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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O2T9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **11/30/2012** (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 IMR	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 **69** (L18)

13.Total Certified Beds **69** (L17)

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

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

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	69			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 12/04/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/05/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(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
Posted 12/17/2012

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/04/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5222

At the time of the standard survey completed October 19, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On November 30, 2012, the Minnesota Department of Health and, on November 30, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on October 19, 2012, effective November 28, 2012. Therefore, the remedies outlined in our letter dated November 2, 2012, will not be imposed.
See attached CMS-2567B forms for the results of the November 30, 2012 revisits.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5222

December 5, 2012

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Onstad:

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 November 28, 2012 the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

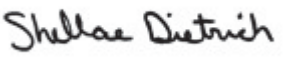
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 4, 2012

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222022

Dear Mr. Onstad:

On November 2, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 19, 2012 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 30, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 30, 2012 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 19, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2012, effective November 28, 2012 and therefore remedies outlined in our letter to you dated November 2, 2012, will not be imposed.

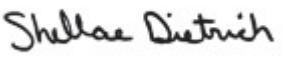
Your request for a continuing waiver involving the deficiency cited under K67 at the time of the October 19, 2012 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5222r113.rtf

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
245222	A. Building B. Wing	11/30/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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 **F0309** Reg. # **483.25** LSC	Correction Completed **11/28/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/28/2012**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **11/28/2012**
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **11/28/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **11/28/2012**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/28/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	12/04/12	18623	11/30/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/19/2012			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245222	A. Building B. Wing **01 - MAIN BUILDING 01**	11/30/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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 K0038	Correction Completed **11/28/2012**	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	Date:	Signature of Surveyor:	Date:
	PS/sd	12/04/12	28120	11/30/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/17/2012

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O2T9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **10/19/2012** (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 IMR	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 **69** (L18)

13.Total Certified Beds **69** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	69			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 11/21/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/03/2012 (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
10/01/1978
(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
Posted 12/4/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5222

At the time of the standard survey completed October 19, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8755

November 2, 2012

Mr. Timothy Johnson, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222022

Dear Mr. Johnson:

On October 19, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

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 November 28, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 28, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 19, 2013 (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 April 19, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

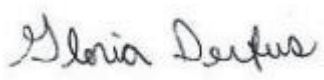
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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. 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 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	**Preparation, submission and implementation of this Plan 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.**	12/8/12
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 observation, interview, and document review, the facility failed to ensure timely administration of pain controlling medications for 2 of 3 residents (R26, R111), who indicated they had pain. Findings include: R26 was admitted 9/15/12, for healing traumatic fracture of the left hip and osteoporosis. R26 was not administered the pain medication after R26 had requested it.	F 309	F 309 • Resident #26 has discharged from the facility. • Resident #111's pain medication order had been changed to prn prior to survey. Current orders have been verified to be correct. • All current residents medication orders have been reviewed and reconciled to ensure they are as ordered • Licensed staff and TMAs will be educated policy for ordering and re-ordering medications from the dispensing pharmacy; medication availability in e-kit and how to appropriately access kit; and on pain management. • DNS/Designee will complete random audits to ensure compliance and will report progress of audits to the QA committee.	12/8/12

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

EXECUTIVE DIRECTOR | 11.15.2012

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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F 309	Continued From page 1 On 10/16/12, at 9:29 a.m. R26 was interviewed. R26 reported she had requested pain medication on 10/15/12, and had been notified by nursing that she was out of pain pills. "The nurse told me they forgot to order them, and they [the facility] couldn't get them yesterday [10/15/12] and had said maybe today [10/16/12]." R26 stated, "It is difficult to do therapy when I am in pain, I tell them to go away." R26 last received oxycodone 5 milligrams (mg) at 1:45 a.m. on 10/15/12, more than 32 hours before the complaint of pain was received. At 10:11 a.m. on 10/16/12, R26 was given acetaminophen (a mild analgesic) 500 mg by mouth for pain. On 10/16/12, at 9:07 p.m. R26 received oxycodone (a narcotic) 5 mg. R26 waited more than 43 hours after the last administered dose of oxycodone to receive the requested pain medication. A pain and pain symptoms risk immediate plan of care dated 9/16/12, indicated R26's acceptable level of pain of 2-3 on a scale of 1 to 10, where a score of 10 was the worst possible pain. The Minimum Data Set (MDS) dated 9/28/12, indicated a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment (without corresponding diagnosis). R26 displayed delirium behaviors of inattention, disorganized thinking, altered level of consciousness and psychomotor retardation which fluctuated. R26 did reject cares one-three times during the assessment period. R26 did require extensive assist of two with transfers, extensive assist of one with bed mobility, locomotion on and off the unit, dressing, toileting and personal cares.	F 309	• The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible • Completion date: November 28, 2012	

