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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NQK6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245273**

2.STATE VENDOR OR MEDICAID NO.
(L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **12/23/2015** (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 **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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

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
	46			
(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 :
Gayle Lantto, Unit Supervisor 01/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/05/2016 (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
03/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245273

January 5, 2016

Mr. Dru Fischgrabe, Administrator
Golden Livingcenter - Franklin
900 3rd Street South
Franklin, MN 55333

Dear Mr. Fischgrabe:

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 December 16, 2015 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 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
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
January 5, 2016

Mr. Dru Fischgrabe, Administrator
Golden Livingcenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5273026

Dear Mr. Fischgrabe:

On November 19, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 16, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2015, effective December 16, 2015 and therefore remedies outlined in our letter to you dated November 19, 2015, 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
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
245273	A. Building B. Wing	12/23/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/16/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/16/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/16/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/16/2015**
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/16/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/16/2015**
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	GL/kfd	1/5/2016	15507	12/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/6/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245273	A. Building 01 - MAIN BUILDING 01 B. Wing	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

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 Reg. # NFPA 101 LSC K0056	Correction Completed 12/16/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TL/kfd	Date: 1/5/2016	Signature of Surveyor: 34764	Date: 12/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/4/2015		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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NQK6

Facility ID: 00934

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245273**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857948200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - FRANKLIN**
(L4) **900 3RD STREET SOUTH**
(L5) **FRANKLIN, MN** (L6) **55333**

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 **11/06/2015** (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 **46** (L18)

13.Total Certified Beds **46** (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
	46			
(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 :
Rebecca Wong, HFE NE II 11/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/14/2015 (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
03/01/1985
(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
November 19, 2015

Mr. Dru Fischgrabe, Administrator
Golden Livingcenter - Franklin
900 3rd Street South
Franklin, MN 55333

RE: Project Number S5273026

Dear Mr. Fischgrabe:

On November 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

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 December 16, 2015, 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 February 6, 2016 (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 May 6, 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		12/16/15

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

Electronically Signed | 11/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	11/06/2015

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations involving resident to resident altercations and unwanted touch were immediately reported to the State agency (SA) for 3 of 4 reportable events involving five residents (R35, R101, R25, R19, R102); the facility failed to thoroughly investigate and immediately report to the SA an allegation of abuse for 1 of 3 residents (R19) and the facility failed to immediately report to the SA reportable allegations of elopement for 1 of 1 resident (R5). Findings include: R35 and R101 A review of incident reports and vulnerable adult reports for R35 are as follows: -On 3/25/15, at 4:30 p.m. indicated an unwitnessed event. R35 reported he had been hit on the arm by R101 in room 117. R35 had two bruises on his lower right arm, each 1 centimeter	F 225	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate	

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F 225	Continued From page 2 (cm) x 1 cm. No injuries were noted for R101. The care plan was reviewed but not updated. The administrator was notified at 4:45 p.m. The event report noted R35 was admitted to long term care (LTC) with diagnoses of dementia, major depressive disorder, and psychosocial circumstances with no cognitive impairment. The form lacked any signature of the administrator. R35 accused R101 (no longer a resident) of hitting him in the arm R101 "was mouthing off, I went to leave the room and when I passed the wheelchair [w/c] he hit me in the arm." The residents were roommates. R35 stated he was not going to sleep in his room another night with R101 because R101 stated, "I am going to kill you." R35 did state he was afraid R101 would hurt him. R35 had a small linear bruise on his forearm. R35 was moved to another room on the secured unit. R101 had a history of hitting/grabbing out when upset. The event was not reported until 3/26/15. In summary the resident to resident altercation, was reported to the SA the next day. R35 was interviewed on 11/3/15, at 5:17 p.m. R35 revealed a large bruise, which staff had measured at 9.0 cm by 6.5 cm on the posterior aspect of the left leg, behind and below the left knee. R35 did not know had he had gotten the bruise, but had noted it while he was dressing. R35 also stated he had been hit by another resident, but could not remember the other resident's name, or the date that it occurred. R35 stated he had been moved to a new room to get away from the other guy. Staff had measured the bruise, reported it to the SA on 11/3/15, and started monitoring the bruise.	F 225	submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F225 Allegations of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property are thoroughly investigated and reported immediately to the administrator and other officials in accordance with State law. All residents have the potential to be affected if allegations are not immediately investigated and reported. Education has been provided to staff on abuse/neglect and investigation and reporting requirements. Audits will be conducted on all events involving residents to insure proper investigation and reporting has occured. Negative findings will be addressed immediately and reported to QAA for further review. DNS/designee will be responsible party.	

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F 225	Continued From page 3 R35 had diagnoses of dementia, major depressive disorder, psychosocial circumstances (a restraining order was in place). The quarterly Minimum Data Set (MDS) dated 9/18/15, indicated R35 was cognitively intact with fluctuating inattention, moderate depression. The CAA dated 3/24/15, indicated R35 had major depression and dementia, severe cognitive impairment, poor judgement and had a history of inappropriate sexual comments. R101's Care Area Assessment (CAA) dated 1/26/15, indicated R101 had moderate cognitive impairment with behavioral disturbances, paranoia and episodic mood disorder with delusions. R101 had severely impaired decision making skills, poor insight into health, well-being, and safety. R101 was wheelchair bound. The Care Plan dated 1/28/14, indicated R101 rejected cares, experienced delusions, inappropriately touched staff during cares, made inappropriate sexual comments, and would holler out during delusions. R101 had been discharged from the facility. R35 and R32 On 8/25/15, at 1:30 p.m. an incident report indicated R35 was in his room. R32 entered his room and when asked to leave, picked up an ice pitcher and started to swing it. R35 was then hit in the lip by the ice pitcher and sustained a split lip. R32 was removed from the room and R35 received first aide to the left upper lip that was split. There was no documentation the event was reported to the SA, and the incident report lacked the signature of the administrator. Copies of the	F 225		

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events were requested but not provided.

On 11/3/15, at 2:00 p.m. "[R35] reported a bruise of unknown origin. Back of left leg below knee, 9.0 cm long by 6.5 cm wide with small bruise outer side of other bruise, measuring 1.0 cm in diameter." No equipment was involved (a hand written note was appended that stated R35 brings out footrest of wheelchair quickly, which could be a possibility to bruising on calf's). "The bruise was described as pruplish [sic] red. No pain noted. No swelling noted. Resident did not know the cause of the bruise, stated no one had bumped or hit him. The care plan was reviewed and revised." The SA was not notified.

R32's quarterly MDS on 9/23/15, indicated R32 was rarely understood, ambulated independently and had behaviors of wandering.

The facility failed to report allegations of abuse with injuries for R35.

R25 was fondled by R35, the facility failed to immediately report to the SA.

An incident report dated 9/18/15, indicated R25 was sitting in the hallway when staff saw R35 leaning over R25 with left hand extended, grabbing and fondling R25's left breast over her clothes. Staff asked R35 to leave, R35 jumped, moved his left hand to R25's hand and stated "she is holding my hand and won't let go." Staff then separated residents and told R35 to go back to his room. Staff member was with R35 at all times until going to bed. Review of the investigative report indicated the resident to resident abuse was not submitted to the SA until 9/19/15, one day after the incident occurred.

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R25 had diagnoses of dementia and Alzheimer's disease listed on the Admission Record dated 11/5/15. The significant change MDS dated 8/26/15, indicated R25 had severe cognitive impairment. CAA dated 8/26/15, indicated R25 had short and long term memory loss, severely impaired decision making skills and poor insight into personal well-being and safety.

