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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4BX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245332**

2. STATE VENDOR OR MEDICAID NO. (L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - EXCELSIOR**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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 **04/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. Date :
Gloria Derfus Unit Supervisor 04/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00454 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245332

April 22, 2016

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, MN 55331

Dear Ms. Lubbesmeyer:

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 April 12, 2016 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 21, 2016

Ms. Jill Lubbesmeyer, Administrator
Golden Livingcenter - Excelsior
515 Division Street
Excelsior, MN 55331

RE: Project Number S5332025

Dear Ms. Lubbesmeyer:

On March 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 18, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 12, 2016 and therefore remedies outlined in our letter to you dated March 17, 2016, will not be imposed.

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

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

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245332 Y1	A. Building B. Wing Y2	4/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0253	Correction	ID Prefix F0282	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0309	Correction	ID Prefix F0314	Correction	ID Prefix F0318	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(e)(2)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0323	Correction	ID Prefix F0353	Correction	ID Prefix F0354	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.30(a)	Completed	Reg. # 483.30(b)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0371	Correction	ID Prefix F0406	Correction	ID Prefix F0431	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.45(a)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	4/21/2016	18623	4/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/3/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245332	A. Building 01 - MAIN BUILDING 01 B. Wing	4/18/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/12/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 04/12/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 04/12/2016
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 (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 4/21/2016	**TITLE** 37009	**DATE** 4/18/2016
FOLLOWUP TO SURVEY COMPLETED ON 3/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4BX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245332**
2.STATE VENDOR OR MEDICAID NO.
(L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - EXCELSIOR**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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 **03/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jacob Mabera, HFE NE II 03/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 0879

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, MN 55331

RE: Project Number S5332025

Dear Ms. Lubbesmeyer:

On March 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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. In addition, at the time of the March 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5332027 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 12, 2016 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 April 12, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 June 3, 2016, 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 September 3, 2016 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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
	245332	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition during the recertification survey complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5332027 was completed. The complaint was unsubstantiated.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for safe practice of self-administration of nebulizer medication (an inhalation treatment of respiratory medication) for 1 of 1 resident (R40) observed self-administering a nebulizer treatment/	F 176		

Accepted 4-06-16 Jenni Dal

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3.21.16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING _____ B. WING _____	03/03/2016

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F 176	Continued From page 1 medication (SAM). Findings include: On 3/1/16, at 11:28 a.m. when walking down the hallway R40's door was observed wide open and a nebulizer machine was heard running. Upon entering R40's room the resident's head was observed leaning to the right shoulder, the resident's eyes were closed and resident held onto the nebulizer with the the right hand and the nebulizer was resting on R40's thigh. -At 11:38 a.m. the nebulizer was running when registered nurse (RN)-A entered R40's room, RN-A verified R40 was asleep then turned the nebulizer off then called R40's name twice before R40 actually woke up. When asked if R40 had an order to self administer medication (SAM) RN-A stated "I will check." RN-A then went through the chart and Physician Orders and was not able to locate an order. RN-A then looked in the computer verified resident did not have either an assessment, order and the care plan had not indicated R40 was able to self-administer the nebulizer. R40's Order Summary Report dated and signed by physician 2/5/16, directed albuterol sulfate HFA Aerosol solution 108 microgram one puff inhale orally every four hours as needed for shortness of breath. The order did not indicate R40 could self-administer that medication nor any others. After the concern was brought to the facility attention, an order was obtained, a care plan was developed however an assessment was not completed to evaluate R40's ability to SAM. R40's quarterly Minimum Data Set dated 1/30/16, indicated R40's diagnoses included chronic	F 176	F176 -R40 completed the self administration assessment and received physician's order for self administration of nebulizer treatments at bedside after staff set-up, and careplanned. -Self Administration assessment placed on ADON checklist to be reviewed for each new admission, re-admission, annual review and significant changes. -3 random audits of residents who utilize inhalers/puffers/nebulizer treatments weekly to ensure proper assessments, orders and careplan. -The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.. RECEIVED APR 01 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 176	Continued From page 2 obstructive pulmonary disease (COPD), and acute pulmonary edema. R40's care plan dated 11/2/15, indicated resident had an alteration in respiratory status due to COPD, was at risk for shortness of breath, had a risk for fatigue due to shortness of breath, was at risk for anxiety due to shortness of breath, was at risk for insomnia due to shortness of breath and was at risk for decline due to smoking. The care plan directed staff to administer medications as ordered and observe for response to medication and treatments, however it did not address R40's self-administration of medication ability. On 3/3/16, at 7:11 a.m., the director of nursing services (DNS) stated R40 required a self-administration assessment and physician order prior to self-administering medications and was supposed to have been added to the care plan. DNS stated after the concern had been brought to the facility attention all of that had been put in place. Self Administration Of Medication policy dated 5/12, directed: "A. If the resident desire to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process... C. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on an ongoing basis or when there is a significant change in condition..."	F 176		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=E	Continued From page 3 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms for 4 of 30 census residents (R57, R76, R54, R39) had their rooms maintained in a safe, functional and sanitary manner. Findings include: Privacy curtain On 3/1/16, at 8:27 a.m. during R39's room observation the privacy curtain located by resident recliner was observed with large brown stains in the bottom visible from the door. On 3/2/16, at 11:36 a.m. the environmental tour was completed with the maintenance director and HCS account manager (housekeeping). During the tour both verified the privacy curtain in R39's room was dirty. When asked who ensured the curtains were kept clean, HCS account manager stated house-keeping staff who did regular/daily cleaning were supposed to check that the curtains were clean and that was in the daily routine however the department was short staffed at the time. HCS manager further stated it was her and another staff doing all the cleaning and that could have been overlooked. Door guards	F 253	F253 -R39's privacy curtain's were replaced with clean one; F54's bathroom door frame and door were repaired; R80's door guard was replaced; R76's dining room dust bunnies and tables were cleaned; R76's shelf above the head light was cleaned of dirt. -Weekly facility tour of resident rooms on Monday's with Housekeeping Director and Maintenance Director. Logging necessary repairs and identifying area's to clean. Follow up from tour from Housekeeping Director and Maintenance Director will be provided to ED or designee by Friday. -The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations..	