RECEIVED
NOV 19 2012
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 2 The pain assessment dated 9/28/12, was documented as 8 out of a 10 point scale, in left hip ache worse when sitting up or walking, better lying on opposite side or rubbing the hip. The assessment noted R26 received Fentanyl patch (a narcotic) 200 micrograms (mcg)/hour (hr), acetaminophen 500 mg, and Lidocaine (used to relieve pain) patch 5% (two patches). The Fentanyl patch dosage was increased from 100 mcg/hr on 9/20/12. The physician (MD) orders dated 9/15/12, indicated R26 was prescribed oxycodone hydrochloride (HCL-a narcotic) 5 mg orally as needed (PRN). The staff was to administer one tab for pain rated 4-6/10 and two tablets for pain rated 7-10/10, every four hours PRN for pain, document pain level before and after 30 minutes of administering the pain medication. Staff were to decrease the pain medication use as pain decreased, follow- up with specialty MD for pain issue (a history of drug use and drug seeking behavior was noted by specialty MD). The care plan initiated on 9/28/12, indicated R26 needed pain management and monitoring related to surgical procedure and history of chronic back pain. The goal was that R26 would maintain an adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort. The interventions were to administer pain medications as ordered, coordinate with patient/family/ to identify patient's favorite items/activities that could serve to distract from pain. Staff were to evaluate and establish level of pain, on numeric scale/evaluation tool and	F 309		

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F 309	Continued From page 3 evaluate characteristics and frequency pattern of pain. Also, the staff was to evaluate need for bowel management regimen, evaluate need for routinely scheduled medications rather than PRN pain med administration, evaluate need to provide medications prior to treatment or therapy and evaluate what makes the patient's pain worse. Staff were to implement the patient's preferred non-pharmological pain relief/relaxation strategies and observe for potential medication side effects. A Care Conference note dated 10/3/12, at 1:30 p.m. indicated R26 was, "Still requesting pain medications frequently, refusing cares and treatments." On 10/16/12, at 9:50 a.m. RN-A verified the oxycodone was unavailable as and stated that report between the nurse's included the pharmacy had been notified. RN-A then called pharmacy at 9:51 a.m., and had to give them the MD information to fax for orders. Clinical manager (CM)-A, who was at the desk with RN-A, was called by the nurse consultant into the back room, then returned and instructed RN-A to call and get something in place of oxycodone until the oxycodone pain medication was available. RN-A replied he was told the pharmacy would immediately send it out when they get the order. CM-A stated the MD for R26 was outside of the system and covered a lot of facilities. The MD was known to be slow to respond, and they (the facility) will need to ask for a partner when the primary MD was not available. CM-A further stated they are still getting used to the new pharmacy system (alixa RX), and you need new signed prescription with every card (medication	F 309		

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F 309	Continued From page 4 dispensing card), but can request refills with the nurse practitioner. R111 did not receive pain medications for 15 hours after admission to the facility. R111 received Percocet (a narcotic) 1-2 tabs every four hours and Ibuprofen in the hospital for pain from osteomyelitis (an infection of the bone.) R111 stated he was not able to get pain relief even when medications were given every four hours. If the facility had been able to get pain medications in a timely fashion, he should have received pain medication at 2:30 in the afternoon on 9/2/12. R111 was admitted to the facility on 9/2/12, for transitional care related to a surgical procedure on left ankle. Hospital discharge summary indicated that the resident was discharged from the hospital after a surgical procedure due to a deep wound infection with infected hardware in the left ankle. R111 had fractured his left ankle and had it surgically repaired on 7/19/12. He then returned to the hospital on 8/29/12, due to increased pain in his left ankle due to osteomyelitis (an infection of the bone). The discharge orders dated 9/2/12, from the hospital included oxycodone-acetaminophen (Percocet) 5-325 mg. R111 was to be administered 1-2 tablets by mouth every four hours. A clinical health status assessment was completed 9/2/12, at 11:45 a.m. which indicated R111 had minimal pain. He had received 600 mg of Ibuprofen at 8:00 a.m. and received Percocet two tablets of 5-325 mg at 10:13 a.m. Resident had indicated on the assessment that the pattern	F 309		

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F 309	Continued From page 5 of his pain was constant and aching; his pain impacted his quality of life and functioning (sleeping and limitations of activity). The physician order dated 9/2/12, was transcribed as follows oxycodone-acetaminophen 5-325 mg by mouth 1-2 tablets every four hours PRN. Progress note 9/2/12, at 3:21 p.m. indicated that resident was capable of communicating his needs and that the mediation list was faxed to the pharmacy. R111 had no complaints during the shift. Progress note 9/3/12, at 12:07 a.m. indicated the nurse called the pharmacy at 8:00 p.m. and the pharmacy indicated that they had not receive the medication orders. The medication orders were then re-faxed to pharmacy and the nurse confirmed that orders were received. At 2:58 a.m. the note indicated that the resident slept well through the night, denied any pain and medications were received from the pharmacy. At 3:07 a.m. R111 requested pain medication for pain rating of 8/10. The resident was able to reposition self and fall back asleep. Physician orders were changed on 9/20/12, to Percocet two tablets every four hours PRN for pain. On 10/19/12, at 10:00 a.m. the director of nursing (DON) indicated the order was transcribed in error. She further remarked that the nurse was able to call the pharmacy if a resident was in need of a medication and could get authorization to remove medication needed from the emergency medication kit (e-kit). She stated that she called the pharmacy and there were no authorizations from the pharmacy for nursing to	F 309		