R35 was admitted on 3/17/15, with admission diagnoses of dementia without behavioral disturbance, problems related to psychosocial circumstances, and major depressive disorder. According to the hospital discharge summary R35 had inappropriate sexual statements and physical touch.

The CAA dated 3/24/15, indicated R35 had severe cognitive impairment, poor judgement, and lack of insight into health, well-being and safety.

The care plan dated 3/30/15, and revised 6/25/15, indicated: R35 was at risk for elopement and made frequent statements of wanting to return to prior LTC facility (according to the hospital discharge summary dated 3/17/15, a restraining order was in place to prevent R35 from returning to his prior LTC due to inappropriate sexual statements and physical actions). R35 received psychotropic medications and had altered cognition-impaired decision making skills with poor insight into personal well-being and safety.

During an interview on 11/5/15, at 1:32 p.m. administrator and director of nursing (DON) verified the incident was reported a day late.

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During initial interview on 11/4/15, at 9:09 a.m. R19 stated a staff member was rough with during cares about six months ago. R19 stated that had been reported to facility staff.

Behavioral CAA dated 6/29/15, indicated, "Resident has behavior of rejecting cares-ADL (activities of daily living) assistance. Staff will continue to monitor behaviors and update MD as needed."

R19's quarterly MDS dated 9/23/15, indicated R19 was cognitively intact, required assist of two people to change position in bed, transfer in and out of bed, dressing toileting and personal hygiene. R19's MDS indicated R19 had a diagnosis of hemiplegia (paralysis of one side of body) as result of a stroke, schizophrenia, anxiety, and depression.

During interview on 11/05/15, at 10:12 a.m. licensed practical nurse (LPN)-A stated when R19 would get upset at someone, R19 would not allow staff to come in to the room for about two weeks. LPN-A further stated if R19 told her someone had been rough, LPN-A would get some details and tell the DON immediately. If it was something worse LPN-A would follow the procedure and make sure the resident was safe, notify the administrator and DON, the resident's doctor and the family. LPN-A would notify CEP (common entry point) and do the online report if no one else was here to do it. If necessary LPN-A could call the police.

On 11/5/15, at 11:28 a.m. the DON was asked to provide a copy of the report of R19's allegation and investigation of allegation. DON asked if

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surveyor meant a grievance. DON stated she was not sure what had been done or if it had been reported to her.

On 11/5/15, at 1:58 p.m. the DON was interviewed and provided a Grievance/Complaint Report dated 7/28/15. The form indicated R19 initiated the complaint to Social Worker (SW)-A. Documentation of grievance/complaint from R19 indicated nursing assistant (NA)-B "is rough when turning resident in bed and getting her in/out. She leave [sic] resident on commode for 1/2 hour and makes resident wait to use commode. [R19] states 'I don't like her'." Documentation of facility follow up indicated a meeting was held with NA-B. Action taken to resolve concern was listed as "Educated staff on taking time during resident cares and to be gentle." Results of action taken "provide another caregiver as staffing allows or have 2 caregivers, while this CNA provides cares." The Report indicated R19's plan of care was not updated. The form was completed by the DON on 7/29/15. In addition, the DON provided a Resident Interview & Resident Observation form that was undated. Question G Abuse "1) Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" Was marked "Yes." Handwritten comments indicated, "NA-B got rough with me. DON wrote her up. Making me wait 30 min to get on toilet and then off toilet." During the interview, the DON stated registered nurse (RN)-A completed the QIS interview with R19 in the middle of September. DON stated I had asked RN-A about that and told RN-A we had already done a grievance on that. When DON was asked why she did a grievance instead of an abuse report and investigation, DON stated that SW-A initiated the grievance. DON stated, "I did a little

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investigation." The investigation was the documentation on the grievance when we spoke with the resident." When asked about allegation from R19 that NA-B left them on the commode for 30 minutes, DON stated that was not allowed, " if I had heard they have been on the commode for half an hour that would be neglect. If an allegation of abuse or neglect was brought to me I would have to review the policies and procedures. I believe that it would be state reportable. I would be doing a verification of investigation and an incident report." When asked did you report this? DON stated, "I would have to look back, I do not remember reporting this. We usually have 24 hours to make the initial report and 5 working days to complete the final investigation report. Usually social worker or I deal with issues. I want the nurse to come tell me then I would usually go talk to the resident to verify the information. I would fill out a grievance form, because that is what we typically start with. If it sounds like a vulnerable adult issue we file a vulnerable adult report. I verify it with the administrator. If staff knew about it a couple days before the grievance they should notified me right away. I let administrator know of any allegations right away. The nurse usually calls the administrator and I." Verified they never reported the allegation of abuse or neglect.

R5's elopement were not immediately reported to the SA.

R5's care plan dated 6/9/14, indicated R5 sometimes had behaviors including wandering and exit seeking. The care plan directed staff to medications as ordered, offer beverage or snack, offer a diversion including cards music calm and quiet environment.

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F 225	Continued From page 9 Cognitive Loss CAA dated 5/15/15, indicated R5 has moderately impaired cognition, poor decision making abilities with poor judgement and insight into health and well-being and safety. A Progress Note on 7/4/15, at 7:40 p.m. "Resident exit seeking. Followed staff through double doors. Apparently a delay in the lock gave him way to get through. Left west wing and was found outside, sitting on glider swing north side of east wing. Was easily redirected inside by conversation about television in fireside room." Review of care plan did not reflect any changes made to the care plan after the event. R5's quarterly MDS dated 8/12/15, indicated resident was cognitively intact and independent with activities of ADL including locomotion on and off the unit even though R5 was on a secured unit. Although the facility identified R5 as having intact cognition, the information contraindicated the CAA dated 5/15/15, where the facility identified R5 as having impaired cognition. A Progress Note on 8/30/15, at 8:54 p.m. indicated, "Staff saw resident walking outside on East end, on cement pathway, walking towards parking lot."... "Res stated that how he got out, is by pushing on door long enough, so it becomes unlocked, and he is able to leave. Once on locked unit, res attempted to push on doors again. Staff asked res not to. Res refused and continued. Nurse than put med cart in front of doors until res went to bed." A Progress note on 9/26/15, at 9:00 p.m. indicated, "Resident was found sitting outside, on the patio on the east wing visiting with resident	F 225		

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91979 from the east side. Unknown how he eloped to east wing. When suggested that he return to west wing with this writer, he got up and accompanied me without incident."

On 11/4/15, at 1:40 p.m. R5 came out the door of the locked unit. Just prior to R5 coming out of the door the surveyor had come through door shortly before and stood in front of the door for one to two minutes prior to ensure the door closed behind the surveyor. R5 was observed exiting the dining room through the porch door. Surveyor called out for a nurse and followed resident out the patio door. The resident would not stop when called by name. The surveyor followed R5 down the sidewalk. As surveyor passed the business office window, knocked loudly on the window and waved to staff for help. R5 went around the corner of the building and across the parking lot when registered nurse (RN)-A came out door and followed R5 to the glider.

A request was made for all of R5's incident reports, and reported or unreported investigations of abuse or neglect for the previous 12 months. All reports provided by facility were reviewed. There were no incident reports or investigations of how R5 managed to exit the locked unit and facility on 7/14/15, 8/30/15, and, 9/26/15.