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F 253	Continued From page 4 On 3/1/16, at 8:55 a.m. during R54's shared room observation, the bathroom door frame had chipped paint on inside creating jagged rough edges, the brown covering of the lower part of the door below the door knob was noted to have a sharp pointed edge which when touched, punctured surveyor skin. In addition the bottom of the same bathroom door and entrance door to room were observed with extended door guards creating sharp pointed edges. R54's quarterly Minimum Data Set dated 1/29/16, indicated R54 had severely impaired cognition. On 3/2/16, at 11:36 a.m. to 12:00 p.m. the environmental tour was completed with the maintenance director and HCS account manager. During the tour in shared bathroom for R54 and R80 the brown door guard below the knob had a sharp edge and was located right at ankle level. The door guard extended beyond the edge of door and had a sharp point and the inside of the bathroom door had jagged rough edges at ankle level. In addition the entrance door to the room, edge door guard was observed to be loose at ankle level; the edge extended beyond the frame and had a pointed sharp point. MD verified findings and stated guards were checked quarterly during room audits. On 3/2/16, at 12:05 p.m. when asked if resident was ambulatory in room, nursing assistant (NA)-F stated R54 was ambulatory in the room and at times would go around the room by himself. R76 On 3/1/16, at 11:04 a.m., during interview, when asked if the building was clean family member	F 253		

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F 253	Continued From page 5 (FA) of R76 stated dust bunnies were everywhere during the weekend and the unit tables were not kept clean. On 3/2/16, at 11:36 a.m. to 12:00 p.m. the environmental tour was completed with the maintenance director and HCS account manager (housekeeping). During the tour to R76's room the shelf above the head light was observed to be covered with dirt throughout that was visible. The HCS account manager verified and explained that the housekeeping staff were supposed to clean the shelves daily during routine room cleaning, however the department was short staffed at the time. On 3/2/16, policy was requested but the maintenance director stated the facility did not have a specific policy but rather followed the building tasks/checks.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for supervison while wandering for 1 of 2 residents (R46) reviewed for accidents; for 1 of 3 residents (R52) identified as having non-pressure related skin conditions and for 1 of 1 resident (R40) who required medications to be given by licensed	F 282	F282 -R46, R40 and R52 careplans were updated. -Re-educate all-staff on following careplans on resident boundaries/wandering/redirecting, reporting skin conditions/bruises, refusals of turning/repositioning and documentation, and providing supervision for required medications. -DNS or designee to follow up with nurse's monthly to review communication between NAR's and Nurse's regarding bruises and necessary skin condition changes. Weekly audit on ACU Unit to monitor of staffing intervention of boundaries, residents wandering into rooms and redirection. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations..	

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F 282	Continued From page 6 staff. Findings include: R46's care plan dated 3/6/13, directed staff, "I sometimes display target behaviors which include intrusive behaviors: hx of following other residents around the unit, telling them where they can be and what they can and can't do, invading other people's space, rummaging through other's belongings and at times being verbally and physically aggressive towards other residents, pacing up and down the hallway and continuous nonsensical talking. Taking shadow boxes off the walls and other residents decorations out of their rooms." Interventions include "Offer me something I like as a diversion, re-direct me when I am going into the wrong room. Staff engage in conversation with me (even though nonsensical). I enjoy social interactions with others. If I need to be redirected it works best to engage me in a conversation and start walking with me to a new location or gently guide me with an arm around my shoulders." R46's cognitive ability care plan noted, "My safety is at risk and there is a potential for abuse due to: Decreased cognitive ability, Wandering." The intervention included, "Please re-direct me when I wander into other rooms or areas that are unsafe for me." R46 was observed on 3/2/16, at 7:30 a.m. R46 wandered into room 100 and sat down on the first bed. Licensed practical nurse (LPN)-E was preparing medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46. R46 exited room 100 at 7:35 a.m. No other residents were in room 100. - 7:37 a.m. R46 walk into room 100 and exit room 100 at 7:38 a.m. while LPN-E was preparing	F 282		

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F 282	Continued From page 7 medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46. -7:40 a.m. R46 entered room 100 and exited room at 7:41 a.m. while LPN-E was preparing medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46 on 3/2/16, at 7:30 a.m. through 8:08 a.m. R46 entered room 102 at 7:50 a.m. R46 was rummaging through the dresser drawers and the bed. R46 also laid in the bed. The bed was in the high position. Registered nurse (RN)-B and LPN-E passed by the room at 7:57 a.m. and did not remove R46. R46 entered room 104 at 8:06 a.m. LPN-E passed the room at 8:08 a.m. and did not redirect R46. On 3/3/16, at 10:53 a.m. LPN-E was interviewed and indicated she was busy passing the morning medication yesterday and did not see R46 in the rooms. At 10:59 a.m. ACU director was interviewed and said, "We try to keep her busy with activities and try not to have her go into POLAR BEAR ROOMS (a polar bear room refers to the room of a resident who was easily angered and might strike out). If in others room we come grab her bring out and redirect." At 11:14 a.m. LPN-E commented, "We keep an eye on [room] 104 as [R46] has had altercation's." R46's plan of care was not followed for re-direction when R46 went into rooms 100, 102 and 104.	F 282		

