating received assistance at meals as identified on the written plan of care. Findings include: R25's significant change Minimum Data Set (MDS), dated 6/12/15 indicated extensive assistance of one staff for eating. R25's nursing assistant care guide, undated indicated R25's ability to feed herself fluctuated and at times she needed to be fed.	F 282	Resident 11 and 25 care plans related to eating assistance have been reviewed and revised as indicated and are receiving eating assistance per care plan. All other residents are receiving eating assistance per care plan. Staff have been educated on providing eating assistance per care plan. The living center administration has developed a meal hostess program for oversight of the resident meal experience and that eating assistance is being	8/10/15

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F 282	Continued From page 15 During observation on 7/13/15, at 12:29 p.m. R25 was observed at the dining room table, seated in a wheelchair with her lunch tray in front of her. R25 was unable to feed herself. At 12:44 p.m. R25 was being assisted by NA-R to eat her meal. NA-R wheeled away from R25 after offering a few bites to help another resident, stating "I'll be back [R25]." Throughout observation of the dining meal, NA-R was unable to stay with R25 for more than a few bites, assisting four other residents to eat and removing a fifth resident from the dining room after he became ill at the table. At 12:55 stated to R25 "I'm sorry [I can't feed you] I have been running around." During interview on 7/16/15, at 1:05 p.m. R25 stated she needed help to be fed because of her sore shoulder. R25 stated she did not feel there was enough staff available to help her eat, stating "They are so busy. I just ask for help or wait till they can help me." R25 indicated her food got cold waiting for assistance. During interview on 7/17/15, at 10:53 a.m. R25 stated she often did not get help eating her meal and she tried to "Keep my patience. A lot of people need help, but you should get help when you need it." R11's significant change in status MDS, dated 7/10/15 identified extensive assistance of one staff member for eating. R11's care plan, dated 7/22/15 indicated R25 was to sit at an assisted table in the dining room for increased supervision/monitoring by staff and assistance with eating as needed.	F 282	provided per care plan. Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits, to include all three meals that eating assistance is being provided per care plan. The results of these audits will be reviewed at QAPI.	

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F 282	Continued From page 16 During observation on 7/13/15, at 12:06 p.m. R11 was observed at the dining room table awaiting lunch. R11 was observed not to be eating her food. NA-R was rolling on a stool between R11's table and another table, assisting four other residents. At 12:47 p.m., NA-R fed R11 a couple of bites of ice cream, then left the table to assist other residents. At 12:54 p.m., R11 fell asleep at the table, unassisted with the remainder of her meal. During interview on 7/17/15, at 11:00 a.m. the director of nursing (DON) stated she would not expect residents to be placed in the middle of the dining room at a table, they should be assisted at their usual place. She stated ideally an aide should only help two or three people at most so the plan of care could be implemented as written. The facility policy, entitled Eating Support, last reviewed 1/26/15 directed staff to never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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: Based on observation, interview and document review the facility failed to ensure 2 of 2 residents	F 312	Residents 11 and 25 care plans related to eating assistance have been reviewed	8/10/15

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F 312	Continued From page 17 (R11 & R25) dependent on staff for eating received assistance at meals. Findings include: R25's significant change Minimum Data Set (MDS), dated 6/12/15 indicated extensive assistance of one staff for eating. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive impairment). R25's nursing assistant care guide, undated indicated R25's ability to feed herself fluctuated and at times she needed to be fed. R25's physician's progress notes, dated 6/15/15 identified a diagnosis of pain in the joints, shoulder and shoulder region. R25's care area assessment (CAA) for nutrition, dated 6/12/15 indicated functional problems affecting ability to eat including partial or total loss of arm movement, arthritis, inability to perform ADLs without assistance and a body mass index (BMI) of 32.7. R25's nutritional assessment, dated 6/12/15 indicated no comprehension or communication problems related to eating, with average meal intakes of 41%, down from 79% the previous quarter. R25's meal intake flowsheet, dated 7/17/15 revealed a meal intake at noon on 7/13/15 of 50%. During observation on 7/13/15, at 12:29 p.m. R25 was seated in a wheelchair with her lunch tray in front of her at the dining room table. R25 was	F 312	and revised as indicated and are receiving eating assistance per care plan. All other residents are receiving eating assistance per care plan. Staff have been educated on providing eating assistance per care plan. All nursing aides and CNAs are provided updated "working sheets" to guide them through a process to assist all residents dependent on staff for eating. Monitoring to ensure compliance will be completed by the DSN/Designee through random weekly audits, to include all three meals, that eating assistance is being provided per care plan. The results of these audits will be reviewed at QAPI.	