During interview on 11/6/15, at 8:25 a.m. RN-A stated, " I placed a Wanderguard on R5 11/5/15, in the morning but I did not put it on tight and R5 had it off within 1 hour. " When asked what interventions were put in place for the time R5 was outside on 9/26/15, at 9 p.m. RN-A stated, " I was not aware of that and will have to ask the DON. "

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F 225	Continued From page 11 During interview on 11/6/15, at 9:46 a.m. the DON said the intervention put in place after, the incident of 9/26/15, was every staff member who went through the double doors were to stand there until the door latched and they would need to check it. The DON further stated staff need to contact administrator, DON and if needed 9-1-1 if a resident left the locked unit unescorted. The DON verified no incident reports were completed and no written verification of investigations were done. DON stated. "I need to train staff on elopement." The facility Abuse Prevention Policy titled, "Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or injuries of Unknown Source in Accordance With Federal and Minnesota State Vulnerable Adult Act Requirements" with revision date of October 2011, indicated "the facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and the Common Entry Point as required by State and Federal law." The policy further indicated any occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property be reported immediately to the executive director and reportable incidents must be reported immediately to the state agency. The facility did not follow the policy for immediately reporting to the SA.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		12/16/15

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F 226	Continued From page 12 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to fully implement the abuse prevention policy to immediately report to the state agency, resident to resident altercations and unwanted touch for 3 of 4 reportable events involving five residents (R25, R101, R35, R32, R46, R102). In addition, the facility failed to have documented screening for 2 of 5 new employees (E2, E4), and failed to thoroughly investigate and immediately report to the SA an allegation of abuse for 1 of 3 residents (R19). Findings Include: The facility Abuse Prevention Policy titled, "Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, or injuries of Unknown Source in Accordance With Federal and Minnesota State Vulnerable Adult Act Requirements" with revision date of October 2011, indicated "the facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Minnesota Department of Health and the Common Entry Point as required by State and Federal law." The policy further indicated any occurrence of abuse, neglect, mistreatment, maltreatment, injuries of unknown source and misappropriation of resident property be reported immediately to the executive director and reportable incidents must be reported immediately to the state agency. The	F 226	F226 Allegations of mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property are thoroughly investigated and reported immediately to the administrator and other officials in accordance with State law. Screening of new hires is completed upon hire. All residents have the potential to be affected if policies/procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property are not fully implemented. Education has been provided to staff on abuse/neglect and investigation and reporting requirements. Education has been provided to hiring managers on completion of required screening of new hires. Audits will be conducted on all events involving residents, to insure proper investigation and reporting has occured. Audits of new hires will be completed to insure screening has been completed. Negative findings will be addressed immediately and reported to QAA for further review.	

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F 226	Continued From page 13 policy also indicated all applicants for employment in the facility shall at a minimum have screening checks that included reference checks with current and/or past employer, appropriate licensing board or registry check, drug testing, fingerprinting and criminal background check. R35 and R101 A review of incident reports and vulnerable adult reports for R35 are as follows: -On 3/25/15, at 4:30 p.m. indicated an unwitnessed event. R35 reported he had been hit on the arm by R101 in room 117. R35 had two bruises on his lower right arm, each 1 centimeter (cm) x 1 cm. No injuries were noted for R101. The care plan was reviewed but not updated. The administrator was notified at 4:45 p.m. The event report noted R35 was admitted to long term care (LTC) with diagnoses of dementia, major depressive disorder, and psychosocial circumstances with no cognitive impairment. The form lacked any signature of the administrator. R35 accused R101 (no longer a resident) of hitting him in the arm R101 "was mouthing off, I went to leave the room and when I passed the wheelchair [w/c] he hit me in the arm." The residents were roommates. R35 stated he was not going to sleep in his room another night with R101 because R101 stated, "I am going to kill you." R35 did state he was afraid R101 would hurt him. R35 had a small linear bruise on his forearm. R35 was moved to another room on the secured unit. R101 had a history of hitting/grabbing out when upset. The event was not reported until 3/26/15. In summary the resident to resident altercation, was reported to the SA the next day.	F 226	DNS/designee will be responsible.	

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R35 and R32
On 8/25/15, at 1:30 p.m. an incident report indicated R35 was in his room. R32 entered his room and when asked to leave, picked up an ice pitcher and started to swing it. R35 was then hit in the lip by the ice pitcher and sustained a split lip. R32 was removed from the room and R35 received first aide to the left upper lip that was split. There was no documentation the event was reported to the SA, and the incident report lacked the signature of the administrator. Copies of the events were requested but not provided.

On 11/3/15, at 2:00 p.m. "[R35] reported a bruise of unknown origin. Back of left leg below knee, 9.0 cm long by 6.5 cm wide with small bruise outer side of other bruise, measuring 1.0 cm in diameter." No equipment was involved (a hand written note was appended that stated R35 brings out footrest of wheelchair quickly, which could be a possibility to bruising on calf's). "The bruise was described as pruplish [sic] red. No pain noted. No swelling noted. Resident did not know the cause of the bruise, stated no one had bumped or hit him. The care plan was reviewed and revised." The SA was not notified.

R46 and R102
An Event report dated 5/17/15, at 3:00 p.m. noted R46 was waving her hands in front of R102 and knocked R102's glasses off her face. R46 and R102 were roommates. The resident's were arguing because R102 wanted the door closed did not like a messy appearing room, and R46 wanted the door open and had a habit of keeping her belongings on the bed during the day. No injury was noted for R46 and R46 was moved to a new room. The event was not reported until

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F 226	Continued From page 15 5/18/15 to SA until the next day. R25 was fondled by R35, the facility failed to immediately report to the SA. An incident report dated 9/18/15, indicated R25 was sitting in the hallway when staff saw R35 leaning over R25 with left hand extended, grabbing and fondling R25's left breast over her clothes. Staff asked R35 to leave, R35 jumped, moved his left hand to R25's hand and stated "she is holding my hand and won't let go." Staff then separated residents and told R35 to go back to his room. Staff member was with R35 at all times until going to bed. Review of the investigative report indicated the resident to resident abuse was not submitted to the SA until 9/19/15, one day after the incident occurred. R25 had diagnoses of dementia and Alzheimer's disease listed on the Admission Record dated 11/5/15. The significant change MDS dated 8/26/15, indicated R25 had severe cognitive impairment. CAA dated 8/26/15, indicated R25 had short and long term memory loss, severely impaired decision making skills and poor insight into personal well-being and safety. R35 was admitted on 3/17/15, with admission diagnoses of dementia without behavioral disturbance, problems related to psychosocial circumstances, and major depressive disorder. According to the hospital discharge summary R35 had inappropriate sexual statements and physical touch. The CAA dated 3/24/15, indicated R35 had	F 226		

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severe cognitive impairment, poor judgement, and lack of insight into health, well-being and safety.

The care plan dated 3/30/15, and revised 6/25/15, indicated: R35 was at risk for elopement and made frequent statements of wanting to return to prior LTC facility (according to the hospital discharge summary dated 3/17/15, a restraining order was in place to prevent R35 from returning to his prior LTC due to inappropriate sexual statements and physical actions). R35 received psychotropic medications and had altered cognition-impaired decision making skills with poor insight into personal well-being and safety.

During an interview on 11/5/15, at 1:32 p.m. administrator and director of nursing (DON) verified the incident was reported a day late. During initial interview on 11/4/15, at 9:09 a.m. R19 stated a staff member was rough with during cares about six months ago. R19 stated that had been reported to facility staff.

Behavioral CAA dated 6/29/15, indicated, "Resident has behavior of rejecting cares-ADL (activities of daily living) assistance. Staff will continue to monitor behaviors and update MD as needed."

R19's quarterly MDS dated 9/23/15, indicated R19 was cognitively intact, required assist of two people to change position in bed, transfer in and out of bed, dressing toileting and personal hygiene. R19's MDS indicated R19 had a diagnosis of hemiplegia (paralysis of one side of body) as result of a stroke, schizophrenia, anxiety, and depression.