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F 282	Continued From page 8 R52's care plan revised on 2/23/16, directed staff R52 had potential for pressure ulcer related to "Skin desensitized, has bowel incontinence, psoriasis." The care plan identified the goal as "skin will remain intact." Interventions identified included conducting weekly skin inspection, skin assessment to be completed per Living Center Policy and treatments as ordered. R52 was observed on 3/1/16, at 9:17 a.m. walking up and down the hallway, wearing a short sleeved shirt. The following skin conditions were observed; dark purple bruises on the outer right forearm and left forearm, psoriasis (skin condition) to bilateral arms and right hand. R52 was unable to answer questions due to severe cognitive impairment. In a follow-up observation on 3/2/16, at 9:51 a.m. R52 was observed walking up and down the hallway, wearing a short sleeved shirt, bruises to right and left arm visible. R52's medical record was reviewed on 3/2/16, at approximately 10:00 a.m. R52's Weekly Skin Review dated 2/25/16, indicated R52's skin was intact but a corresponding note identified "chronic psoriasis on various body parts." None on the documentation in the medical records revealed R52's bruising on his right and left arms. A review of R52's physician orders dated 2/8/16, indicated R52 had an order for Hydrocortisone Ointment 2.5% (used to relieve itching or irritation) to be applied to "affected areas topically three times a day for Plaque psoriasis." A nursing assistant (NA)-A was interviewed on 3/2/16, at 10:12 a.m. and explained that if a	F 282		

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F 282	Continued From page 9	F 282		

bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising on R52's arms but "did not report." NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now."

A licensed practical nurse (LPN)-E was interviewed on 3/2/16, at 1:37 p.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately" and the nurse will start an incident report, and then it was documented in the treatment administration record (TAR) until healed. LPN-E explained that she was unaware of R52's bruising "until [NA-A] notified me this morning after you asked her." LPN-E confirmed no bruise documentation was available in R52's medical records. LPN-E explained that nurses did perform routine skin body audits during shower days.

The director of nursing services (DNS) was interviewed on 3/3/16, at 8:48 a.m. and explained that her expectations were for bruises or other skin conditions be reported to the nurse.

R40's care plan dated 11/2/15, directed staff R40 had an alteration in respiratory status due to COPD, was at risk for shortness of breath, had a risk for fatigue due to shortness of breath, was at risk for anxiety due to shortness of breath, was risk for insomnia due to shortness of breath and was at risk for decline due to smoking. The care plan directed staff to administer medications as ordered and observe for response to medication and treatments. The plan of care was not

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F 282	Continued From page 10 followed for R40 as the licensed staff was to administer the medication. R40's door was observed wide open and a nebulizer machine was heard running on 3/1/16, at 11:28 a.m. Upon entering R40's room the resident's head was observed leaning to the right shoulder, the resident's eyes were closed and resident held onto the nebulizer with the the right and the nebulizer was resting on R40's thigh. -At 11:38 a.m. the nebulizer was running when RN-A entered R40's room, RN-A verified R40 was asleep then turned the nebulizer off then called R40's name twice before R40 actually woke up. When asked if R40 had an order to SAM, RN-A stated "I will check." RN-A then went through the chart and Physician Orders and was not able to locate an order. RN-A then looked in the computer verified resident did not have either an assessment, order and the care plan had not indicated R40 was able to self-administer the nebulizer. R40's Order Summary Report dated and signed by physician 2/5/16, directed albuterol sulfate HFA Aerosol solution 108 microgram one puff inhale orally every four hours as needed for shortness of breath. The order did not indicate R40 could self-administer medications.	F 282	F309 -R52 incident report was completed, GNP was updated and GNP saw resident and states res skin condition were not bruises, updated orders and providing updates to GNP on 4/13/16 on skin condition. -Re-educate all-staff on reporting skin conditions and bruises to the nurses, completing weekly skin review on bath days, completing incident reports on bruises and then ADON monitoring bruises on Wound Flow sheet weekly. -DNS or designee to perform 1 audit of a resident with non-pressure related skin conditions per week to ensure compliance with incident report and follow through with Wound Flow weekly sheet. -The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations..	
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.	F 309		

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to monitoring bruises for 1 of 3 residents (R52) in the sample identified as having non-pressure related skin conditions. Findings include: R52 was observed on 3/1/16, at 9:17 a.m. walking up and down the hallway, wearing a short sleeved shirt. The following skin conditions were observed; dark purple bruises on the outer right forearm and left forearm, psoriasis (skin condition) to bilateral arms and right hand. R52 was unable to answer questions due to severe cognitive impairment. In a follow-up observation on 3/2/16, at 9:51 a.m. R52 was observed walking up and down the hallway, wearing a short sleeved shirt, bruises to right and left arm visible. R52's quarterly Minimum Data Set (MDS) dated 2/9/16, indicated R52 was severely cognitively impaired. MDS indicated R52 required extensive physical assistance from one persons with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS also identified that R42 was totally dependent of one person physical assist with bathing. R52's care plan revised on 2/23/16, identified potential for pressure ulcer related to "Skin	F 309		