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F 309	Continued From page 6 go into the ekit for R111 on 9/2/12 to administer the pain medication. R111 did not receive the necessary care and services for the management of pain. The pharmacy consultant services policy for Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy dated 5/12, indicated, "Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. A. Ordering Medication from the Dispensing Pharmacy. 1) Medication orders are written on a medication order form provided by the pharmacy, written in the chart by the physician or written on a transfer order from and transmitted to the pharmacy. 2) If not automatically refilled by the pharmacy, repeat medications (refills) are (written on a medication order form/ordered by peeling the reorder stick from the pharmacy label and placing it in the appropriate area on the order from provided by the pharmacy for that purpose and ordered as follows: a. .....re-order medication three to seven days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand. c. The refill order is called in, faxed, or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label (including bar-code, if used) is pulled and transmitted to the pharmacy. 3) "Stat" and emergency medications.. a. During regular pharmacy hours, the pharmacy is notified of the emergency or "stat" order; the order is then phoned or faxed to the	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 7 pharmacy. ("Stat must be clearly written on emergence faxed orders) such medications are delivered and administered with (4) hours. If available, the initial dose is obtained from the emergency kit, when necessary. b. After hours, medications should be ordered as outlined in the Emergency Pharmacy Service and Kits Policy (See Emergency Pharmacy Service and Emergency Kits). c. For emergency controlled medications (See 2.2: Controlled Substance Prescriptions). 4) When phoning or faxing a medication order to the pharmacy, the following information is given: a. Resident's name and other identifying information when necessary b. Prescription number if a refill. c. Complete order if a new medication order or direction changes to a previous order. d. Name of prescriber for a new order, if different than the attending physician. e. Indication for use. f. Name of person calling in order. B. Receiving medications from the pharmacy. 2. Delivery records are retained for one year."	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F 329 • Resident #114's sleep assessment and sleep monitoring sheets will be completed. • All other residents that utilize medications for sleep/insomnia will have sleep assessments and monitoring sheets put in place • Licensed staff and TMAs will be educated on requirements for sleep monitoring for residents. • DNS will report results of audits to the QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS are responsible. • Completion date: November 28, 2012	11-28-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 8 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor sleep for 1 of 10 residents reviewed for unnecessary medication use (R114), who was a prescribed sedative-hypnotic. Findings include: R114 was admitted to the faiclity with multpile diagnoses which included insomnia. The physician orders indicated that Amblen (used to treat insomnia) was ordered on 9/19/12. Ambien 5 milligrams (mg) by mouth as needed (PRN) at hour of sleep (HS). On 10/4/12, the physician order was changed to Ambien 5 mg by mouth PRN at HS and may repeat one time as needed overnight. September 2012 medication and October 2012 administration records indicated that the resident had taken the medication 20 days out of 30 days. R114's care plan 9/28/12, addressed that the	F 329		

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F 329	Continued From page 9 resident was at risk for sleep pattern disturbance and had an order for sleep medication. Staff was to administer sleep medications as ordered by physician and to assess R114's usual pattern of sleep. A pharmacy review was completed on 10/3/12, and recommended to evaluate the use of Ambien for the resident. The documentation in the medical record lacked evidence to determine the effectiveness of Ambien was noted. A general progress note were reviewed and noted: - on 9/26/12, indicated, "requested and given Ambien at 1:00 a.m. had been sleeping well since. - on 10/5/12, indicate that R114 had been sleeping well tonight, a repeat sleeping pill was given tonight. According to the Minimum Data Set (MDS) dated 10/9/12, the resident was able to verbalize needs. The MDS also noted R114 was administered a hypnotic. At 12:15 p.m. on 10/18/12, the registered program manager (RN)-A reviewed R114's medical record and was unable to find documentation of sleep to determine the effectiveness for taking the sleep medication.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% for 2 of 10 residents (R117, R72) observed during the medication administration observation. The facility had a medication error rate of 8.5%. Findings include: R117's morning medication pass was observed on 10/16/12, and R117 was observed to have the blood pressure checked after Carvedilol (management of essential hypertension) was administered. On 10/16/12, at 8:34 a.m. trained medication aide (TMA)-A was observed to administer R117's morning medications, which included Carvedilol. TMA-A returned to the medication cart to sign the medication administration record (MAR) after R117 took the medications. At that time, TMA-A noted that R117 was to have his blood pressure checked prior to administering the Carvedilol. TMA-A notified registered nurse (RN)-B that R117's blood pressure was not checked prior to administering the medications. RN-B then took R117's blood pressure and it was noted as 110/74 (after the administration of the medication). TMA-A verified that R117's blood pressure was not checked prior to administering the medications. The October 2012 MAR directed staff to check R117's blood pressure prior to administering Carvedilol.	F 332	F 332 • Resident #72's medications have been obtained from pharmacy. • Licensed staff and TMAs will be educated to obtain and record any vital signs deemed necessary prior to medication administration; on policy for ordering and re-ordering medication; and also educated on what to do if a medication is not available. • DNS/Designee will complete random audits to ensure compliance and will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible • Completion date: November 28, 2012	