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F 312	Continued From page 18	F 312		

unable to feed herself. At 12:44 p.m. R25 was being assisted by nursing assistant (NA)-R to eat her meal. NA-R left R25 after offering a few bites to help another resident, stating "I'll be back [R25]." Throughout observation of the dining meal, NA-R was unable to remain with R25 for more than a few bites, assisting four other residents to eat and removing a fifth resident from the dining room when the resident became ill while eating. At 12:55 NA-R stated to R25, "I'm sorry [I can't feed you] I have been running around."

When interviewed on 7/16/15, at 1:05 p.m. R25 stated she required staff assistance with eating because of a sore shoulder. R25 stated she did not feel there was enough staff available to help her eat, stating "They are so busy. I just ask for help or wait till they can help me." R25 also indicated her food got cold waiting for assistance.

During a further interview on 7/17/15, at 10:53 a.m. R25 stated she often did not get staff assistance with the meal but she tried to "Keep my patience. A lot of people need help, but you should get help when you need it."

R11's significant change in status MDS, dated 7/10/15, identified extensive assistance of one staff member for eating and a BIMS score of 14 (cognitively intact). R11's CAAs were still in progress and had not yet been completed.

R11's care plan, dated 7/22/15 indicated R25 was to sit at an assisted table in the dining room for increased supervision/monitoring by staff and assistance with eating as needed.

R11's nutritional assessment, dated 7/6/15

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F 312	Continued From page 19	F 312		

identified an current weight of 173 pounds (lbs), with an ideal body weight range of 125-220 lbs, with an average meal intake of 51%.

A nutrition progress note, dated 7/6/15 indicated R11 had a significant weight loss of 19% within the last 6 months and required supervision with meals.

R11's meal intake flowsheet for the date of 7/13/15 revealed a noon meal food intake of 1%.

During observation on 7/13/15, at 12:06 p.m. R11 was observed at the dining room table awaiting lunch. R11 was observed not to be eating her food. NA-R was rolling on a stool between R11's table and another table, assisting four other residents. At 12:47 p.m., NA-R fed R11 a couple of bites of ice cream, then left the table to assist other residents. At 12:54 p.m., R11 fell asleep at the table, unassisted with the remainder of her meal.

During interview on 7/17/15, at 11:00 a.m. the director of nursing (DON) stated she would not expect residents to be placed in the middle of the dining room at a table, they should be assisted at their usual place. The DON confirmed there were usually only two aides in the dining room during the lunch meal; however, was not able to state whether this was enough assistance for the number of residents who required assistance. She stated ideally an aide should only assist two or three people at most.

The facility policy, entitled Eating Support, last reviewed 1/26/15 directed staff to never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your

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F 312	Continued From page 20 complete attention.	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision and interventions were in place to prevent elopement for 1 of 1 resident (R55) reviewed with multiple elopement occurrences, resulting in an immediate jeopardy (IJ) with the potential risk of serious harm, injury or death. The IJ began on 7/15/15, at 12:33 p.m. when R55 was observed to exit the facility without staff knowledge nor intervention. The administrator, director of nursing (DON) and senior director of nursing (DON-S) were notified of the IJ on 7/15/15, at 4:03 p.m. The immediate jeopardy was removed on 7/16/15, at 3:30 p.m., however, non-compliance remained at the lower scope and severity level D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R55's new admission checklist dated 7/10/15,	F 323	Resident 55 no longer resides in the living center. Immediately upon notification and until discharge, resident 55 was placed on 1:1 24 hours a day. In accordance with MD recommendations and family wishes, resident was discharged on 7/16/15 to a facility with a secured memory care unit. All other residents identified as an elopement risk, care plans have been reviewed and revised as indicated. The living center Elopement Book has been updated to include pictures of residents identified as an elopement risk. The system for checking function and placement of the alarm indicator bracelets has been reviewed. A new door alarming system has been ordered and will be installed.	7/18/15