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F 309	Continued From page 12 desensitized, has bowel incontinence, psoriasis." The care plan identified the goal as "skin will remain intact." Interventions identified included conducting weekly skin inspection, skin assessment to be completed per Living Center Policy and treatments as ordered. R52's medical record was reviewed on 3/2/16, at approximately 10:00 a.m. R52's Weekly Skin Review dated 2/25/16, indicated R52's skin was intact but a corresponding note identified "chronic psoriasis on various body parts." None of the documentation in the medical records revealed R52's bruising on his right and left arms. A review of R52's physician orders dated 2/8/16, indicated R52 had an order for Hydrocortisone Ointment 2.5% (used to relieve itching or irritation) to be applied to "affected areas topically three times a day for Plaque psoriasis." A nursing assistant (NA)-A was interviewed on 3/2/16, at 10:12 a.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising on R52's arms but "did not report." NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now." A licensed practical nurse (LPN)-E was interviewed on 3/2/16, at 1:37 p.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately" and the nurse will start an incident report, and then it was documented in the treatment administration record (TAR) until healed. LPN-E explained that	F 309		

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F 309	Continued From page 13 she was unaware of R52's bruising "until [NAR-A] notified me this morning after you asked her." LPN-E confirmed no bruise documentation was available in R52's medical records. LPN-E explained that nurses did perform routine skin body audits during shower days. The director of nursing (DON) was interviewed on 3/3/16, at 8:48 a.m. and explained that her expectations were for bruises or other skin conditions to be reported to the nurse. The nurse then started an incident report and monitored the bruising. DON stated that, "I just received [R52's] incident report this morning and I was just reviewing it (pointing to the report)." A facility's undated Skin Integrity Guidelines, directed that, "Patients/Residents will be observed by the CNA daily for reddened/open areas, edema of feet or sacrum. Changes will be reported to the licensed nurse and documented."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 314	F314 -R22 has a pressure reduction mattress in place. -Evaluate all new admissions/re-admission/significant changes for need of pressure relief vs. pressure reduction mattresses. Re-educate staff on completing weekly skin checks and updating on any new changes in skin requiring new interventions in place, refusals of off-loading/turning and repositioning to nurse, and possible further intervention of pressure relieving devices. -DNS or designee to perform 1 audit weekly of an identified resident with high risk of skin breakdown. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations..	

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F 314	Continued From page 14 review, the facility failed to ensure interventions were implemented to ensure wound healing of a pressure ulcer for 1 of 1 residents (R22) reviewed for pressure ulcers. Findings include: During continuous observation of R22 on 3/3/16 from 7:49 a.m. until 9:37 a.m. - At 3/3/16, at 7:49 a.m. R22 sitting in wheel chair (w/c), nursing assistant (NA)-E wheeled R22 to the dining room for breakfast. R22 ate breakfast from 7:59 to 8:34 a.m. - At 8:34 a.m. R22 sitting in w/c, NA-E wheeled R22 from the dining room to her room. NA-E setup R22 at a table in her room to work on a jigsaw puzzle. - At 8:35 a.m. R22 sitting in w/c in her room, R22 activated call light. - At 8:40 a.m. R22 sitting in w/c in her room, NA-C entered R22's room. The call light was deactivated. - At 8:44 a.m. R22 sitting in w/c in her room working on jigsaw puzzle until 9:29 a.m. - At 9:29 a.m. licensed practical nurse (LPN)-A notified by surveyor R22 had not been repositioned since 7:49 a.m. -At 9:34 a.m. R22 activated the call light, NA-E immediately entered R22's room to answer call light. NA-E came out of R22's room and reported to LPN-A that R22 had refused to be repositioned. -At 9:35 a.m. LPN-A entered R22's room and when she came out informed NA-E that R22 had agreed to be repositioned. -At 9:37 a.m. NA-C and NA-E entered R22's room to reposition her. R22 had not been repositioned for one hour and 48 minutes.	F 314		

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F 314	Continued From page 15 R22's admission Minimum Data Set (MDS) dated 1/5/16, indicated R22 had moderate cognitive impairment and required assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. R22 was frequently incontinent of bowel and bladder. Diagnoses listed on MDS included diabetes, multiple sclerosis and dementia. The Pressure Ulcer care area assessment dated 10/7/15, indicated R22 had been admitted to facility with a stage three pressure ulcer on heel. R22 was frequently incontinent of bowel and bladder, needed extensive assistance with dressing, grooming, toileting, bed mobility and transfers. R22 required a special mattress and seat cushion to reduce or relieve pressure. R22's tissue tolerance observation dated 10/5/15 indicated R22 needed to be repositioned every hour due to skin redness, non-blanchable and a Braden score (a tool used to predict pressure ulcer risk) of 15. The care plan revised on 12/31/15, indicated R22 had a pressure ulcer on coccyx, a Braden score of 18 or less and required assistance with repositioning. The care plan interventions included, administer treatments as ordered, turning and repositioning from side to side per assessment schedule, daily skin observations with cares and weekly skin/wound assessments were to be completed. R22's NA assignment sheet dated 3/2/16, indicated R22 was to be repositioned/offloaded side to side every hour while in bed. The undated turn and reposition tracker indicated that R22 was to be turned and repositioned every one hour	F 314		