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F 332	Continued From page 11 The administration procedures for All Medications policy dated 5/12, was reviewed. The policy directed to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. R72's medication administration was observed on 10/17/12, at 7:51 a.m. The TMA-A omitted three medications for R72 because there were not available in the facility for the resident. The medications were Marinol (a medication for nausea and vomiting), Folic acid (a medication to help rebuild red blood cells in the body) and carboymethylcellouse (lubricating eye drops). On 10/17/12, at 7:51 a.m. TMA-A requested RN-C to remove the Marinol from the locked refrigerator so that TMA-A could dispense it. RN-C checked the locked refrigerator and told TMA-A that Marinol was not in the refrigerator. TMA-A requested that RN-C call the pharmacy and re-order it. TMA-A stated, "All the TMA's can do is notify the nurses when something is not available or running out and the nurses are responsible for re-ordering the medications, and it did not always get done." TMA-A attempted to dispense Folic acid for R72, and was not able to locate the Folic acid. TMA-A noted the medication administration record (MAR) for 10/16 was marked as "7" (other/see nursing notes), "which means they didn't have any last night either and should have ordered it". TMA-A attempted to locate the lubricating eye drops for R72 and was not able to locate them, TMA-A marked the MAR as "7" (other/see nursing notes) and requested RN-C check the	F 332		

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	245222	A. BUILDING _____ B. WING _____	10/19/2012

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F 332	Continued From page 12 locked refrigerator for them, they were not present. TMA-A requested RN-C deal with the missing Marinol, Folic acid, and lubricating eye drops. RN-C replied that it would be taken care of. On 10/18/12, at 12:00 p.m. the Medical Director stated, "I was not aware that medications were not being received at facility in a timely manner, until yesterday when I was called about one (for R26)." On 10/19/12, at 3:00 p.m. a voicemail was left for the consultant pharmacist, to discuss the medications that were not available for R26 and R72. The consultant pharmacist did not return the call during the survey.	F 332		
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 residents received medication as ordered by the physician for 1 of 10 residents (R14) whose medications was reviewed; in addition, the facility failed to ensure residents are free of significant medication errors for 1 of 10 residents (R1) reviewed for medication administration. The facility had a medication error rate of 8.5%. Findings include:	F 333	F 333 • Resident #14's insulin orders were reviewed and orders verified. • Resident #1's digoxin order was reviewed and order verified • Audited all diabetics' insulin and oral diabetic medication • Audited all current resident orders for 'end date' to ensure correct transcription • Digoxin orders for all other residents were audited. • All current residents medication orders have been reviewed and reconciled to ensure they are as ordered.	

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F 333	Continued From page 13
	R14 was admitted to the facility on 7/10/12, with mulitple diagnoses which included diabetes mellitus. R14 had a physician's orders for Lantus insulin (a medication used to treat diabetes) twice a day. R14 did not receive the morning dose of Lantus insulin which started on 9/1/12, when the new month's medication administration record (MAR)'s were begun and did not receive it for 47 days until the error of omission was discovered during a review for unnecessary medications (the last received ordered dose of a.m. Lantus insulin was 8/31/12).
	
	Review of R14's September 2012 and October 2012 MAR indicated that R14 did not receive Lantus insulin at 7:00 a.m.
	
	A review of R14's physician progress notes dated 10/4/12, 9/20/12, and 8/31/12, indicated that R14 was on Lantus 10 units in the a.m. and 20 units in the p.m.
	
	R14 continued to receive Humalog (short acting) insulin on a sliding scale, at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. A review of R14's blood sugar levels showed a range of 114-323 from 9/1-9/20/12. No blood sugars were recorded after 9/20/12.
	
	R14's care plan for alteration in blood glucose due to insulin dependent diabetes mellitus directed to give medications as ordered.
	
	On 10/17/12, at 3:00 p.m. the director of nursing (DON) was interviewed and verified that there had been a medication error for R14's Lantus insulin and there were no orders to discontinue the 7:00 a.m. dose.
		F 333	• TMAs that administered resident's digoxin from 10-6-12 through 10-18-12 completed the following:
			  • Had med pass observation
			  • Received education on 5 rights of medication pass
			  • Took medication test.
			  • Received counseling on safe medication pass practice.
			• Education provided to all licensed nurses on correct transcription of orders.
			• All TMAs and nurses received education on 5 rights of medication pass and have taken med test.
			• Direct observation of med pass were completed on all TMAs prior to their next scheduled med pass.
			• All TMAs have completed medication dosing education.
			• Random direct observation med pass transcription of medication audits will be completed at least weekly.
			• DNS/Designee will report progress of audits to the QA committee.
			• The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.
			• DNS is responsible
			• Completion date: November 28, 2012
				11-28-12

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F 333	Continued From page 14 R1's diagnoses included atrial fibrillation, anemia, HTN with a history of cardiac and respiratory arrest. R1 received the incorrect dose of digoxin (an anti-arrhythmic) on 10/16/12. The physician orders dated 10/5/12, directed to increase R1's digoxin dose to 0.375 milligrams (mg) daily. R1's morning medication pass was observed on 10/16/12. R1 was observed to receive an incorrect dosage of digoxin, according to the MAR and physicians orders. On 10/16/12, at 8:49 a.m. trained medication aide (TMA)-A was observed to administer R1's morning medications, which included 0.25 milligrams (mg) of digoxin. The physician's orders dated 10/5/12, directed the staff to increase R1's digoxin dose to 0.375 mg daily. R1's digoxin level was noted to be 0.4 on 10/5/12, and was noted to be less than 0.1 on 10/11/12. The normal range for digoxin was listed as 0.5-2.2. Review of R1's October MAR indicated R1 was scheduled to receive 0.125 mg of digoxin and 0.25 mg of digoxin to equal 0.375 mg ordered by the physician. The 0.125 mg of digoxin was signed as given on 10/16/12, and the 0.25 mg was not signed as given. On 10/18/12, at 2:25 p.m. licensed practical nurse (LPN)-A was interviewed and verified that a card	F 333		

