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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NIMV

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 **09/30/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 10/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/07/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
09/16/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245386

October 7, 2014

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

Dear Ms. Pridal:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 16, 2014 the above facility is certified for or recommended 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
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 7, 2014

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

RE: Project Number S5386024

Dear Ms. Pridal:

On August 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2014, effective September 16, 2014 and therefore remedies outlined in our letter to you dated August 21, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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	9/30/2014

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 **09/16/2014**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **09/16/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	10/07/2014	22113	09/30/2014
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
8/7/2014			

AH Form Approved
10/7/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00915	A. Building B. Wing	9/30/2014

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21685 Reg. # MN Rule 4658.1415 Subp. : LSC	Correction Completed 09/30/2014	ID Prefix 21855 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 09/30/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** KS/KFD	**Date:** 10/07/2014	**Signature of Surveyor:** 22113	**Date:** 09/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/7/2014

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 6, 2014

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

Re: Reinspection Results - Project Number S5386024

Dear Ms. Pridal:

On September 30, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 30, 2014, with orders received by you on August 21, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

AH Form Approved
10/21/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00915	A. Building B. Wing	9/30/2014

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. :** LSC	**09/16/2014**	ID Prefix **21855** Reg. # **MN St. Statute 144.651 Sul** LSC	**09/16/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KFD	10/07/2014	22113	09/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/7/2014

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: NIMV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245386**
2.STATE VENDOR OR MEDICAID NO.
(L2) **660385800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **08/07/2014** (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: **B *** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jodi Johnson, HFE NE II 08/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/11/2014 (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

Electronically delivered
August 21, 2014

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

RE: Project Number S5386024

Dear Ms. Pridal:

On August 7, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Kathryn.serie@state.mn.us
Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 16, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 7, 2014 (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 February 7, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING _____ B. WING _____	08/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and 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.	F 164		9/16/14

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

Electronically Signed | 08/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 1 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 and interview the facility failed to provide personal health care services in a manner that promoted personal privacy for 1 of 1 resident (R11) who had a laboratory blood test while in the dining room with other residents and a visitor present. Findings include: During resident cares on 8/7/14, at 10:25 a.m. R11 was observed seated at a dining room table in the main dining room with four other residents seated around him. At 10:27 a.m. laboratory technician (LT)-A was observed to enter the dining room with a cart which contained the blood draw supplies. LT-A informed R11 that a blood draw to check for blood coagulation levels (International Normalized Ratio or INR) was going to be performed. LT-A was observed to place a tourniquet around the right forearm of R11 and perform a blood draw while four residents were seated directly around R11. While the blood was drawn from the forearm of R11, R23 scooted back in her chair to observe the procedure. There were also visitors seated in the dining room at the time of the observation. During interview with the acting director of nursing	F 164	Preparation, submission and implementation of this Olan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared executed as a means to continuesly improve the quality of care and to comply with all the applicable state and federal regulatory requirements. F164 It is the Policy and Procedure of Golden Living Center-Slayton to provide privacy and confidentiality for our residents. Staff were reeducated on the needs of resident R11 and all living center residents. Staff will be in serviced on the Policy and procedure for privacy as well as the facility expectatins for all residents. Random monitoring of providing privacy will be done by the D.N.S. or designee. Further monitoring will be done in QAPIas needed.	