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F 314	Continued From page 16 while in bed and w/c. R22 did not receive the turning and repositioning as indicated on the turn and reposition tracker. During interview on 3/3/16, at 9:14 a.m. NA-C stated she was not aware of the last time R22 was repositioned. NA-C further stated R22 needed to be repositioned every one hour. During interview on 3/3/16, at 9:35 a.m. LPN-A stated NA's are responsible for turning and reposition R22 and nurses are responsible to ensure R22 was repositioned timely. LPN-A further stated NA's are to report any care refusals to the nurse. When asked if NA reported R22 refusing to be repositioned, LPN-A denied any one reporting R22 refusing to be repositioned. During interview on 3/3/16, at 9:35 a.m. NA-E stated R22 needs to be repositioned every one hour. NA-E stated further R22 had refused to be repositioned after breakfast and the nurse was informed. When surveyor informed NA-E that nurse had stated that no one reported R22 refusing to be repositioned. NA-E stated "maybe she did not hear me." On 3/3/16, at 10:42 a.m. director of nursing services stated her expectation was for repositioning to be done per turning and repositioning schedule. Further stated if any resident refuses cares, care refusals need to be reported to the nurse. A policy for pressure ulcers, following care plan, turning and reposition was requested but none provided.	F 314		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 17 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) ability for 1 of 1 resident (R18) reviewed for limitations in range of motion. Findings include: On 3/1/16, at 10:51 a.m. R18's left arm rested against on her abdomen with fingers on her left hand tightly clenched into a closed fist. There was no splint or rolled wash cloth in place in the R18's left hand. When R18 was asked if she could open her hand and stretch out her fingers she stated that she was not able to. R18's Admission Record dated 3/3/16, indicated R18 had diagnoses that included dementia, contracture of a muscle and cerebrovascular disease (stroke). R18 did not receive range of motion services to minimize limitations in ROM. R18's quarterly Minimum Data Set (MDS) dated 12/31/15, indicated R18 had contracture of a muscle, severe cognitive impairment, had limited	F 318	F318 -R18 was reviewed for limitations of range of motion, updated MD, received order to provide hand roll and careplanned. -Re-educate staff on reporting any new signs/symptoms of contractures to nurse for follow through with therapy interventions. Devices used for contractures will be placed on TAR for compliance and NAR care sheets for compliance. -Audit 1 resident weekly who has potential for limitations of range of motion. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 318	Continued From page 18 ROM on one side of the body and required total staff assistance with all activities of daily living. R18's annual MDS dated 10/6/15, also identified R18 as having limited ROM on one side of her body. The Care Area Assessments for the annual MDS related to impaired ROM did not trigger for completion. R18's Functional Limitation in Range of Motion Assessment dated 12/31/15, indicated R18 had limitations in ROM on one side of her upper and lower extremity. R18's care plan revised on 12/30/15, indicated R18 was dependent upon staff for all activities of daily living and directed staff to monitor and report any changes in ROM ability. On 3/2/16, at 10:52 a.m. nursing assistant (NA)-C stated she cared for R18 regularly and R18 had weakness on her left side. NA-C further stated R18 did not receive any special treatment from nursing assistants for treatment of the weakness on the left side. - At 11:05 a.m. the facility's director of nursing services (DNS) stated R18 had a contracture when admitted to the facility on her left hand related to hemiparesis (weakness of the entire left or right side of the body) and that the resident did not use any splints or receive any restorative ROM services. - At 11:52 a.m. the DNS stated she expected residents with contractures and those assessed with functional limitation in ROM to be provided with ROM services to minimize limitations in ROM and increase in contractures. - At 12:52 p.m. when asked if R18 received any restorative nursing services, licensed practical nurse-F stated R18 did not receive any	F 318		

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F 318	Continued From page 19 restorative nursing services. - At 1:13 p.m. registered nurse (RN)-B verified she completed the MDS assessment and functional ROM assessment on R18. RN-B stated "at one point [R18] could squeeze her hand but now won't do it." When asked if R18 received any ROM services, RN-B stated R18 did not receive any ROM services. - At 1:48 p.m. NA-D stated she cared for R18 regularly and it was difficult to get R18 dressed on her left extremity. NA-D further stated R18 did not receive any restorative nursing services. A policy for restorative nursing, range of motion and resident contractures was requested but none provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review facility failed to provide supervision for wandering for 1 of 2 (R46) residents who was reviewed for accidents. Findings include: R46 was observed on 3/2/16, between 7:30 a.m.	F 323	F323 -R46 was redirected and gently guided from rooms that resident was at risk for accidents. -Re-educate staff regarding resident boundaries/wandering/redirection using the "Polar Bear" analogy. Update south group 1 care sheets to indicate need to re-direct from other resident rooms. Completing mandatory yearly Alzheimer's Dementia Care Training with all-staff for week of 3/21/16-3/31/16 and will continue annually. -ED or Designee to audit ACU milieu 1 hour per week for supervision of accidents and wandering/redirection and appropriate bed height. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 323	Continued From page 20 and 10 a.m. the following was noted: -7:30 a.m. R46 wandered into room 100 and sat down on the first bed. Licensed practical nurse (LPN)-E was preparing medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46. R46 exited room 100 at 7:35 a.m. No other residents were in room 100. - 7:37 a.m. R46 walked into room 100 and exit room 100 at 7:38 a.m. while LPN-E was preparing medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46. -7:40 a.m. R46 entered room 100 and exited room at 7:41 a.m. while LPN-E was preparing medications at the medication cart outside room 100. LPN-E did not say anything to or attempt to redirect R46. -7:50 a.m. R46 was observed in room 102 rummaging through the first resident's bedside dresser drawer and unmaking the first bed. Registered nurse (RN)-B walked pass room 102 and did not say anything to R46. The bed next to the window was in high position with the top of the mattress at the top of R46's hips. R46 was observed to crawl up into the bed and lie on right side at the edge of the bed. Surveyor maintained close observation through doorway while R46 in bed. -7:57 a.m. R46 lying on the bed next to the window in room 102. Bed remained in high position. RN-B walked past room 102 but did not say anything to R46. -7:59 a.m. LPN-E walked past room 102 and did not say anything to R46. -8:00 a.m. R46 slid out of the bed and walked out of room 102. -8:06 a.m. R46 entered room 104 and rearranged the covers on the first bed.	F 323		