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F 333	Continued From page 15 with 0.25 mg of digoxin was in the medication cart for R1. There was not a change of direction label on the card. LPN-A then located two cards of 0.125 mg of digoxin in the bottom drawer of the medication cart (where extra medications were kept). The delivery date on the 0.125 mg cards of digoxin was 10/6/12. LPN-A verified that none of the 0.125 mg tablets of digoxin had been used. The medication ordering and receiving from pharmacy policy dated 5/12, was reviewed. The policy directs staff when receiving medications from the pharmacy to assure medications are incorporated into the resident's specific allocation prior to the next medication pass.	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, the facility failed to date dry packaged food when opened and to store these items in a closed container. This had the had the potential to affect 63 of 64 residents, who ate food prepared in the kitchen.	F 371	F371 • Dietary Manager will educate all dietary staff on the proper procedures for food storage and labeling. • Dietary Manager will complete random weekly audits to ensure all dry packaged food and frozen food that is opened is resealed properly and dated when opened. • Dietary manager will report audit results to QA committee. • The QA committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QA will dictate the continuation or completion of this monitoring process based on the compliance noted. • Dietary Manager will be responsible. • Completion date: November 28, 2012	11-28-12

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F 371	Continued From page 16 Findings include: At 12:00 p.m. on 10/15/12, the kitchen was obseved. During a tour of the kitchen dietary staff indicated that they were serving the noon meal and had been trying to get the groceries put away that had just come in. There were two boxes of instant mashed potatoes, a box of quick oats, and one bag of potato chips in the dry food storage room, which were observed to be opened and in original packages, and were not dated, or resealed appropriately. There was one bag of onions, one bag of potatoes and one box of bananas sitting on the floor in front of the storage racks. Frozen vegetables and packages of meat in the freezer were open, but not dated or resealed to prevent contamination or freezer burn and to ensure these items are used within the specified time frames. When interviewed on 10/19/12, at 2:35 p.m. the dietary manager and the dietician indicated that anything opened should be dated and in a closed package. Dried food items are discarded after three months, and frozen food after six months. The dietician indicated that she had gone through the dry, frozen and refrigerated food storage and disposed of items that were open, not dated and not being stored properly. The dietary manager stated that she was having some problems with her staff implementing proper procedure when it comes to dating opened items. These items that were found were removed and disposed of during that time. The Dining Service policy and procedure regarding storage of foods dated 2011 (there was	F 371		

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F 371	Continued From page 17 no date or month documented, just the year), indicated, "All food must be stored six inches from the floor or on dollies with wheels in store rooms. To store bulk items in approved container with tight fitting lids. Label the lid and side of the container with the product name and the date bin was filled. Packaged items must be stored in a container or sealed tightly to avoid insect infestation. Open only one container of an item at a time, and ensure that only one open item was in storage at a time. Label all open items with date opened. Reseal any boxes or bags effectively. Use food-grade plastic bags."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F425 • Resident #26 has discharged from the facility. • Resident #72's medications have been obtained from pharmacy. • Resident #111's pain medication order had been changed to prn prior to survey. Current orders have been verified to be correct. • All current residents orders have been reviewed and reconciled to ensure they are as ordered • Licensed staff and TMAs will be educated on olicy for ordering and receiving medications from the dispensing pharmacy; medication availability in e-kit and how to appropriately access kit; on policy for ordering and re-ordering medication; and also educated on what to do if a medication is not available.	11-30-12

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F 425	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure that medications were available as prescribed by the physician in a timely manner for 3 of 3 residents (R26, R72, R111). Findings include: R26 reported on 10/16/12, at 9:29 a.m. that she had requested pain medication on 10/15/12, and had been notified by nursing that she was out of pain pills for my hip. R26 indicated, "The nurse told me they forgot to order them, couldn't get them yesterday [10/15/12] 'maybe today' [10/16/12]. R26 stated, "It was hard to walk without the pain medication" and "It was difficult to do therapy when I am in pain, I tell them to go away." R26 last received oxycodone (an analgesic) 5 milligrams (mg) on 10/15/12, at 1:45 p.m. more than eight hours before the complaint of pain was received. On 10/16/12, at 10:11 a.m. R26 was given acetaminophen (a mild analgesic) 500 mg by mouth for pain. On 10/16/12, at 9:07 p.m. R26 received oxycodone 5 mg, more than 43 hours after the last administered dose of oxycodone. The facility did not utilize the emergency medication to control R26's pain. R26 was admitted 9/15/12, for healing traumatic fracture of the left hip and osteoporosis. A pain and pain symptoms risk immediate plan of care dated 9/16/12, indicated R26's acceptable level of pain of 2-3 on a scale of 1 to 10, with 10 being the worst pain level. The Minimum Data Set (MDS) dated 9/28/12,	F 425	• DNS/Designee will complete random audits to ensure compliance and will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible • Completion date: November 28, 2012	