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During interview on 11/05/15, at 10:12 a.m. licensed practical nurse (LPN)-A stated when R19 would get upset at someone, R19 would not allow staff to come in to the room for about two weeks. LPN-A further stated if R19 told her someone had been rough, LPN-A would get some details and tell the DON immediately. If it was something worse LPN-A would follow the procedure and make sure the resident was safe, notify the administrator and DON, the resident's doctor and the family. LPN-A would notify CEP (common entry point) and do the online report if no one else was here to do it. If necessary LPN-A could call the police.

On 11/5/15, at 11:28 a.m. the DON was asked to provide a copy of the report of R19's allegation and investigation of allegation. DON asked if surveyor meant a grievance. DON stated she was not sure what had been done or if it had been reported to her.

On 11/5/15, at 1:58 p.m. the DON was interviewed and provided a Grievance/Complaint Report dated 7/28/15. The form indicated R19 initiated the complaint to Social Worker (SW)-A. Documentation of grievance/complaint from R19 indicated nursing assistant (NA)-B "is rough when turning resident in bed and getting her in/out. She leave [sic] resident on commode for 1/2 hour and makes resident wait to use commode. [R19] states 'I don't like her'." Documentation of facility follow up indicated a meeting was held with NA-B. Action taken to resolve concern was listed as "Educated staff on taking time during resident cares and to be gentle." Results of action taken "provide another caregiver as staffing allows or have 2 caregivers, while this CNA [certified

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nursing assistant] provides cares." The Report indicated R19's plan of care was not updated. The form was completed by the DON on 7/29/15. In addition, the DON provided a Resident Interview & Resident Observation form that was undated. Question G Abuse "1) Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" Was marked "Yes." Handwritten comments indicated, "NA-B got rough with me. DON wrote her up. Making me wait 30 min to get on toilet and then off toilet." During the interview, the DON stated registered nurse (RN)-A completed the QIS (Quality Indicator Survey) interview with R19 in the middle of September. DON stated I had asked RN-A about that and told RN-A we had already done a grievance on that. When DON was asked why she did a grievance instead of an abuse report and investigation, DON stated that SW-A initiated the grievance. DON stated, "I did a little investigation." The investigation was the documentation on the grievance when we spoke with the resident." When asked about allegation from R19 that NA-B left them on the commode for 30 minutes, DON stated that was not allowed, "if I had heard they have been on the commode for half an hour that would be neglect. If an allegation of abuse or neglect was brought to me I would have to review the policies and procedures. I believe that it would be state reportable. I would be doing a verification of investigation and an incident report." When asked did you report this? DON stated, "I would have to look back, I do not remember reporting this. We usually have 24 hours to make the initial report and 5 working days to complete the final investigation report. Usually social worker or I deal with issues. I want the nurse to come tell me then I would usually go talk to the resident to

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verify the information. I would fill out a grievance form, because that is what we typically start with. If it sounds like a vulnerable adult issue we file a vulnerable adult report. I verify it with the administrator. If staff knew about it a couple days before the grievance they should notified me right away. I let administrator know of any allegations right away. The nurse usually calls the administrator and I." Verified they never reported the allegation of abuse or neglect.

R5's elopement were not immediately reported to the SA.

R5's care plan dated 6/9/14, indicated R5 sometimes had behaviors including wandering and exit seeking. The care plan directed staff to medications as ordered, offer beverage or snack, offer a diversion including cards music calm and quiet environment.

Cognitive Loss CAA dated 5/15/15, indicates R5 has moderately impaired cognition, poor decision making abilities with poor judgement and insight into health and well-being and safety.

A Progress Note on 7/4/15, at 7:40 p.m. "Resident exit seeking. Followed staff through double doors. Apparently a delay in the lock gave him way to get through. Left west wing and was found sitting outside, on glider swing north side of east wing. Was easily redirected inside by conversation about television in fireside room." Review of care plan did not reflect any changes made to the care plan after the event.

R5's quarterly MDS dated 8/12/15, indicated resident was cognitively intact and independent

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with activities of ADL including locomotion on and off the unit even though R5 was on a secured unit. Although the facility identified R5 as having intact cognition, the information contraindicated the CAA dated 5/15/15, where the facility identified R5 as having impaired cognition.

A Progress Note on 8/30/15, at 8:54 p.m. indicated, "Staff saw resident walking outside on East end, on cement pathway, walking towards parking lot."... "Res stated that how he got out, is by pushing on door long enough, so it becomes unlocked, and he is able to leave. Once on locked unit, res attempted to push on doors again. Staff asked res not to. Res refused and continued. Nurse than put med cart in front of doors until res went to bed."

A Progress note on 9/26/15, at 9:00 p.m. indicated, "Resident was found sitting outside, on the patio on the east wing visiting with resident 91979 from the east side. Unknown how he eloped to east wing. When suggested that he return to west wing with this writer, he got up and accompanied me without incident."

On 11/4/15, at 1:40 p.m. R5 came out the door of the locked unit. Just prior to R5 coming out of the door the surveyor had come through door shortly before and stood in front of the door for one to two minutes prior to ensure the door closed behind the surveyor. R5 was observed exiting the dining room through the porch door. Surveyor called out for a nurse and followed resident out the patio door. The resident would not stop when called by name. The surveyor followed R5 down the sidewalk. As surveyor passed the business office window, knocked loudly on the window and waved to staff for help. R5 went around the

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corner of the building and across the parking lot when registered nurse (RN)-A came out door and followed R5 to the glider.

A request was made for all of R5's incident reports, and reported or unreported investigations of abuse or neglect for the previous 12 months. All reports provided by facility were reviewed. There were no incident reports or investigations of how R5 managed to exit the locked unit and facility on 7/14/15, 8/30/15, and, 9/26/15.

During interview on 11/6/15, at 8:25 a.m. RN-A stated, " I placed a Wanderguard on R5 11/5/15, in the morning but I did not put it on tight and R5 had it off within 1 hour." When asked what interventions were put in place for the time R5 was outside on 9/26/15, at 9 p.m. RN-A stated, "I was not aware of that and will have to ask the DON."

During interview on 11/6/15, at 9:46 a.m. the DON said the intervention put in place after, the incident of 9/26/15, was every staff member who went through the double doors were to stand there until the door latched and they would need to check it. The DON further stated staff need to contact administrator, DON and if needed 9-1-1 if a resident left the locked unit unescorted. The DON verified no incident reports were completed and no written verification of investigations were done. DON stated. I need to train staff on elopement."

In addition the facility lacked documentation of screening of 2 of 5 new employees:
E2 a NA was hired 3/9/15, received abuse training 3/19/15, had a background study

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F 226	Continued From page 22 clearance on 3/20/15, but did not have registry verification until 11/5/15 (8 months after hire). E4 a NA was hired 9/7/15, had a background study clearance on 9/8/15, received abuse training 9/14/15, but did not have registry verification until 11/5/15 (2 months after hire). On 11/6/15, at 1:35 the Administrator stated the facility had called the registry, then realized they didn't have documentation, so called again last night (11/5/15), and the state agency faxed documentation within 2 hours. The facility failed to follow their vulnerable adult policy for screening of new employees.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/16/15

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F 280	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to update the care plan for 1 of 2 (R20) residents who developed a skin tear reviewed for non-pressure related skin issues. Findings include: R20's care plan dated 3/27/14, indicated R20 had a physical functioning deficit related to self-care impairment and directed staff to inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse. The Progress Note dated 9/10/15, indicated R20 did have a skin tear to right posterior hand. The Order Summary Report indicates R20 was on Neurontin (used to treat nerve pain) which had potential side effects of jerky movements and lack of coordination per the package insert by Medsource Pharmaceuticals revised on 8/26/15. On 11/05/15, at 7:50 a.m. the area was observed on the outer aspect of R20's right wrist that was approximately 2 centimeter (cm) x 1cm irregular shaped, raised yellow scabbed area with approximately 0.5 cm red area surrounding the scab. During interview on 11/05/15, at 10:02 a.m. LPN-A stated we are not monitoring it anymore because it was closed. R20 had an episode of delusions and psychosis and he had ended up with a couple of skin tears. He had a lot of	F 280	F280 R20's care plan has been reviewed and updated to reflect current skin issues. All residents with impaired skin integrity have the potential to be affected if care plans are not updated to address current status. Licensed staff has been provided education on updating care plans with changes. Weekly care plan audits will be conducted on residents with impaired skin integrity to insure updates are completed to address current interventions. Negative findings will be addressed immediately and reported to QAA for furter review. DNS/designee will be responsible.	