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F 164	Continued From page 2 (DON) on 8/8/14, at 11:30 a.m. it was stated the practice of drawing blood in the proximity of other residents or visitors would be a breach of personal privacy. The DON concurred that privacy should be provided when blood draws are conducted by laboratory personnel.	F 164		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to administer medications via gastrostomy tube (g-tube) with water flushes between and via gravity as stated in facility policy and physician order for 1 of 1 resident (R47) in the sample reviewed who had a g-tube. Findings include: A significant change assessment dated 6/7/14, identified R47's diagnoses to include stricture and stenosis of the esophagus, diverticulum of the esophagus and atrial fibrillation. The assessment further indicated R47 utilized a feeding tube. Review of the undated discharge summary instruction from Sanford Medical Center Radiology included the following: "Do not mix any medications-always flush with water before and after each medication." The discharge instructions had a handwritten date of 4/15/14 and was signed by the licensed practical nurse (LPN)-B at the facility.	F 281	GLC-Slayton recognizes the importance of administration of gastrostomy (Enternal Tube) medication to its residents by acceptable standards of quality. The Safe administration of gastrostomy (Enternal Tube0 medications for resident R-47 has been reviewed with staff. To prevent further incident to other residents all licensed nurses will be reeducated on the policy of safe proper administration of gastrostomy medications for residents. Random audits will be completed by the D.N.S or designee. Further monitoring will be done in QAPI as needed.	9/16/14

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	245386	A. BUILDING _____ B. WING _____	08/07/2014

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 281	Continued From page 3 The "Enteral Tube Medication Administration (Golden Living Centers Specific)" procedure dated 11/13 included: (11) Remove plunger from the 60 ml catheter-tipped syringe and connect syringe to clamped tubing. (12) Put 30 ml of water in syringe and flush tubing using gravity flow. Clamp tubing after the syringe is empty, allowing water to remain in the tube. 13) Pour dissolved/dilute medication in syringe and unclamp tubing, allowing medication to flow by gravity. 14) Flush with 5 ml water between each medication. Alternatively, crushed medications may be mixed together, diluted with sufficient water, and administered together so long as no incompatibilities exist as determined by a pharmacist review. On 8/6/14, at 8:49 a.m. licensed practical nurse (LPN)-A prepared the following medications: (1) aspirin 325 milligram (mg) tablet, (2) calcium carbonate-vitamin D 600-400 mg-unit tablet, (3) cardura 1 mg tablet, (4) losartan potassium 25 mg tablet and (5) metoprolol tartrate 50 mg tablet into the same medication cup. LPN-A stated the medication will be separated when they were crushed, prior to administration. LPN-A then proceeded to measure the following liquid medications into separate medication cups: (6) 5 milliliters of omeprazole suspension 4 mg per milliliter (ml) and (7) 7.5 ml of potassium chloride liquid 20 milliequivalents (MEQ) per 15 ml . Next, LPN-A measured (8) polyethylene glycol powder 17 grams (gm) into a 6 ounce (oz) cup and added approximately 120 cubic	F 281		

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F 281	Continued From page 4	F 281		

centimeters (cc) of water and stirred them together to combine. LPN-A then separated each of the tablet medications except the metoprolol and losartan into separate medication cups (left the metoprolol and losartan together in the same cup). LPN-A was observed to crush each of the tablet medications separately and returned them to separate medication cups except the metoprolol and losartan which were crushed together. When questioned why the metoprolol and losartan were crushed and administered together, LPN-A stated, "No rhyme or reason, just because they're small". LPN-A then added approximately 5 cc's of water to each of the crushed medications.

After the medications were prepared, LPN-A entered R47's room, applied gloves, checked the g-tube placement and then drew up approximately 30 cc's of water into a 60 cc syringe. The 30 cc of water was flushed through the g-tube with the use of the plunger in the syringe. LPN-A then drew up the metoprolol and losartan mixed medications and administered both through R47's g-tube by pushing down the plunger of the syringe. After they had been administered via g-tube, LPN-A then flushed the g-tube with approximately 10 cc's of water. LPN-A then administered the remainder of C47's medications through the g-tube in the same manner but did not flush the g-tube with water inbetween each medication per facility policy.