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F 425	Continued From page 19 indicated a Brief Interview for Mental Status (BIMS) score of 5, which was indicative of severe cognitive impairment (without corresponding diagnosis). R26 did reject cares one-three times during the assessment period. R26 did require extensive assist of two with transfers, extensive assist of one with bed mobility, locomotion on and off the unit, dressing, toileting and personal cares. The MDS also noted R26 refused cares. The pain assessment dated 9/28/12, was documented as 8/10 in left hip. The ache worse when sitting up or walking and better when lying on opposite side or rubbing the hip. The pain was managed with medication which included a Fentanyl patch (a narcotic) 200 micrograms (mcg)/hour (hr) patch, acetaminophen 500 mg, and Lidocaine (indicated for relief of pain) patch 5% (two patches). R26 received oxycodone 5 mg as needed (PRN) for breakthrough pain and the Fentanyl patch was increased in dosage from 100 mcg/hr on 9/20/12. The physician (MD) orders dated 9/15/12, indicated oxycodone hydrochloride (HCL) 5 mg orally PRN and to give one tab for pain rated 4-6/10 and two tabs for pain rated 7-10/10, every four hours PRN for pain. Staff was to document pain level before and 30 minutes after administering the PRN medication. Staff was also to decrease the use of the pain medication as pain the decreased and to follow-up with the specialty MD for pain issue, as R26 had a history of drug use and drug seeking behavior was noted by specialty MD. The care plan initiated on 9/28/12, indicated R26 needed pain management and monitoring related	F 425		

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F 425	Continued From page 20	F 425		

to a previous surgical procedure and history of chronic back pain. The goal was that R26 will maintain adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort. The interventions were to administer pain medications as ordered, coordinate with patient/family/to identify patient's favorite items/activities that could serve to distract from pain. Staff were to evaluate and establish level of pain, on numeric scale/evaluation too and evaluate characteristics and frequency pattern of pain. Staff were to evaluate need for routinely scheduled medications rather than PRN pain med administration and evaluate the need to provide medications prior to treatment or therapy. Also, staff were to evaluate what makes the patient's pain worse and implement the patient's preferred non-pharmalogical pain relief/relaxation strategies. Staff was to monitor/observe for potential medication side effects.

A Care Conference note dated 10/3/12, at 1:30 p.m. indicated R26 was "still requesting pain medications frequently, refusing cares and treatments."

On 10/16/12, at 9:50 a.m. RN-A verified the oxycodone was unavailable as and further stated that verbal report included that the pharmacy had been notified. RN-A then called pharmacy at 9:51 a.m., and had to give them the MD information to fax for orders. Case manager (CM)-A, who was at the desk with RN-A, was called by the nurse consultant into the back room, then returned and instructed RN-A to call and get something in place of oxycodone until the oxycodone pain medication was available. RN-A replied he was

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F 425	Continued From page 21 told the pharmacy would immediately send it out when they get the order. CM-A stated the MD for R26 was outside of the system and covered a lot of facilities. The MD was known to be slow to respond, and they (the facility) will need to ask for a partner when the primary MD was not available. CM-A further stated they are still getting used to the new pharmacy system (Alixa RX), and you need new signed prescription with every card (medication dispensing card), but can request refills with the nurse practitioner. R72's medication administration was observed. The TMA-A at 7:51 a.m. on 10/17/12, three medications were omitted for R72 because there were not available in the facility for the resident. The medications were Marinol (a medication for nausea and vomiting), Folic acid (a medication to help rebuild red blood cells in the body) and carboymethylcellouse (lubricating eye drops). R72 was admitted to the facility on 9/25/12, with diagnosis of malnutrition, loss of weight, anxiety, major depressive disorder, and constipation. The MDS indicated a score of 15/14, which indicated R72 was cognitively intact. R72 had little interest or please in doing things and felt down or depressed most days, R72 felt bad about self, more than half the days, felt tired and had trouble with concentration for several days. R72 was independent with all activities of daily living and had no trouble chewing or swallowing. TMA-A requested RN-C to remove the Marinol from the locked refrigerator so that TMA-A could dispense it. RN-C checked the locked refrigerator and told TMA-A that Marinol was not in the refrigerator. TMA-A requested that RN-C call the	F 425		

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F 425	Continued From page 22 pharmacy and re-order it. TMA-A stated, "All the TMA's can do is notify the nurses when something is not available or running out and the nurses are responsible for re-ordering the medications, and it did not always get done." TMA-A attempted to dispense Folic acid for R72, and was not able to locate the Folic acid. TMA-A noted the medication administration record (MAR) for 10/16 was marked as "7" (other/see nursing notes), "which means they didn't have any last night either and should have ordered it". TMA-A attempted to locate the lubricating eye drops for R72 and was not able to locate them, TMA-A marked the MAR as "7" (other/see nursing notes) and requested RN-C check the locked refrigerator for them, they were not present. TMA-A requested RN-C deal with the missing Marinol, Folic acid, and lubricating eye drops. RN-C replied that it would be taken care of. Upon receipt of the MAR's on 10/19/12, the Marinol and Folic acid were checked which indicated having been dispensed (times are pre-set and not noted at the time of medication administration). A listing of emergency medications used for R27 and R72 in the past week was requested and no further information was provided by the facility. R111 was prescribed pain medication by the MD and the facility failed to ensure R111 had the pain medications readily available. R111 was admitted to the facility on 9/2/12, for	F 425		