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F 323	Continued From page 21 identified a diagnoses of dementia and mood/behavioral issues including wandering, elopement risk and anxious behaviors. The "additional information/comments section" indicated R55 would need a wanderguard (a device worn by the resident which activates an alarm on an exit door when the resident is nearby) in place. The section entitled "cognition" indicated R55 had a very short term memory- "needs a lot of redirecting". The checklist further identified that R55 was independent with ambulation and transfers. A physician's progress note dated 7/7/15, indicated R55 had a history of elopement from her home, had been retrieved by the local police department on multiple occasions, and could not remember anything she was told for more than a couple of seconds. R55's physician's orders dated 7/9/15, indicated R55 had been admitted to the nursing home due to an inability to care for herself and wandering. A Clinical Health Status form dated 7/10/15, identified R55 as having short term memory problems and a history of wandering. R55's Nursing and Restorative Care Instructions, undated, identified a risk of elopement and indicated to monitor closely. Interventions for behaviors included distraction with cards (solitaire), 1:1 attention, call husband if beneficial, and to put a gown (night gown) on her. R55's Immediate Plan of Care re., Elopement Risk last revised on 7/15/15, identified problems including: wandering risk, elopement risk, and dementia. The care plan indicated R55 had	F 323	Residents are assessed, including all future residents, for elopement risk upon admission, quarterly, and with a significant change of condition. Staff have been educated on: *Elopement Policy - including the use of door alarms and imnmediate response expectations. *Elopment: Prevention and action education has been printed off and distributed to all staff. *Emergency / 911 Manual *Cognitive Assessments *Update care plans The Wanderguard systems will be monitored per manufacture recommendations. Staff will conduct a review of all Wanderguard alarms to assure functionality per manufacture recommendations. Monitoring to ensure compliance will be completed by the ED/Designee through random weekly audits that the components of the Elopement Policy are in place - bracelet function and placement, door function checks, staff response to door alarms, elopement book is current. Elopement drills will be conducted monthly x 3 months and then quarterly, and randomly thereafter. The results of the audits will be reviewed at QAPI.	

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F 323	Continued From page 22 behaviors including: wandering with no rational purpose, seemingly oblivious to safety needs, and attempted to leave facility first eight hours of stay. History of elopement, R55 states "I am leaving" or is angry at placement. The care plan also identified interventions including: (1) enjoys activities such as games, puzzles, cards; (2) medications as needed; (3) offer bath/shower; and (4) daughter says if in a gown will not leave, offer to change her into a nightgown. An additional care plan form dated 7/13/15, listed interventions which included: (5) wanderguard in place, (6) referral to Deer Oaks Psychology, (7) target/mood behavior log in place for monitoring, (8) speak calmly, offer comfort, support and reassurance, and (9) redirect resident to an appropriate/safe place. R55's Social Work Admission note dated 7/10/15, indicated R55 had made several attempts to leave the facility and had successfully made it out the door. The note indicated R55 had forgotten her home and had wandered to a house which had been her childhood home. The SW also documented R55 could be quickly distracted. R55's Nursing progress notes included the following entries: 7/10/15-Wanderguard on right wrist. Anxious, wandering hallways of the facility, able to exit out east door x 3 thus far. 7/11/15, at 1:07 a.m.-Resident has wanderguard on wrist and has gotten outside the building three times since 6 p.m. (7/10/15) Resident is now sitting up at the nurses' station looking at a magazine. Resident refuses to go to bed have tried more than once to show her where her room	F 323	New exit magnetic locks with Wanderguard activation will be installed per MDH approval of the Construction Plan Review Submittal Form. Staff will be educated on manufacture recommendations for monitoring and function.	