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F 323	Continued From page 21 -8:08 a.m. R46 came out of room 104 and was walking in the hallway. Nursing assistant (NA)-F approached R46 in the hallway and escorted R46 to the dining room. -9:06 a.m. R46 was in room 110 when R76 who lived in the room returned to room. R46 came and stood in the doorway of blocking R76 entrance to the room. R76 told R46 to move and entered the room. R46 attempted to follow R76 into the bathroom. R76 closed the bathroom door. R46 walked out of the room. -9:58 a.m. The door to room 110 was almost completely shut. R46 opened the door and entered room 110. R46 was asked to leave by family member (F)-A. The care plan for R46 initiated 3/6/13, indicated, "I sometimes display target behaviors which include intrusive behaviors: hx of following other residents around the unit, telling them where they can be and what they can and can't do, invading other people's space, rummaging through other's belongings and at times being verbally and physically aggressive towards other residents, pacing up and down the hallway and continuous nonsensical talking. Taking shadow boxes off the walls and other residents decorations out of their rooms." Interventions for staff included, "Offer me something I like as a diversion, re-direct me when i [sic] am going into the wrong room." In addition care plan instructed staff, "Staff engage in conversation with me (even though nonsensical). I enjoy social interactions with others. If I need to be redirected it works best to engage me in a conversation and start walking with me to a new location or gently guide me with an arm around my shoulders." Care plan also indicted "My safety is at risk and there is a potential for abuse due to: Decreased cognitive ability, Wandering" and	F 323		

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instructed staff, "Please re-direct me when I wander into other rooms or areas that are unsafe for me." In addition, the care plan indicated, "I have little or no awareness of safety, or boundaries related to other's personal space. Please help me remain in a living environment that meets and supports my need to safely wander such as a secured unit or specialized care unit. Wandering about my living space, going into other resident's rooms, rummaging through items that aren't mine. Taking pictures out of shadow boxes or the boxes off the wall. I really like to keep busy." The care plan instructed staff, "If I'm pacing/wandering throughout my living space, I may be looking for a bathroom. Quietly ask me if you could help me get to my bathroom" and "Sometimes I wander into other people's rooms. Gently re-directing me with suggestions of visiting at another time may help. Offer me another place to go visit." R46 was identified as being at risk for falls related to wandering and use of medication instructs staff, "assist of 1 for transfers and ambulation as resident allows."

R46's annual Minimum Data Set (MDS) dated 11/21/15, indicated R46 was severely cognitively impaired, required supervision when ambulating on the unit, identified R46 wandered one to three days during the assessment period and that wandering had worsened since the previous MDS. MDS also indicated R46 had slurred speech and sometimes was able to understand and respond to others. R46's annual MDS indicated diagnoses of dementia, schizophrenia, depression, and arthritis.

The Mood State Care Area Assessment (CAA) dated 11/21/15, indicated R46 had moderate

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F 323	Continued From page 23	F 323		

depression and a diagnosis of dementia and schizophrenia. "Res [resident] has a very short attention span and wanders in and out of rooms most of the day." Will continue to care plan with goal of minimize risk.

The Behavior Symptoms CAA dated 11/23/15, indicated CAA was triggered due to resident wandering and rejecting care. "Res [resident] has a very short attention span and walks throughout the unit and in rooms the entire day. She likes to "shop" through other residents items and closets. Res has a dx [diagnoses] of dementia and schizophrenia. Staff re direct res with food/drinks. Redirect with activities but allow res to come and go as she pleases. Strength for res is that her sister and friend visit weekly. Will continue to care plan." Care plan overall objective indicated to "Minimize risks."

The Progress Notes dated 11/27/15, indicated "At approx [approximately] 1020 [10:20 a.m.], pt [patient- R46] was slapped across left ear and upper neck by another resident on unit. Pt had gone into 104-1 and was trying to lay on bed while 104-1 resident was in bed. 104-1 became agitated and angry and proceeded to yell at pt to "get out". When pt did not leave room 104-1 proceeded to slap pt across L[left] ear and L upper neck. Pt ear was reddened and L upper neck was slightly reddened as well. Staff on unit stated pt cried but settled once staff arrived to help. VSS [vital signs stable] and WNL [with in normal limits]. Pt is wandering unit per usual. Writer asked staff to keep close eye on pt to keep her out of 104-1 room. Will continue to monitor."