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F 280	Continued From page 24 different skin issues at any time, he bruises easily and had fragile skin. R20 would bump into things and gets a skin tear or bruise and they heal well. The process for monitoring for a skin tear, with a treatment, was a minimum of at least daily to ensure dressing was in place. Monitoring was typically on our treatment record. -At 10:10 a.m. LPN-A observed right wrist. LPN-A stated, "I would not count it closed, but if the registered nurse had said it was healed, I might still monitor it." LPN-A stated it was red, with no warmth. It was boggy or swollen with no fluid noted. "I think it was the wound that we were treating in the past." During interview on 11/06/15, at 9:37 a.m. the director of nurses (DON) stated, "I expect them to do weekly skin checks. I reviewed the skin assessment dated 11/3/15. R20's skin is not intact if there is a scab. I would expect them to put it in the eMAR (electronic Medication Administration Record) to do daily monitoring until healed. I would expect a care plan because of R20's high risk for bruises and skin tears."	F 280		
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, facility failed to ensure the safety 1 of 3 (R5) residents who left the locked unit and were	F 282	F282 R5 elopement attempts will be	12/16/15

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F 282	Continued From page 25 reviewed for exit seeking behavior. Findings include: R5 came out the door of the locked unit on 11/4/15, at 1:40 p.m. Just prior to R5 coming out of the door the surveyor had come through door shortly before and stood in front of the door for one to two minutes prior to ensure the door closed behind the surveyor. R5 was observed exiting the dining room through the porch door. Surveyor called out for a nurse and followed resident out the patio door. The resident would not stop when called by name. The surveyor followed R5 down the sidewalk. As surveyor passed the business office window, knocked loudly on the window and waved to staff for help. R5 went around the corner of the building and across the parking lot when registered nurse (RN)-A came out door and followed R5 to the glider. On 11/05/15, at 8:35 a.m. during a random observation R5 was seen through open doors between East and West unit by the keypad on the West unit side. R5's care plan dated 6/9/14, indicated R5 sometimes had behaviors which included wandering and exit seeking. The care plan directed staff to administer medications as ordered, offer beverage or snack, offer a diversion including cards music calm and quiet environment. Review of care plan did not reflect any changes made to the care plan after resident successfully left unit. A Progress Note on 7/4/15, at 7:40 p.m. "Resident exit seeking. Followed staff through	F 282	documented and reported according to regulation should elopement attempts occur. R5 care plan interventions have been reviewed. Exit doors from locked unit have been set to immediately lock when closing. Alarm sounds if door is opened without entering exit code. Residents at risk for elopement have the potential to be affected if elopement protocols are not followed. Staff has been provided education on elopement protocol including reporting requirements. Audits will be completed on all events involving residents exiting the locked unit without staff supervision. Negative findings will be addressed immediately and reported to QAA for further review. DNS/designee will be responsible.	

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F 282	Continued From page 26	F 282		

double doors. Apparently a delay in the lock gave him way to get through. Left west wing and was found sitting on glider swing north side of east wing. Was easily redirected inside by conversation about television in fireside room." Review of care plan did not reflect any changes made to the care plan after this event.

The Progress Note on 8/30/15, at 8:54 p.m. indicated, "Staff saw resident walking outside on East end, on cement pathway, walking towards parking lot."... "Res stated that how he got out, is by pushing on door long enough, so it becomes unlocked, and he is able to leave. Once on locked unit, res attempted to push on doors again. Staff asked res not to. Res refused and continued. Nurse than put med cart in front of doors until res went to bed." Review of care plan did not reflect any changes made to the care plan after resident successfully left unit.

A Progress Note on 9/26/15, at 9:00 p.m. indicated, "Resident was found sitting on the patio on the east wing visiting with resident 91979 from the east side. Unknown how he eloped to east wing. When suggested that he return to west wing with this writer, he got up and accompanied me without incident." Review of care plan did not reflect changes.

The Summary Report of Meeting dated 10/1/15, indicated the subjects covered included dementia and Alzheimer-what is it? Examples of difficult behaviors and how they might be handled, and that "Staff must stand by all doors to ensure they lock before walking away."

A Progress Note on 11/4/15, at 6:10 p.m. "Resident exited secured unit following surveyor

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by withholding door from latching after she passed through. Resident followed by surveyor and escorted back into facility by staff. MD [medical doctor] and guardian notified. Resident had no deviation from normal daily routine. Reviewed and determined no injuries." Review of care plan reflected: "Wanderguard in place"(11/5/15) intervention was yellowed out.

The Nursing Assistant Assignment sheet undated, did not identify resident as having exit seeking behaviors or specific interventions to reduce risk.

During interview on 11/6/15, at 8:25 a.m. RN-A stated, "I placed a WanderGuard on [R5] on 11/5/15, in the morning but I did not put it on tight and [R5] had it off within 1 hour." When asked what interventions were put in place for the time R5 was outside on 9/26/15, at 9 p.m. RN-A stated, "I was not aware of that and will have to ask the DON [director of nursing]."

During interview on 11/6/15, at 9:46 a.m. the director of nursing (DON) said the intervention put in place after, the incident of 9/26/15, was every staff member who goes through those double doors are to stand there until the door latches and they need to check it. DON further stated staff need to contact administrator, myself and if needed 9-1-1 if a resident leaves the locked unit unescorted. DON stated staff are supposed to update the care plan with the fact the resident is at high risk for elopement and what the new interventions are. R5 did not leave the premise on 9/26/15. No incident reports were done, No written voi's [verification of investigations] were done. DON stated, "I need to train staff on elopement."

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, facility failed to monitor a non-healed abrasion for 1 of 2 (R20) residents reviewed for non-pressure skin concerns. Findings include: R20's care plan dated 3/27/14, indicated R20 had a physical functioning deficit related to self-care impairment and directed staff to inspect skin with care. The staff were to report reddened areas, rashes, bruising, or open areas to charge nurse. R20's quarterly Minimum Data Set (MDS) dated 8/12/15, indicated R20 was moderately cognitively impaired and independent with all activities of daily living (ADL). Diagnosis listed included dementia. A Progress Note dated 9/10/15, indicated R20 did have a skin tear to right posterior hand. The Treatment records from 9/15/15 until 10/5/15, indicated "Monitor skin tear to (L) elbow et [and] to (R) [right] top of hand. Tegaderm [a waterproof and transparent dressing] in place.	F 309	F309 R20's skin intergrity risk has been care planned and monitoring is being completed for non-pressure related skin concerns. Residents with impairment of skin integrity have the potential to be affected if monitoring is not completed until healed. Licensed staff has been provided education on requirements for monitoring skin integrity. Random weekly audits will be conducted on residents with impaired skin integrity to insure monitoring is in place until healed. Negative findings will be addressed immediately and reported to QAA for further review. DNS/designee will be responsible.	12/16/15

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Change PRN [as needed] or when drsg [dressing] can be changed to a non-adherent drsg. Every day shift." No monitoring documented after 10/5/15, except weekly skin assessments that indicated skin was intact.