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F 323	Continued From page 23 is at and but states she has to go home and does not have a bed here and refuses to go to sleep. 7/11/15, at 2:57 p.m.-Outside x 1 today-wanderguard bracelet worn. 7/11/15, at 5:40 p.m.-Resident continued to be very confused and always looking for a door to leave- very difficult to redirect. 7/12/15, at 2:52 p.m.-Resident outside x 1 without assist-did come back with guidance. 7/12/15, at 9:39 p.m.-From 6:00 p.m. to 8:00 p.m. resident succeeded in getting out of the facility about ten times or more. 7/13/15, at 6:34 p.m.-Attempts to leave facility, wanderguard on, has managed to leave x 1 today and was assisted back with staff. 7/14/15, Making attempts throughout the day to leave the facility to get home and take care of things. Has gotten outside of the facility door today. 7/15/15,- 1430 (2:30 p.m.) -Exited the facility this morning. Orders for Lorazepam (an anti-anxiety medication) 0.25 milligrams one tab daily as needed for agitation/mood disorder. R55's July Behavior flowsheets identified target behaviors which included: wandering and anxious, nervous or scared of something. Interventions included: (1) redirect to appropriate place; (2) Offer activities of interest, walks, games, puzzles; (3) Speak calmly-offer comfort, support and reassurance.	F 323		

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The following incidents were recorded related to the identified behaviors:
-3 behaviors on 7/10/15- no intervention code or outcome was identified. The comments section indicated R55 left building multiple times in search of home, stating she had an appointment.

-2 behaviors on 7/10/15-no intervention code, behavior type or outcome identified.

- 1 behavior on 7/14/15- listed in comments section that R55 had crawled into bed with another resident.

-2 behaviors on 7/15/15- no intervention code, behavior type or outcome identified.

During the survey dates and hours of 7/13/15, at 11:00 a.m. until 7/16/15, at 4:00 p.m. R55 was observed to wander the facility asking which door would open and attempting to exit via the various facility doors. When R55 was unable to open a door she would turn and ask staff or other persons in the area how she could "Get out". R55 was observed to ambulate rapidly and without gait and/or balance difficulties during these observations.

During observations on 7/15/15, at 12:29 p.m. R55 was noted to wander around the nursing station, asking staff which doors were open and how she could get out of the facility. R55 continued to persistently look for the location of an open door, asking housekeeping and maintenance staff (unidentified) which door was open, as she had an appointment. R55 was pacing and approached anyone located in the vicinity. It was noted the maintenance supervisor (MS) encouraged R55 to sit down. The director

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of nursing (DON) approached R55, asking her to sit down and talk; however, this was unsuccessful. R55 asked the DON how she could get out of the building as she had an appointment. Although R55 repeatedly had attempted to locate the exit doors while questioning multiple persons, the DON walked part way down the East hallway with R55. Subsequently, the DON returned to the nursing station while R55 continued down the East hall, unattended, toward the exit door.

During observation on 7/15/15, at 12:33 p.m. R55 was walking quickly down the East hallway toward the exit door. When asked where she was going, R55 responded she had an appointment and had to leave. R55 proceeded to the door where she depressed the exit bar resulting in the alarm sounding; R55 just walked out the door. Facility staff did not immediately respond to the alarm. The surveyor immediately instructed an unidentified family member to alert the facility staff that R55 had exited the building from the East exit door. The surveyor called out to R55, who hesitated for approximately 15 seconds when spoken to, prior to stating she "had to go." R55 was observed to walk rapidly across the lawn towards the street. R55 was approximately 500 feet from the building when the social worker (SW), who had been summoned by a second surveyor, came out of building at 12:35 p.m. asking where R55 was. The SW was then observed to run across the lawn in an attempt to catch up to R55. The SW reached R55 as she approached the sidewalk, rounding a fence bordering the facility property. R55 was resistant to redirection. No additional staff were observed outside the building at this time. Survey staff summoned additional staff

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assistance by knocking on another door to the building. Registered nurse (RN)-A responded, but was unable to open the exit door to leave the building as the door would not release. RN-A then summoned additional staff to help with the elopement situation. R55 and the SW were observed to walk back toward the building prior to the administrator and/or additional staff exiting the facility from the front entrance. Upon return to the facility at 12:38 p.m., the SW stated R55 didn't know which direction to turn but she [SW] was able to convince and finally redirect R55 back toward the facility.

A group interview with the senior director of nursing (DON)-S, SW and administrator was conducted on 7/15/15, at 3:30 p.m. The DON-S indicated R55's family had wanted to transfer R55 to an inpatient behavior facility prior to discharge to another care center. The SW stated R55 had been declined admission by two inpatient geriatric psychiatric facilities. The SW further verified that no other referrals at this time had been made to any health care providers with a secured unit. The administrator identified staff interventions to be used to prevent R55 from wandering included: giving her puzzles, cards, sorting, or doing board games with her. The administrator also stated there had been no incident reports completed for R55 for any other elopements. The DON-S stated staff did not consider the resident's attempts at leaving the building as elopements because they were aware of R55 exiting, and had witnessed her go out the door.