The Minnesota Incident Report dated 11/27/15, indicated R46 was slapped across left ear and

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F 323	Continued From page 24 neck by another resident. Interventions taken to prevent reoccurrence instructed staff will keep close eye on R46 to keep from wander into room 104. The Progress Notes dated 2/3/16, indicated, the Alzheimer's care director (ACD) and LPN-F heard a loud yell and found R36 in hall going after R46. R36 stated R46 was laying in her bed and that R36 hit R46. R46 was found crying and ACD asked where R36 hit her and R46 stated on her head. ACD didn't find any marks on her head but sat with R46 and comforted her, reminded her not to go in R36's room. Staff were informed to keep R46 out of room 104. The undated Excelsior: South Group 1 Nursing Assistant Assignment Sheet instructed staff that R46 had a Wanderguard (alarm worn by resident to alert staff if resident leaves the unit), "observe for unsteadiness or dizziness, resident is very busy, and difficulty sitting still at times." The NA care sheet lacked evidence of informing staff to redirect away from other patient rooms. During interview on 3/1/16, at 10:27 a.m. family member (FM)-B said, "There is another client who keeps climbing into [R76]'s bed. [R76] tells me it disturbs her. I spoke to the director about this. She told me that the woman likes this room and there is not anything they could do. I suggested changing rooms and she could have this one. They shut the door more. That woman keeps going into the room." During interview on 3/3/16, at 9:41 a.m. NA-B said, "When we see [R46] go into a room we try to direct to own room. Some residents become angry when she enters their room and will strike	F 323		

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F 323	Continued From page 25 out." During an interview on 3/3/16, at 10:53 a.m. LPN-E said, "The philosophy of the unit is to allow to wander but to try to keep them out of peoples rooms." LPN-E acknowledged yesterday was very busy and did not intervene when R46 went into room 102 or room 104. LPN-E verified LPN-E passed the rooms passing medications. LPN-E stated, "She was busy." During interview on 3/3/16, at 10:59 a.m. ACD said we try to keep R46 busy with activities and try not to have her go into "polar bear rooms." A polar bear room refers to the room of a resident who was easily angered and might strike out. Room 104 was a polar bear room. If (R46) was in others room's staff would come get her and bring out and redirect her. During an interview on 3/3/16, at 11:14 a.m. the executive director said we keep an eye on R36 because R36 had altercations. If R46 was in room 104 staff are to go get R46 and bring out R46 of the room. During interview on 3/2/16, at 10:04 a.m. R76 stated, "It makes me so mad when someone comes into my room." FM-A stated, "That wandering woman comes in all the time. [R46] will climb into [R46]'s bed and rummage through her drawers." During interview on 3/3/16, at 11:14 a.m. executive director stated R76's family had not told her that there was an issue with R46 wandering into room. "We want the residents to feel that every room here is their own and tell families that residents do wander into each other's rooms.	F 323		

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F 323	Continued From page 26 There are interventions we can put in place." The facility failed to protect R46 from entering other patient rooms, which put her at risk for potential resident to resident altercations, which had occurred twice within the past six months.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient staff to prevent falls and pressure ulcer development and to provide supervision. This had the potential to affect all the 44 residents in the facility which	F 353	F353 -Facility provided sufficient staffing per census to provide all nursing related services to our residents. -Re-educate staff on protocol for replacement of call-in's of staff to provide sufficient staffing per union rules for replacements. -ED, DNS or Designee to audit staffing levels weekly to monitor for sufficient staffing levels. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 353	Continued From page 27 required care and services. Findings include: While reviewing the staff schedules, it was noted that staff work double shifts, or pick up extra shifts. A review of the open positions in the planned (block schedule 1.0 full time equivalent (FTE) = 80 per pay period or 40 hour per week) revealed the facility was short staffed by two full time nurses and seven full time nursing assistant (NA) across the three shifts (24 hour day), in a two week pay period. Which was evident by the same nurses working multiple shifts during the survey time. The facility provided the open licensed staff position list that included: - The day shift registered nurse (RN) /licensed nurse (LPN) was lacking one-eight hour shift = .1 FTE (which required a staff nurse to pick up extra, or a leadership nurse to work the floor). - The evening registered nurse (RN)/licensed nurse (LPN) was missing 1.4 FTE which equaled one nurse working an eight hours shift seven days a week (required two people to fill the shifts since it totaled 56 hours a week). - The night shift needed a .5 FTE nurse to fill the shifts. The NA shifts open included: day shift was missing 2.8 FTE (2) .8, a .5, a .4, and a .3. Evenings shift needed 2.8 FTE a 1.0, a .8, a .6, and a .4. Night shift needed a .8, a .4, and a .2 position. A review of the facility website indicated there were three LPN charge nurse jobs, one RN charge nurse job and two NA jobs open (March	F 353		

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F 353	Continued From page 28 11th), the website did not indicate the sign on bonuses were available for MN, but did list them for other states. A random sample review of staffing sheets from 11/26/15, going forward indicated: On 11/26/15 - one LPN was replaced with a trained medication aide (TMA). On 11/27/15 - day shift two LPN's were replaced with TMA, a hand written note indicated the director of nursing services (DNS) "may come in today" and short one NA. The evening shift an LPN was replaced by a TMA (on a double shift). On 11/28/15 - on day shift an LPN was replaced by an extra NA. Evenings an LPN did a double shift, and an LPN was replaced by a TMA. On 11/29/15 - day shift an LPN was replaced by an extra NA, one LPN doubled to evening shirt. On NA picked up evening shirt (double to night shift). On 11/30/15 - days one LPN doubled to evening shift, one LPN doubled from scheduled evening to night shift. One NA picked up evenings and nights (double shift). On 12/2/15 - one LPN picked up day shift and doubled to evening shift, one LPN picked up day shift. One NA picked up days and evenings (double shift), one NA doubled to evening shift. One NA picked up night shift. On 3/1/16 - one LPN picked up and doubled to evenings, one LPN short on shift. One NA picked up and doubled to evenings, three additional NA picked up day shift. One LPN short on evening shift, and one NA short on night shift. On 3/1/16, at 10:57 a.m. family member (F)-B was interviewed and stated, "One evening there was a patient being hit by another patient and we had to stop it because there were no staff around.	F 353		

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There is another client who keeps climbing into other resident's bed. I spoke to the director about that. She told me that the woman likes this room and there is not anything they could do." F-B went onto say, "We see enough staff around meals, other times it was very hard to find somebody especially a charge nurse. We joke who is running the facility because it is just residents. We cannot find a charge nurse especially on weekends and evenings."