During administration of the liquid omeprazole and potassium choloride medications, LPN-A was observed to also draw up approximately 20 cc's of the polyethylene glycol mixture into the syringe with each of these medications prior to administration. After administration of all the

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F 281	Continued From page 5 medications, LPN-A drew up approximately 30 cc's of water into the syringe and flushed the g-tube by pushing down the plunger into the syringe. When interviewed on 8/6/14, at 9:19 a.m., LPN-A stated she was unaware whether there was a physician order which allowed mixing the medications together. LPN-A then proceeded to check the physician order, which did not indicate the medications could be combined. LPN-A stated she usually tried to flush the g-tube with water between each medication administered and further stated she would flush the tube between the oral/crushed medications but with the liquid medications would dilute them with water as they are "already liquid". LPN-A further stated she has always drawn medications up into the syringe and pushed through the g-tube with the use of the plunger rather than by gravity. LPN-A stated, "I've been a nurse for 37 years and have always done it that way". When interviewed on 8/6/14, at 9:30 a.m. the interim director of nursing (DON) confirmed a physician order would be required prior to mixing medications together and administering the medications through a g-tube. The DON could not confirm or deny whether the g-tube should be flushed with water between each medication nor whether there was a policy related to administration with the use of the plunger/syringe vs. gravity.	F 281		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		9/16/14

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F 356	Continued From page 6 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post the correct number of nursing assistants who worked and failed to identify the total number of actual hours worked by each category of employee, which had the potential to affect 39 of 39 residents who reside in the facility.	F 356	The facility posts the avtual hours worked for daily nursing staff. All residents , family members and visitors have the potential to be affected by the deficient practice. Scheduling personnel have been	

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F 356	Continued From page 7 Findings include: During the initial tour on 8/4/14, at 12:30 p.m. the facility had the nursing hours posted on a bulletin board located in the main hallway by the main nurses station. The hours posted failed to identify the total number of hours actually worked by staff of each category. The posted hours indicated the number of staff working and the shifts worked but failed to indicate the total hours worked. On 8/7/14, at 11:07 a.m. certified nursing assistant (NA)-A was interviewed about facility staffing patterns. During the interview NA-A questioned the staffing ratio requirement and indicated that only two (2) NA's were working on the floor and stated it was usually better staffed but there was a call-in from staff that was unable to work and they were working short today. During observation of the posted staffing hours on the bulletin board, it indicated that three (3) NA's were working at the time instead of two (2). The posted hours did not accurately reflect the number of nursing assistants that were working. During interview with the acting director of nursing (DON) on 8/7/14, at 11:30 a.m. it was verified the posted hours were incorrect. The DON stated there had been a staff call-in and the posted hours had not been changed to reflect the current staffing.	F 356	educated and the scheduling form has been updated to include actual hours scheduled for daily nursing staff. Daily review of posting hours will be conducted to ensure actual hours of scheduled daily nursing staff is posted. Further monitoring of postings will be reviewed as needed in QAPI	
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		9/16/14

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F 456	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to properly maintain the freezer/refrigerator equipment in the kitchen which had the potential to affect 39 of 39 residents in the facility. Findings include: During the initial tour of the kitchen on 8/4/14, at 12:35 p.m. an observation was made of the four door freezer unit located against the back wall of the kitchen. This unit had condensation located around the handles and the lock area on the outside of the freezer doors. A towel was observed on the floor in front and under the freezer as water was observed to run down the front of the doors and drip onto the towel. When the freezer doors were opened, it was noted that the gaskets located around the perimeter of the doors had a buildup of ice, were cracked and had pieces of missing gasket. It was also noted during the tour that the three door refrigerator located across from the freezers had loose handles that did not properly latch when closed. The dietary manager (DM) was interviewed on 8/4/14, at 1:00 p.m. and verified the gaskets were cracked and in poor repair. The DM stated the refrigerator was old and the handles were worn. The DM and dietitian were interviewed on 8/7/14, at 8:00 a.m. They verified the gaskets on the four door freezer were in poor repair and needed to be replaced. Verification was also made of the handles on the refrigerator needing to be repaired and the counter beside the sink in the dining room.	F 456	GLC-Slayton maintains its essential and mechanical, electrical and patient care equipment in safe operating condition. All residents, family members and visitors have the potential to be affected by the defiicient practice. Staff have been reeducated on the appropriate maintenance of the freezer and refrigerator. The gasket on the freezer will be replaced, the handles on the refrigerator have been tightened and the counter fixed. Random audits will be completed by the dietary manager or designee. Further monitoring will be done in QAPI as needed.	