During interview on 7/15/15, at 4:03 p.m. nursing assistant (NA)-M stated that last week, at approximately 1:00 p.m., R55 had exited the building, crossed the street and reached the

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church. NA-M stated R55 had attempted to open two different doors prior to staff interception.

During interview on 7/15/15, at 4:06 p.m. RN-A stated she had gone outside the building to retrieve R55 once, she thought the date was on 7/13/15 (2 days prior). RN-A stated R55 had been able to get as far as the church door, (across the street and off the facility property) before she was intercepted by staff and redirected back to the facility. RN-A stated that prior to admission, R55 used to walk to and from the facility to visit a friend and had taken the route by the church. In addition, RN-A stated that R55 continued to come/walk to the facility to visit this friend (who was since deceased). R55 had not recalled the friend had died and was no longer in the facility.

During interview on 7/15/15 at 4:10 p.m., NA-M and NA-A indicated they were not aware of any special monitoring implemented related to R55's elopement behavior and further stated they were not aware that R55 had exited the building by the East door that day (7/15/15). In addition, they stated they could not always respond immediately when the door alarm was activated as they were assisting other residents who could not be left unattended.

During interview on 7/15/15, at 5:04 a.m., NA-A also verified R55 had walked off the grounds on the evening shift of 7/13/15. NA-A stated R55 had been found on the church premises and was returned to the facility by the SW.

During interview on 7/15/15, at 5:09 p.m. the SW stated on the evening of 7/13/15, R55 had left the facility and the SW had picked her up in her

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personal vehicle. The SW stated R55 was running and two aides were chasing her to the church parking lot (which was across the street and off facility property). The SW stated she hadn't filled out an incident report as she was off duty.

When interviewed on 7/15/15, at 6:24 p.m. DON-S stated when the door alarms sounded, staff generally checked multiple doors. She stated there was a panel located at the nursing station which displayed the specific door which alarmed. DON-S was unable to state the rationale for why staff did not utilize this panel to identify the location of which door had alarmed so the resident's location could be identified and staff quickly disseminated.

During interview on 7/16/15, at 9:30 a.m. the maintenance staff (MS) stated the resident's spouse would lock the resident in a room in the house to keep her from wandering away from the home.

When further interviewed on 7/16/15, at 12:33 p.m. the SW stated that R55 was going to be discharged home with her elderly spouse. The SW verified she was uncertain whether the home environment was safe as she had never been to the home and was unsure whether R55's spouse could provide the necessary care and supervision.

During interview on 7/16/15, at 12:34 p.m. the director of nursing (DON) stated she was unaware whether a home safety evaluation had been completed.

During interview with the SW and DON on

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F 323	Continued From page 29 7/16/15, at 12:34 p.m. they indicated that if the husband took the resident home it would be against medical advice (AMA). They also discussed what services R55 would require at home. During interview on 7/16/15, at 1:23 p.m. the administrator stated she had seen R55 wandering in the community multiple times since she [administrator] had started working at the facility. She indicated she had witnessed R55 wander in one door of the facility and out another door prior to her admission to the nursing home, in an attempt to visit an old friend who was no longer residing there. The administrator stated she had thought the wanderguards would be sufficient to maintain safety for R55, and had not realized the extent of R55's wandering tendencies were "that bad." The facility's Elopement Policy and Procedure last revised 1/11, included: "elopement, for purposes of this policy and procedure is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety needs and therefore at risk for injury outside the confines of the living center, has left the living center without knowledge of staff." The policy further indicated the purpose of the Elopement policy was to "identify residents at risk for elopement, minimize episodes of elopement, protect residents that are not capable of protecting themselves, provide techniques and equipment to minimize safety risks and educate staff." The immediate jeopardy that began on 7/15/15, at 12:33 p.m. was removed on 7/16/15, at 3:30 p.m. when it was verified that facility staff had implemented an appropriate removal plan which	F 323		