A Skin Assessment dated 11/3/15, indicated R20's skin was intact.

The Order Summary Report indicates R20 was on Neurontin (used to treat nerve pain) which had potential side effects of jerky movements and lack of coordination per the package insert by Medsource Pharmaceuticals revised on 8/26/15.

On 11/05/15, at 7:50 a.m. the area was observed on the outer aspect of R20's right wrist that was approximately 2 centimeter (cm) x 1cm irregular shaped, raised yellow scabbed area with approximately 0.5 cm red area surrounding the scab.

On 11/5/15, at 7:50 a.m. R20 said, "I bumped it on a door." At 10:10 a.m. R20 told Licensed practical nurse (LPN)-A, "I bumped it on the bedside table."

During interview on 11/05/15, at 10:02 a.m. LPN-A stated we are not monitoring it anymore because it was closed. R20 had an episode of delusions and psychosis and he had ended up with a couple of skin tears. He had a lot of different skin issues at any time, he bruises easily and had fragile skin. R20 would bump into things and gets a skin tear or bruise and they heal well. The process for monitoring for a skin tear, with a treatment, was a minimum of at least daily to ensure dressing was in place. Monitoring was typically on our treatment record.

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F 309	Continued From page 30 -At 10:10 a.m. LPN-A observed right wrist. LPN-A stated, "I would not count it closed, but if the registered nurse had said it was healed, I might still monitor it." LPN-A stated it was red, with no warmth. It was boggy or swollen with no fluid noted. "I think it was the wound that we were treating in the past." On 11/6/15, at 7:29 a.m. surveyor viewed R20's right with registered nurse (RN)-A. RN-A stated wound was not opened and it was scabbed over. It would depend on the nurse if they would call it closed. "In my opinion it is not healed. It is my expectation that the nursing assistant and nurse will be looking at it for any changes and update as needed. It should still be on daily monitoring." During interview on 11/06/15, at 9:37 a.m. the director of nurses (DON) stated, "I expect them to do weekly skin checks. I reviewed the skin assessment dated 11/3/15. R20's skin is not intact if there is a scab. I would expect them to put it in the eMAR (electronic Medication Administration Record) to do daily monitoring until healed. I would expect a care plan because of R20's high risk for bruises and skin tears."	F 309		
F 323 SS=D	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.	F 323		12/16/15

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F 323	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the safety 1 of 3 (R5) residents who left the locked unit and were reviewed for exit seeking behavior. Findings include: R5 came out the door of the locked unit on 11/4/15, at 1:40 p.m. Just prior to R5 coming out of the door the surveyor had come through door shortly before and stood in front of the door for one to two minutes prior to ensure the door closed behind the surveyor. R5 was observed exiting the dining room through the porch door. Surveyor called out for a nurse and followed resident out the patio door. The resident would not stop when called by name. The surveyor followed R5 down the sidewalk. As surveyor passed the business office window, knocked loudly on the window and waved to staff for help. R5 went around the corner of the building and across the parking lot when registered nurse (RN)-A came out door and followed R5 to the glider. On 11/4/15, at 1:47 p.m. an observation was made of the entrance/exit to secured unit. There was no sign posted, which instructed staff or visitors to ensure no one follows them through door. Two surveyors checked the secure unit doors. There was an audible click when the door was unlocked from the East side (not secured side). When the door was opened from the West side (secured unit side), there was a bang noise when the door closed. However, the door did bounce away from the latch. The door bounced three different times when someone came from	F 323	F323 R5 elopement attempts will be documented and reported according to regulation should elopement attempts occur. R5 care plan interventions have been reviewed. Exit doors from locked unit have been set to immediately lock when closing. Alarm sounds if door is opened without entering exit code. Residents at risk for elopement have to potential to be affected if elopement protocols are not followed. Staff has been provided education on elopement protocol including reporting requirements and safety awareness when entering/exiting locked unit. Audits will be completed on all events involving residents exiting the locked unit without staff supervision. Negative findings will be addressed immediately and reported to QAA for further review. DNS/designee will be responsible.	

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locked unit. The door did not bounce when surveyor went from unlocked unit to the locked unit. According to the administrator "the resident is known to stand by the nursing station window, and reach out to prevent the door from closing. "

On 11/5/15, during continuous observation of door between the East (unsecured) and West (secured) units from 7:10 a.m. until 8:11 a.m.
-7:54 a.m. licensed practical nurse (LPN)-A came through the door from the locked unit and continued to walk to medication cart (approximately 10 feet), the door closed without bounce, and the latch was heard to click.
-8:07 nursing assistant (NA)-A walked through door from the locked unit to the unlocked unit and walked away from the door without checking.
-8:11 dietary staff to West, two staff were standing in doorway and talking with door open. Then one staff member with a beverage cart walked away to West.
-8:11 NA-A walked away from door without checking.

The secured doors were monitored continuously for 61 minutes, during that time four of 20 observed employees who went back and forth between the secured and non-secured units, did not stop to ensure the doors were secured when exiting or entering the secured unit.

On 11/5/15, at 8:35 a.m. during a random observation R5 was seen through open doors between East and West unit by the keypad on the West unit side.

R5's care plan dated 6/9/14, indicated R5 sometimes had behaviors which included wandering and exit seeking. The care plan

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directed staff to administer medications as ordered, offer beverage or snack, offer a diversion including cards music calm and quiet environment. Review of care plan did not reflect any changes made to the care plan after resident successfully left unit.

The care plan dated 6/9/14, indicated R5 resided on the secure unit was an elopement risk and wandered. The care plan directed staff that R5 would be able to walk freely throughout the unit and staff would remove R5 from dangerous situations.

A Quarterly Interdisciplinary Resident Review dated 11/12/14, Section L Risk for Elopement indicated continuous to door seek, has had one episode of leaving unit and going out to sit on swing.

The Quarterly Interdisciplinary Resident Review dated 2/11/15, Section L Risk for Elopement indicated continues to door seek and has made attempts to through door, was easily redirected.

The Cognitive Loss Care Area Assessment dated 5/15/15, indicated R5 had moderately impaired cognition, poor decision making abilities with poor judgement and insight into health and well-being and safety.

The Progress Note on 7/4/15, at 7:40 p.m. "Resident exit seeking. Followed staff through double doors. Apparently a delay in the lock gave him way to get through. Left west wing and was found sitting on glider swing north side of east wing. Was easily redirected inside by conversation about television in fireside room." Review of care plan did not reflect any changes

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made to the care plan after the event.

A Quarterly Interdisciplinary Resident Review dated 8/10/15, Section L Risk for Elopement indicated no attempts to leave the ground but has left unit via door to go outside to sit on swing able to be redirected back inside without problems

R5's quarterly Minimum Data Set dated 8/12/15, indicated resident was cognitively intact and independent with activities of daily living including locomotion on and off the unit even though R5 was on a secured unit.

The Progress Note on 8/30/15, at 8:54 p.m. indicated, "Staff saw resident walking outside on East end, on cement pathway, walking towards parking lot."... "Res stated that how he got out, is by pushing on door long enough, so it becomes unlocked, and he is able to leave. Once on locked unit, res attempted to push on doors again. Staff asked res not to. Res refused and continued. Nurse than put med cart in front of doors until res went to bed." Review of care plan did not reflect any changes made to the care plan after resident successfully left unit.