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(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 425	Continued From page 23 transitional care related to a surgical procedure on left ankle. Hospital discharge summary dated 9/2/12, indicated the resident was discharged from the hospital after a surgical procedure due to a deep wound infection with infected hardware in the left ankle. R111 had fractured his left ankle and had it surgically repaired on 7/19/12. He then returned to the hospital on 8/29/12, due to increased pain in his left ankle due to osteomyelitis (an infection of the bone). Discharge orders dated 9/2/12, from the hospital included oxycodone-acetaminophen (Percocet) 5-325 mg 1-2 tablets by mouth every four hours. The MD order was transcribed as the follows, oxycodone-acetaminophen 5-325 mg by mouth 1-2 tablets every four hours PRN. Upon admission a clinical health status assessment was completed on 9/2/12, at 11:45 a.m. which indicated R111 had minimal pain. He had received 600 mg of Ibuprofen (an anti-inflammatory) at 8:00 a.m. and Percocet two tablets of 5-325 mg were given at 10:13 a.m. R111 had indicated on the assessment that the pattern of his pain was constant and aching. R111 also indicated the pain impacted his quality of life and functioning (sleeping and limitations of activity). The progress notes were reviewed and the following was noted: - On 9/2/12, at 3:21 p.m. indicated the resident was capable of communicating his needs and that the medication list was faxed to the pharmacy. R111 had no complaints during the shift. -On 9/3/12, at 12:07 a.m. indicated that the nurse	F 425		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 425	Continued From page 24 called the pharmacy at 8:00 p.m. and the pharmacy indicated that they did not receive the medication orders. Medication orders were then re-faxed to pharmacy and the nurse confirmed the orders were received. At 2:58 a.m. the note indicated the resident slept well through the night. R111 denied any pain. The medications were received from the pharmacy at that time. At 3:07 a.m. R111 requested pain medication at that time, indication he rated his pain 8/10. The physician orders were then changed on 9/20/12, to Percocet two tablets every four hours PRN for pain. On 10/18/12, at 12:00 p.m. the Medical Director stated, "I was not aware that medications were not being received at facility in a timely manner, until yesterday when I was called about one (for R26)." Interview with the director of nursing (DON) 10/19/12, at 10:00 a.m. indicated the pain medication order was transcribed in error. The DON further commented that the nurse was able to call the pharmacy if a resident was in need of a medication and could get authorization to remove medication needed from the emergency medication kit (e-kit). She stated that she called the pharmacy and there were no authorizations for nursing to go into the Emergency Kit (E kit) to access (a stock of medications provided by the pharmacy that may be used with permission from the pharmacy to replace resident medications not available) pain medications for R111. On 10/19/12, at 2:30 p.m. the pharmacy was contacted regarding the Ekit and no return call was received.	F 425		

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F 425	Continued From page 25 The Alixa policy for Emergency Pharmacy Service and Emergency Kits dated 5/12, indicated, "Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, products for infusion in limited quantities in portable, sealed containers in compliance with applicable state regulations. Procedures A. Telephone/fax numbers for emergency pharmacy service are posted at nursing stations B. There is a physician on call 24/7 and telephone numbers are posted at nursing stations C. The dispensing pharmacy is called if an emergency arises requiring immediate pharmacist consultation concerning appropriateness of therapy, drug information, etc. If the required information is unavailable from the dispensing pharmacy, the pharmacy will determine the appropriate method for obtaining it, including speaking with the facility's consultant pharmacist. D. The dispensing pharmacy supplies emergency or "stat" medications according to the dispensing pharmacy provider, non-contract or infusion therapy products agreement. Emergency drugs, antibiotics, infusion products and controlled substances are stored separately /together. E. Medications are not borrowed from other residents. the ordered medication is obtained either from the emergency box, form the provider	F 425		

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F 425	Continued From page 26 pharmacy, or a back-up pharmacy that is determined by the provider pharmacy. F. The emergency supply is maintained at a designated area, along with a list of supply contents and expiration dates... G. When an emergency or "stat" order is received, the nurse follows the procedure for order documentation in accordance with the policy on Prescriber medication Orders.... H. To access medication from the emergency kit secondary to a new order or when medication for which there is a current prescription is not readily available, the nurse should not take a mediation from the ebox without checking allergies on the medical record and possible drug - drug interactions with the pharmacist: 1. The nurse confers with the prescriber to determine whether the order is a true emergency, i.e., order cannot be delayed until the scheduled delivery. If the medication is a controlled substance, the prescriber either faxes a complete prescription to the facility and pharmacy or communicates the verbal order to both the nurse and directly to the pharmacist along with details about the situation to verify that it meets the criteria of an "emergency situation." 2. Only after verifying that the above communication has occurred, the pharmacy has received a complete prescription and drug allergies, interactions, and other contra indications have been checked , the nurse unlocks the container....If the medication is not available in the emergency kit, the nurse contacts the pharmacy, using the after-hours emergency numbers(s) if necessary. 3. The nurse records the medication use from the emergency kit on the medication	F 425		

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F 425	Continued From page 27 order/use form and calls the pharmacy for replacement of the kit/dose...." The Alixa RX Controlled Substance Prescriptions policy dated 5/12, indicated, "Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore the prescriber issuing the chart order must also provide the pharmacist with a valid prescription. The written prescription maybe faxed to the pharmacy for long term care facility residents. Verbal orders for controlled medications are permitted for Class II (CII) controlled drugs only in emergency situations. Verbal orders for controlled medications received by facility nursing staff should be noted in the resident's medical record and nursing facility staff must confirm that the prescriber or the prescriber's employee has communicated the orders before authorized nursing facility staff may access any controlled substances from the emergency supply located in the facility. ... C. The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available....."	F 425		

golden living

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164

November 16, 2012

Ms. Derfus,

Enclosed is the plan of correction for Golden LivingCenter- Chateau. We are alleging to be in compliance by November 28, 2012. If you have any questions or comments after reading our plan of correction please do not hesitate to call me at (612) 874-1603.