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F 323	Continued From page 30 included: 1:1 supervision for R55 until placement in a secured unit could be arranged; updates to the care plans for other at-risk residents with wandering behaviors; updates to cognitive assessments for other at-risk residents; review and updates to the facility elopement book; education and competency evaluation of staff members related to elopement policies and procedures; initiation of audits of the wanderguard and alarm systems; and the submission of orders for new facility doors with relay egressable magnetic locks. The administrator was notified the IJ was removed on 7/16/15, at 3:30 p.m. but the noncompliance remained at the lower scope and severity of a D, no actual harm with a potential for no more than minimal harm, isolated because adequate supervision and interventions related to R55's physical safety had not been thoroughly completed.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing	F 353		8/24/15

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F 353	Continued From page 31 personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to meet resident needs related to supervision to prevent elopement, assistance with dining, toileting, and meals for 13 of 42 residents (R1, R8, R11, R16, R20, R24, R25, R30, R33, R38, R41, R49 & R55). This had the potential to affect all 42 residents residing in the facility. Findings include: Based on observation, interview and document review, the facility failed to ensure adequate supervision and interventions were in place to prevent elopement for 1 of 1 resident (R55) reviewed with multiple elopement occurrences, resulting in an immediate jeopardy (IJ) with the potential risk of serious harm, injury or death. Refer to F323. Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 3 of 3 residents (R24, R33, R25) who required supervision or assistance with eating and 4 of 4 residents (R8, R20, R41 & R30) who experienced incontinence related to extended waits for toileting assistance. Refer to F241.	F 353	The living center does provide sufficient 24-hour nursing staff to meet the needs of the residents. Residents 33 and 55 no longer reside at the living center. Residents 1, 8, 11, 16, 20, 24, 25, 30, 38, 41, and 49 are recieving cares per care plan for safety and supervision, assistance with eating, toileting, and other activities of daily living. The living center administration has reviewed and revised the workflow of the staff to meet the needs of residents. The DNS has hired 4 additional nursing assistants and continues to recruit for any open positions. Current staff and any new staff will be educated on providing cares per care plan. Monitoring to ensure compliance will be completed through daily review of the schedule. Random weekly audits of direct care and	

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F 353	Continued From page 32 Based on document review and staff interview the facility failed to communicate any decisions to the resident council group related to the long call light response times expressed by the group. This has the potential to affect all of the 42 residents who reside in the facility. Refer to F244. Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R11 & R25) who were dependent on staff for eating received assistance with meals. Refer to F312. Additional interviews related to insufficient nursing staff: R1's quarterly Minimum Data Set (MDS), dated 6/26/15 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS identified R1 was frequently incontinent of bowel and bladder. During interview on 7/14/15, at 12:39 p.m. R1 stated there were not enough staff to change him when he experienced incontinence. R1 stated he put his call light on and staff would shut the light off, stating they'd be right back but it took 45 minutes. R1 stated this was worst on the afternoon shift. R38's annual MDS, dated 6/21/15 revealed a BIMS score of 15 (cognitively intact). During interview on 7/13/15, at 2:47 p.m. R38 stated she had to wait a long time for assistance when she activated the call light. R38 stated after meals and bedtime were the worst for prolonged waits.	F 353	meal observations, call light audits, and resident interviews. The results of the audits will be reviewed monthly at QAPI.	

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R49's quarterly MDS, dated 6/26/15 revealed a BIMS of 15 (cognitively intact).

During interview on 7/14/15, at 12:46 p.m. R49 stated there was not enough staff to ensure cares were done in a timely manner. R49 stated she had to wait every time she used the call light for "Quite a while," or that staff "Didn't show up at all."

R16's quarterly MDS, dated 5/15/15 revealed a BIMS score of 7 (severe cognitive impairment), and a bladder continence score of occasional incontinence (less than 7 episodes of incontinence) and was continent of bowel.

During interview on 7/14/15, at 12:49 p.m. R16 stated she was frequently left sitting in her wheelchair after meals without her call light. R16 stated this was because there wasn't enough staff to push her all the way into her room. She was instead left in the doorway. R16 was observed at this time in her room without her call light in reach, trying to move her wheelchair back and forth to get to her bed.