The Behavior Monthly Flow Sheet 9/1/15 through 9/30/15, exit seeking 29 times on the day shift. Zero times on evenings or 27 times on nights.

The Progress Note on 9/26/15, at 9:00 p.m. indicated, "Resident was found sitting on the patio on the east wing visiting with resident 91979 from the east side. Unknown how he eloped to east wing. When suggested that he return to west wing with this writer, he got up and accompanied me without incident." Review of care plan did not reflect changes.

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A form Golden LivingCenter-Franklin dated 9/28/15, indicated under the area of resident concerns- [R5] outside.

The Summary Report of Meeting dated 10/1/15, indicated the subjects covered included dementia and Alzheimer-what is it? examples of difficult behaviors and how they might be handled, and that "Staff must stand by all doors to ensure they lock before walking away."

The Behavior Monthly Flow Sheet 10/1/15 through 10/31/15, noted R5 sought exit seeking 42 times on the day shift. Zero times on evenings and 27 times on nights.

The Behavior Monthly Flow Sheet 11/1/15 through 11/5/15, noted R5 sought exit seeking 26 times on the day shift. Zero times on evenings or nights.

The Progress Note on 11/4/15, at 6:10 p.m. "Resident exited secured unit following surveyor by withholding door from latching after she passed through. Resident followed by surveyor and escorted back into facility by staff. MD [medical doctor] and guardian notified. Resident had no deviation from normal daily routine. Reviewed and determined no injuries."

The Nursing Assistant Assignment sheet undated, did not identify resident as having exit seeking behaviors or specific interventions to reduce risk.

During interview on 11/4/15, at 1:55 p.m. the administrator stated, "We stay at the door and check to see it is locked before we step away. If

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someone pushed on the door for 20 seconds it will unlock and alarm. You must not have stood there long enough."
- At 2:05 p.m. the administrator stated R5 had a habit of putting his hand on the door to prevent it from latching when someone goes through the door. Then R5 will try to go through the door. We might catch R5 being missing at activity, but they would catch R5 at snack time. "When he goes out he goes to the glider and sits down. We might not have seen him go past the window. He could have gotten off the property and gotten lost."
- At 2:04 p.m. the administrator stated the facility had residents go through the doors of the secure unit but none have gone missing. "All stayed on the property. It's been over a year since anyone was missing. Most of the time we are with them when they go out." The administrator was not aware of any audible noise when the doors locks.

During interview on 11/5/15, at 10:22 a.m. LPN-A stated (R5) makes attempts because wants to smoke. R5 would stand there and push. R5 would go straight out to the swing. R5 was mentally able to make the decision to put on warm clothes. "It does not alarm if he pushes on it, or if it does, it is not very loud. I know the couple of times [R5] has pushed through the door we have seen him and not heard any alarms but I do not know if that is because we were following him."
- At 10:37 a.m. the administrator stated, "I had seen him walking by as you went past. We made an initial report yesterday, the interdisciplinary team met informally yesterday to try to figure out what happened and what we could do to prevent it from happening again. We did some work on the doors, changed the code, fiddled with the timing, you now have to very quick to get to the door or it will lock on you. We did not do anything

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	245273	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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 323	Continued From page 37 about it bouncing because we did not see it bounce while we were working on it. " - At 12:56 p.m. When asked how got out the door yesterday R5 smiled and said "it didn't latch all the way. I was going out and swinging. I got a cigarette. I go out about once a week by myself, the staff chase me. Sometimes I go to the swing sometimes I go and walk circles in the courtyards. I like to smoke and I like to be outside." - At 1:45 p.m. maintenance-A stated, "I changed the door code, and shortened the time from five seconds to two seconds to open the door. If you open the door all the way it will lock before it closes which is the way it should have been. Now he would have to follow you out. All staff know to watch on that side for someone trying to go out. When asked why the door bounced on occasion when it closed maintenance-A replied, that's because it had five seconds so the magnet had not engaged. It would close and bump back if you slid through. I check all the doors when I go through them. I check that the alarms on the outside doors daily but doors are not checked on weekends unless staff reports problems. The therapy door locks at six p.m. and the main locks at 10:00 p.m." During interview on 11/6/15, at 9:46 a.m. the DON said the intervention put in place after, the incident of 9/26/15, was every staff member who goes through those double doors are to stand there until the door latches and they need to check it. DON further stated staff need to contact administrator, myself and if needed 9-1-1 if a resident leaves the locked unit unescorted. DON stated staff are supposed to update the care plan with the fact the resident is at high risk for elopement and what the new interventions are.	F 323		

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F 323	Continued From page 38 R5 did not leave the premise on 9/26/15. No incident reports were done, No written verification of investigations were done. DON stated, "I need to train staff on elopement." The facility's Elopement policy revised May 2010, indicated the definition of "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. Residents on the secured unit will be deemed at risk for elopement."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R19) was free of significant medication error observed for insulin administration. This had the potential to affect 5 residents receiving insulin via insulin pens. Findings include: R19's quarterly Minimum Data Set (MDS) dated 9/23/15, indicated R19 was cognitively intact, had a diagnosis of diabetes and received insulin injections daily.	F 333	F333 R19 is recieving the ordered amount of insulin via pen. Residents requiring insulin via pen have the potential to be affected if the insulin pen is not primed according to manufacturer direction. Licensed staff has been provided education on procedure for insulin pen use including priming the pen. Random audits will be completed weekly on insulin injection via pen to insure	12/16/15

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F 333	Continued From page 39 The Order Summary printed 11/6/15, indicated R19 had an order for Lantus Solostar Solution Pen-injector 100 unit/milliliter (ml) inject 44 units twice a day. Review of blood sugars from 10/6/15 through 11/5/15, indicated R19's blood sugar was greater than 200 milligrams per deciliter (mg/dl) 59 out of the 126 blood sugar tests. During observation of insulin administration on 11/06/15, at 8:56 a.m. licensed practical nurse (LPN)-C checked the dose of Lantus insulin at the medication cart, dialed up the dose, assisted R19 to room off dining room and provided privacy. LPN-C explained procedure to R19 and allowed R19 to check the dose of insulin. LPN-C wiped the rubber stopper with alcohol and attached needle. LPN-C wiped R19's abdomen with alcohol pad and brought Lantus SoloStar pen toward R19 abdomen. Surveyor stopped administration. LPN-C primed pen and administered Lantus to R19. During interview on 11/06/15, at 8:57 a.m. LPN-C stated, "I did not prime the pen. I should have primed the pen. I have been taught to prime the pen before giving insulin. I do not know what the reason was that I forgot to." During interview on 11/06/15, at 9:01 a.m. director of nurses (DON) stated when the nurses give insulin with an insulin pen they are supposed to do their checks, then they prep the pen by wiping the tip with alcohol, attach a needle, prime the pen to ensure there is insulin up to the tip and dose the resident according to doctors ' orders. If they do not prime the pen, they are not going to get the correct dose. A call was placed to pharmacist on 11/6/15, at	F 333	proper procedure is being followed. Negative findings will be addressed immediately and reported to QAA for further review. DNS/designee will be responsible.	