Sincerely,

Ryan Onstad
Executive Director
Golden Living Center - Chateau

Golden LivingCenter -
Chateau
2106 Second Ave. South
Minneapolis, MN 55404
Phone: 612-874-1603
Fax: 612-874-9042
www.goldenlivingcenters.com

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Chateau was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	RECEIVED NOV 19 2012 DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POCok w/AW for K67 FS 11-20-12	

DC: 11.28.2012

EXIT: 10.19.2012

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

See Health 2567 for signature 11/15/2012

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 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 69 beds and had a census of 63 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:15 PM on 10/17/2012, observation revealed that the stairwell doors are maglocked with a keypad. There is no code posted on the egress side of the door. These deficient practices were verified by the administrator at the time of the inspection.	K 038	K038 • The plaques that hold the code to the stairwell doors has been relocated to the egress side of the door • The maintenance director, executive director, and department managers were all educated and aware that the codes are to be present on the egress side of the corridor • The corridors will be randomly audited by Maintenance supervisor to ensure that the codes remain on the egress side of the door • Maintenance Supervisor will be responsible • Completion date: November 28, 2012	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include:	K 067	K067 • Waiver requested. Refer to justification on form Part IV Recommendation for waiver of Specific Life Safety Code Provisons.	

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K 067	Continued From page 3 On facility tour between 10:00 AM and 12:15 PM on 10/17/2012, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, November 20, 2012 3:39 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'Johnson, Timothy 20 [LC00871]'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Golden Livingcenter Chateau (245222) K67 Annual Waiver Request

This is to inform you that, as a part of their POC, GLC Chateau is requesting an annual waiver for K67, corridors as a plenum. The exit date was 10-19-12.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility
GGNSC Minneapolis Chateau dba: Golden Living Center - Chateau

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K67 The building Heating, Ventilation and Air Conditioning (HVAC) Equipment does not comply with the Life Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K-67. A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: The facility received an estimate on March 14, 2012 for the cost of upgrading the HVAC system to be in compliance with NFPA 90. The cost estimate for a complying HVAC is $432,250.00. This estimate does not include costs of major structural engineer work or major structural work related to the HVAC upgrade, which will be needed according to the estimate scope. Also, this cost does not include the cost of financing, which will need to be done in able to afford the project. Financing will add approximately $86,400 to $194,400 to the overall costs of the project. Under current CMS reimbursement rates, it is estimated to take approximately a minimum of 8 to 15 years to recoup the costs. This approximation will need to be extended when taking into account the costs of current facility projects that are under way such as whole house window replacement, first floor flooring replacement, front and back door replacement, plus routine equipment and service projects and emergencies such as the kitchen plumbing system. A complying HVAC system has a large scope of work included at this particular facility. A project with a scope of this scale will force the a high degree of disruption to the facility residents. The estimate states that the work will able to be done in 4 resident rooms at the same time. This has the potential of displacing 8 - 10 residents at the same time. This is especially challenging when the medical, mental, and psychological states of our residents are taken into consideration. We have some residents who prefer to remain in their rooms and get agitated, aggressive, and abusive when disturbed in this capacity. The resident's rooms are located on 2nd, 3rd, and 4th floor. The dining room, the kitchen, and staff offices are located on the first floor. On an average day, there is about 35 staff members with about 66 residents for a ratio of 1:1.89. The facility staffs at a rate of 4.77 hours per patient, per day. The building is 50 years old and there are no known plans for the facility to be replaced and no end date has been determined for the buildings usable life. There are concerns of whether or not the new HVAC system would put the facility out of compliance due the the fact that the corridors will be less than 6 feet and 8 inches tall, which is not allowed against LSC. There are also concerns about whether the building electrical system is adequate to handle the additional HVAC equipment required or if the penetration of load bearing walls to install required duct work would adversely affect the structural integrity of the building. There will be no adverse effect on the building occupants safety in accordance with SOM 2480B because of the type of building and the way the building is outfitted and staffed to ensure compliance and maximum safety for our residents. The facility is a type II (222) type construction. The interior finishes are of Class A or Class B. The walls, floors, ceiling and vertical opening resist the passage of smoke. The facility's life safety features are an EST and Notifier fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification; complete supervised automatic wet standpipe sprinkler system throughout ; portable fire extinguishers are located on all units; pyrochem kitchen hood wet chemical system. Annual service and maintenance contracts are in place to keep all systems in effective operating condition. The facility also has a fire safety plan that is in accordance with LSC 19.7.2.2. The facility does operate under safe smoking policies and procedures, fire policies, fire watch, and housekeeping and laundry operate under safe dryer policies. Two smoke compartments on each floor, so there is a total of eight smoke compartments in the entire building. The closest fire department is .93 miles away and has an average response time of 2-4 minutes.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 11-20-12