During interview on 7/15/15 , at 7:31 a.m. NA-M stated the facility was "Short of help here," and that there were only three aides available to provide resident care after 10:00 a.m. many days. NA-M stated she thought five aides were really necessary to accomplish their resident care workload, especially with baths and restorative nursing. NA-M indicated it was difficult to feed residents in the dining room at noon as only two aides could assist residents, with the third aide monitoring residents in their rooms and/or serving room trays. NA-M stated they attempted to

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obtain help from a nursing pool agency but was unsuccessful.

During interview on 7/15/15, at 7:50 a.m. family member (FM)-C stated she didn't feel there was enough staff to meet needs of residents. FM-C stated her mother didn't have cold water frequently, as staff sated they hadn't had time to pass water. FM-C stated staff didn't answer call lights promptly as they were busy with other residents, so she would have to assist her mother to the toilet, and heard beeping of the unanswered call lights a lot.

During interview on 07/15/15, at 8:31 a.m. trained medication aide (TMA)-B stated her medication pass could be difficult to accomplish in a timely manner, and stated one resident who was ill or needed anything out of the usual it would throw the entire med pass off schedule. TMA-B stated it was hard to feed residents at the noon meal, if she had time she would try to assist the aides in the dining room.

During interview on 7/15/15, at 8:44 a.m. NA-A stated administration did not usually help with resident care, and that it was unusual the DON, administrator and dietician were assisting with transport of residents to and from the meal this morning. NA-A further stated the facility had been "Running short of staff," since 8/14.

During interview on 7/15/15, at 9:21 a.m. NA-F stated the DON generally didn't assist with transport of residents after meals, and "Didn't know why this happened [today]."

During interview on 7/15/15, at 9:27 a.m., licensed practical nurse (LPN)-A stated "Hell no

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there isn't enough staff." She added "They have everyone working on the floor today." LPN-A stated the dietician usually only came once a month for half a day, however was in the facility all day yesterday and again today. LPN-A further added they had been short staffed for almost a year, and didn't feel she had done a good job at the end of her shift. LPN-A stated the DON usually was "Never on the floor," and felt resident safety was an issue as a result of staffing and it was difficult to fill open shifts if someone called in sick. LPN-A stated residents had been incontinent because staff weren't available to get them to the bathroom.

During interview on 7/15/15, at 9:50 a.m. NA-J stated the facility was short staffed and the aides had been working twelve hour shifts since last October as a result. Recently, there had been staff turnover and a staff injury resulting in only one NA on night shift. The facility had attempted to have someone come in early to help, however that NA would have already been scheduled for 12 hours so would be working 14 hours. NA-J stated she felt pressured from management to complete paperwork and had difficulty providing cares to residents.

During interview on 7/15/15, at 12:24 p.m. NA-M stated she was "Not doing a good enough job with the residents," related to not having enough staff. NA-M stated "I have to hurry when providing cares". NA-M indicated it required rushing the residents in order to get everything done. NA-J indicated morning cares were frequently not completed by 10:00 a.m. NA-J indicated the residents left until last are residents that eat in their rooms or are not able to complain about having to wait.

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	245386	A. BUILDING _____ B. WING _____	07/17/2015

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

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F 353	Continued From page 36 During interview on 7/15/15, at 12:33 p.m. FM-D stated she had concerns related to facility not having enough staff, especially during lunch time until about 1-1:30 p.m. when residents are done eating and needing assistance with toileting. FM-D indicated she plans her visits at this time because her family member frequently needs assistance during this time. FM-D indicated If there is someone available from another wing, then there is not a lift available. She then indicated there was only one NA available on that wing to assist and multiple persons require two persons to assist them. During interview on 7/15/15, at 4:28 p.m. registered nurse (RN)-C indicated the facility had been short staffed since last September. RN-C stated at night there was a nurse and two aides, however if one of the aides called in sick sometimes they worked with only one. During interview on 7/17/15, at 11:00 a.m. the DON stated she "Randomly," observed call light response times however had not completed any formalized audits to ensure timely responses were occurring. The DON further stated there were usually two aides in the dining room at lunch and supper, however was unable to state if this was enough to assist with feeding residents. During interview on 7/17/15, at 12:30 p.m. the administrator stated the facility "Had a full schedule," and felt there were adequate staff on to meet resident needs, however could not state how the number of staff required was determined.	F 353		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		8/10/15

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F 431	Continued From page 37 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to properly store and label an opened and accessed vial of Tubersol	F 431	It is policy of this facility that all unused and outdated medications be disposed of in the proper manor.	