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F 333	Continued From page 40 1:33 p.m. and messaged left. A return call was made by pharmacist on 11/10/15, at 12:21 p.m. Pharmacist verified nurses' must prime insulin pens prior to drawing up insulin dose or the dose given may be incorrect. The Lantus SoloStar performance Checklist dated 2014. "3. Perform a safety test * Dial 2 units (dosing window all automatically return to 0 after test) * Pull needle cover straight off * Holding pen with the needle pointing straight upward, tap the reservoir to remove air bubbles * Keeping needle pointing straight upward, fully depress injection button * Check needle tip to ensure insulin is coming out * if no insulin comes out, repeat test 2 more times *if there is still no insulin coming out after third time replace needle * if no insulin comes out with new needle, use a different pen The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on August 2015, directed the provider/consumer to: "Perform a Safety test Dial a test dose of 2 units. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.	F 333		

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F 333	Continued From page 41 Always perform the safety test before each injection."	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to maintain sanitary food serving equipment. This had the potential to affect all 39 of 40 residents who were served food from the steam table. Findings include: On 11/3/15, at 4:51 p.m. the steam table was observed filled with the evening meal. The steam left the kitchen area and was wheeled to the dining room for the dinner service. The sides and the front panels of the steam table was observed to have splattered areas of dried thick food build-up. The bottom front and side runners had a heavy build-up of brown sticky substance. On 11/3/15, at 5:23 p.m. dietary cook stated steam table should be wiped off daily with each meal. She further stated it was wiped that	F 371	F371 Steam table unit has been thoroughly cleaned including the side and front panels and bottom front and side runners. AM/PM Cook daily cleaning schedules have been updated to include cleaning the outside and bottom of the steam table unit. All residents have the potential to be affected if food serving equipment is not maintained in a sanitary manner. Dietary staff has been educated regarding cleaning of the steam table unit. Audits will be completed twice weekly on cleanliness of the steam table unit. Negative findings will be addressed immediately and reported to QAA for further review.	12/16/15

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F 371	Continued From page 42 morning and confirmed it should have been wiped clean. On 11/5/15, at 2:13 p.m. dietary manager, stated she never thought to clean bottom area grooves because that part does not come into contact with food. Review of Dining Services Policies and Procedures - Chapter 6: Sanitation, updated version dated 2/13/13, indicated "follow the steps below to clean moist-heat steam tables after each use: "5 remove burnt-on food residue with soft-bristle brush or nylon scratcher." "AM/PM Cook Daily Cleaning Schedules" were provided for September and October 2015, which included steam table-inserts and shelf. The schedules did not include cleaning the outside or bottom of the steam table unit. The November 2015 cleaning schedules were not provided.	F 371	DSM/designee will be responsible.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the environment was maintained in a clean and safe manner for 8 residents (R20, R9, R31, R19, R25, R1, R38, R10) reviewed for environmental concerns.	F 465	F465 The wall outside the bathroom has been repaired, bathroom wall has been repaired/repainted, bathroom floor has been cleaned; R19 wall outside bathroom	12/16/15

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F 465	Continued From page 43 Findings include: On 11/6/15, at 12:57 p.m. during environmental tour with the maintenance director (MD), housekeeping supervisor (HS)-A, and housekeeping supervisor from another facility (HS)-B, the following concerns were observed. R20 and R9's room wall outside bathroom had a corner protector. Four inches above the protector, the wall was rough with remnants of glue on the wall. The bathroom wall was noted to have a large effervescing area under the sink on either side and the paint was peeling away. The bathroom floor was dirty with black to brown build-up, especially in the corners and at the transition area between bathroom and resident room. R20's quarterly MDS dated 8/12/15, indicated R20 had moderate cognitive impairment, and was independent with most activities of daily living (ADL's). R9's 30-day scheduled assessment dated 8/28/15, indicated R9 was cognitively intact, and required one to two person assistance with most ADL's. R31's room had two room corners protectors. Four inches above each protector the wall was rough with remnants of glue on the wall. R31's quarterly MDS dated 9/30/15, indicated R31 had moderate cognitive impairment, and required extensive assistance with most ADL's. R19's wall outside bathroom had large gouge in it	F 465	has been repaired/repainted and area in right side of bathroom sink has been repaired/repainted; stains have been removed from around the toilet of R25 and R1 bathroom; baseboard has been secured to wall and wall has been repainted in R38 and R10 room. All residents have the potential to be affected if a safe, functional, sanitary, and comfortable environment is not maintained. Maintenance Director has been educated on preventive maintenance. Education has been provided to staff on reporting maintenance needs promptly. Non-clinical room audits will be completed twice weekly. Negative findings will be addressed immediately and reported to QAA for further review. ED/designee will be responsible.	

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F 465	Continued From page 44	F 465		

which bared the sheetrock beneath making the area uncleanable. The wall on the right side of the bathroom sink was noted to have a large effervescing area just above the floor.

R19's quarterly MDS assessment dated 9/23/15, indicated R19 was cognitively intact, and required extensive assistance with most ADL's.

R25 and R1's bathroom had a large brown discoloration/spillage/stains around the toilet bottom.

R25's quarterly MDS assessment dated 5/27/15, indicated R25 required extensive assistance with most ADL's.

R1's quarterly MDS assessment dated 10/1/15, indicated R1 had moderate cognitive impairment, and required one to two person physical assist with most ADL's.

R38 and R10's room baseboard, which measured approximately three inches wide was not secure to the wall, was jutting out, and could potentially present a tripping hazard. The wall above the area was patched, not painted.

R38's quarterly MDS dated 10/7/15, indicated R38 was cognitively intact, and was independent with most ADL's.

R10's quarterly MDS dated 10/21/15, indicated R10 was independent with transfers and ambulation and required extensive assistance with dressing, toileting and personal hygiene.

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F 465	Continued From page 45 On 11/6/15, at 2:37 p.m. MD stated currently no bids are out for baseboard work to be done. On 11/6/15, at 2:46 p.m. MD stated he fixed the baseboard a month ago, it came out, did not know when it happened. The MD verified and confirmed the areas of concern and indicated the issues needed to be repaired. The MD further indicated the system for reporting repairs was the building engines system. MD stated staff would put a work order in which he prints reports daily. Reviewed Work Order List and PM List provided by Administrator dated 11/6/15, which did not identify above environmental concerns. Reviewed blank Preventative Maintenance for 00875 - Golden Living Center - Franklin - MN dated 11/6/15, which identified "4. Check wall conditions (paint and wallpaper) and repair as needed. 6. Inspect wall cove base and repair as needed. 13. Inspect doors, hardware and frames, entrance and toilets and repaint or refinish as required. 15. Inspect all plumbing fixtures for proper operation or leaks and repair as needed. 20. Check condition of ceramic tiles and repair as needed."	F 465		

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K 000	INITIAL COMMENTS 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 November 04, 2015. At the time of this survey, Golden Living Center Franklin 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) 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

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

Electronically Signed | 11/24/2015

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 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 Living Center Franklin was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The building has a complete 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 46 beds and had a census of 41	K 000		

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K 000	Continued From page 2 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system has not been installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all patients, the staff and any guests of the facility. Findings include: On facility tour between between 10:00 AM and 11:00 PM on 11/04/2015, observations and an	K 056	Preparation, submission and implementation 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 and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. K 056 Golden Living Center- Franklin will add sprinkler protection to the food storage	12/16/15

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	245273	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKLIN	**900 3RD STREET SOUTH** **FRANKLIN, MN 55333**

(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
K 056	Continued From page 3 interview with the Director of Maintenance revealed that a closet that is built into the wall is approximately 3 feet above the ground, 4 feet deep and a foot from the ceiling and it was determined that it was not sprinklered. This closet is used as food storage with 4 wood shelves in it. These deficient practices were confirmed by the Director of Maintenance (MD) at the time of the inspection.	K 056	closet identified in this 2567. The closet will be modified to ensure that shelving material will allow for water penetration from the sprinkler and that items are located at least 18 inches below the sprinkler head. The Maintenance Director will direct installation and monitor for compliance.	