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	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 05, 2014. At the time of this survey, Golden LivingCenter Slayton was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Golden LivingCenter Slayton was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected and is Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 39 at time of the survey.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 21, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5386024

Dear Ms. Pridal:

The above facility was surveyed on August 4, 2014 through August 7, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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	00915	A. BUILDING: _____ B. WING _____	08/07/2014

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GOLDEN LIVINGCENTER - SLAYTON	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00915	A. BUILDING: _____ B. WING _____	08/07/2014

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/4/14, 8/5/14, 8/6/14 and 8/7/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to properly maintain the freezer/refrigeratory equipment in the kitchen which had the potential to affect 39 9f 39 residents in the facility. Findings include: During the initial tour of the kitchen completed 8/4/14, at 12:35 p.m. an observation was made of the four door freezer unit located against the back wall of the kitchen. This unit had condensation located around the handles and lock area on the outside of the freezer doors. A towel was observed on the floor in front and under the freezer as water was observed to run down the front of the doors and drip onto the towel. When the freezer doors were opened, it was noted that the gaskets located around the perimeter of the doors had a buildup of ice, were cracked and had pieces of missing gasket. It was noted during the tour that the three door	21685		

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21685	Continued From page 3 refrigerator located across from the freezers had loose handles that did not properly latch when closed. The dietary manager (DM) was interviewed on 8/4/14, at 1:00 p.m. and verified the gaskets were cracked and in poor repair. The DM stated the refrigerator was old and the handles were worn. During an observation of the dining area on 8/4/14, at 6:40 p.m. it was noted that the laminate counter top which surrounded the sink had an area that was 8-10 inches in length, cracked and covered with gray tape with frayed edges. The DM and dietitian were interviewed on 8/7/14, at 8:00 a.m. They verified the gaskets on the four door freezer were in poor repair and needed to be replaced. Verification was also made of the handles on the refrigerator needing to be repaired and the counter beside the sink in the dining room. The dietitian further stated that she was not aware of the poor condition of the countertop and both the DM and dietitian verified the counter had grey tape applied to the damaged area. SUGGESTED METHOD OF CORRECTION: An audit could be developed with the assistance of the maintenance staff to assure that all kitchen equipment be maintained on a regular schedule. The result of the audit could be reported to the quality assurance committee TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and	21855		

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21855	Continued From page 4	21855		

personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation and interview the facility failed to provide personal health care services in a manner that promoted personal privacy for 1 of 1 resident (R11) who had a laboratory blood test while in the dining room with other residents and a visitor present.

Findings include:

During resident cares on 8/7/14, at 10:25 a.m. R11 was observed seated at a dining room table in the main dining room with four other residents seated around him. At 10:27 a.m. laboratory technician (LT)-A was observed to enter the dining room with a cart which contained the blood draw supplies. LT-A informed R11 that a blood draw to check for blood coagulation levels (International Normalized Ratio or INR) was going to be performed. LT-A was observed to place a tourniquet around the right forearm of R11 and perform a blood draw while four residents were seated directly around R11.

While the blood was drawn from the forearm of R11, R23 scooted back in her chair to observe the procedure. There were also visitors seated in the dining room at the time of the observation.

During interview with the acting director of nursing

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21855	Continued From page 5 (DON) on 8/8/14, at 11:30 a.m. it was stated the practice of drawing blood in the proximity of other residents or visitors would be a breach of personal privacy. The DON concurred that privacy should be provided when blood draws are conducted by laboratory personnel. SUGGESTED METHOD OF CORRECTION: The director of nurses could contact and inservice staff from an outside agency related to privacy rights. An audit could be developed to ensure privacy is maintained during lab draws and reported to quarterly quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		