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F 431	Continued From page 38 medication to preserve and maintain it's effectiveness. This practice had the potential to affect all newly admitted residents who would receive a tuberculin skin test (TST). Findings include: During inspection of the main medication storage room on 7/16/15, at 2:25 p.m. with licensed practical nurse (LPN)-A it was noted the medication storage refrigerator contained a multi-dose vial of Tubersol (diagnostic antigen to identify presence of tuberculosis infection). The vial had only 1 of 5 doses remaining in it and was not dated when opened and accessed with a needle to identify whether the agent was expired or not. When interviewed on 7/16/15, at 2:28 p.m. the director of nursing (DON) verified the multi-dose vial was not dated when opened and indicated the Tubersol solution should be discarded. The DON failed to provide a facility policy for storage of Tubersol. The manufacturers instructions for storage of Tubersol was noted to indicate the agent would need to be discarded 30 days after being opened and penetrated with a needle. The facility was unable to determine when the vial of Tubersol was opened and/or whether it was considered an expired solution.	F 431	Licensed staff and TMAs have been educated on proper labeling and storage of medications to include removal of medications that have expired. Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits of medication pass, medication carts, and medication room for proper labeling, storage and removal of expired medications. The results of the audits will be reviewed monthly at QAPI.	
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 497		8/10/15

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F 497	Continued From page 39 education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide documentation that 5 of 5 nurse aides (NA-A, NA-F, NA-M, NA-R and NA-S) reviewed had an annual performance evaluation and who were employed at least 12 months at the facility. This practice had the potential to affect all 42 residents who reside in the facility. Findings include: When interviewed on 7/16/15, at 11:30 a.m. the director of nursing (DON) was requested to provide a copy of annual evaluations for NA-A, NA-F, NA-M, NA-R and NA-S. The DON stated she was not sure whether the evaluations were completed as they would have been conducted by the previous DON. The DON verified on 7/16/15, at 2:00 p.m. she was unable to locate the any of the requested evaluations and was unable to determine whether the evaluations were completed.	F 497	Nursing Assistant annual performance reviews / 12-hour inservices have been completed. The system for completing the annual performance reviews / 12-hour inservices has been revised. Monitoring to ensure compliance will be completed by the ED/Designee through audits of the inservice calendar. The results of these audits will be reviewed monthly at QAPI.	

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	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2015**

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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 July 14, 2015.. 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 2000 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden LivingCenter 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 50 beds and had a census of 41 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		8/10/15

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 41 residents. Findings include: On facility tour between 9:15 AM and 12:15 PM on 07/14/2015, observation revealed that the following was found: 1. The door to oxygen torage room (over 50 sq. ft.) does not have a self-closing device. 2. There is an open penetrations in the Boiler Room walll, around conduit runs. These deficient practices were confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 029	It is Policy and Procedure of Golden Living Center Slayton to provide and maintain smoke-resistant partitions and doors. All oxygen tanks were removed on 07/15/2015, upon notification, from E5 and placed in outside storage. Staff are educated as to where to retrieve oxygen tanks and store full and empty tanks. All open penetrations in the boiler room have been caulked with fire-proof caulk. This was completed on 07/15/2015.	

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K 154	Continued From page 3	K 154		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:15 AM and 12:15 PM on 07/14/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (CS) at the time of discovery.	K 154	It is Policy and Procedure of Golden Living Center Slayton to have in place documentation revealing an out-of-service plan for the sprinkler system plan. On 07/15/2015, the out-of-service sprinkler system policy and procedure was obtained, signed by the administrator, and copies placed in the 911 book and in the Life Safety Manual.	8/10/15
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period,	K 155		8/10/15

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K 155	Continued From page 4 the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:15 AM and 12:15 PM on 07/14/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (CS) at the time of discovery.	K 155	It is Policy and Procedure of Golden Living Center Slayton to have in place documentation revealing an out-of-service fire alarm plan for the sprinkler system plan. On 07/15/2015, the out-of-service fire alarm policy and procedure was obtained, signed by the administrator, and copies placed in the 911 book and in the Life Safety Manual.	