LPN-A was interviewed on 3/3/16, at 9:17 a.m. explained at times she works up to 160 hours per pay period because "we don't have staff to work." LPN-A explained shortage of nursing staff has been a 'huge" problem. LPN-A stated that "we are working short of an NA right now because there was none available to work." LPN-A explained there are no RNs available to work and LPNs do all the assessments and orders. LPN-A explained some work is left uncompleted over the weekends if there are admissions, as there is no RN available to "double check the orders." LPN-A explained that "I've seen other staff break down and cry with frustrations because they cant get any help." LPN-A also explained that, at times TMAs are left in charge of floors because of nurse shortages. LPN-A explained whenever there was a call-in, there was no replacement as there was no one to call. LPN-A stated, (almost tearing down), "I sometimes work four doubles back and back and I get frustrated. We have many staff working doubles because of shortage."

NA-B was interviewed on 3/3/16, at 9:36 a.m. explained he was working a "double" shift that day because of the shortage. NA-B explained he usually works approximately six extra shifts every

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F 353	Continued From page 30 pay period because "we are mandated to work if there is one available, but we still end up working doubles and short at same time." On 3/3/16, at 11:06 a.m. an interview with the DNS, staffing coordinator and human resources manager stated they worked very hard to fill shifts, and mandated shifts (staff were forced to stay) as little as possible, usually they were able to get someone to pick up a shift, or to stay on for the next shift without mandating. The facility also offered bonuses for some shifts, but not all open shifts. The facility did verify that not all shifts had enough staff to fill the staffing plan. In addition, the facility did not meet the requirement of a RN eight consecutive hours a day, seven days a week. There was a manager on duty (MOD) every weekend, but the MOD was not always a nurse. LPN-E was interviewed on 3/3/16, at 11:12 a.m. explained nursing staff are mandated to work overtime "a lot." LPN-E explained there was no RN available to work on the floor. If there was an admission, whoever the nurse on duty was responsible for doing assessment. LPN-E explained there was no RN coverage on the weekends "unless the director of nursing (DON) or assistant director of nursing (ADON) is scheduled to be here, which is very rare." In addition: Refer to F176: the facility failed to assess for safe practice of self-administration of nebulizer medication (an inhalation treatment of respiratory medication) for 1 of 1 resident (R40) observed self-administering a nebulizer treatment/ medication (SAM).	F 353		

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F 353	Continued From page 31 Refer to F282: the facility failed to provide supervision while wandering for 1 of 2 residents (R46) reviewed for accidents; the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R52) in the sample identified as having non-pressure related skin conditions and the facility failed to revise the care plan for 1 of 1 resident (R40) to include self-administration of medication (SAM). Refer to F309: the facility failed to provide the necessary care and services related to monitoring bruises for 1 of 3 residents (R52) in the sample identified as having non-pressure related skin conditions. Refer to F314: the facility failed to ensure interventions were implemented to ensure wound healing for a pressure ulcer for 1 of 1 residents (R22) reviewed for pressure ulcers. Refer to F318: the facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) ability for 1 of 1 residents (R18) reviewed for limitations in range of motion. Refer to F323: the facility failed to provide supervision for wandering for 1 of 2 residents (R46) reviewed for accidents.	F 353		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354		

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F 354	Continued From page 32 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a registered nurse (RN) coverage for eight consecutive hours, seven days a week, and did not have an RN waiver. This had the potential to affect all the 44 residents in the facility which required care and services. Findings include: A review of the nursing hours were reviewed from 11/26/15, going forward. The review identified there was no RN coverage on 11/26/15, and no RN coverage on weekends. A licensed practical nurse (LPN)-A was interviewed on 3/3/16, at 9:17 a.m. explained at times she works up to 160 hours per pay period because "we don't have staff to work." LPN-A explained shortage of nursing staff has been a 'huge" problem. LPN-A stated "we are working short of an NA right now because there was none available to work." LPN-A explained there are no registered nurses (RNs) available to work and LPNs do all the assessments and orders. LPN-A explained some work was left uncompleted over the weekends if there are admissions, as there was no RN available to "double check the	F 354	F354 -Golden Living Excelsior would like to request a waiver under F354 for RN waiver of at least 8 consecutive hours a day/7 days a week of RN coverage. Facility has 24 hour on-call provided by Director of Nursing. -Granting this waiver would not adversely affect the residents residing in the facility. The resident's health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complains from residents or families regarding RN staffing and coverage. -Increase advertising for RN hires, wages and sign-on bonuses, and adjust schedule as necessary to provide RN supervision as required. -ED, DNS or Designee to audit staffing levels weekly to monitor for sufficient staffing levels. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 354	Continued From page 33 orders." LPN-A explained that "I've seen other staff break down and cry with frustrations because they can't get any help." LPN-A also explained that, at times trained medication aides (TMA) are left in charge of floors because of nurse shortages. LPN-A explained whenever there was a call-in, there was no replacement as there was no one to call. LPN-A stated, (almost tearing down), "I sometimes work four doubles back and back and I get frustrated. We have many staff working doubles because of shortage." LPN-E was interviewed on 3/3/16, at 11:12 a.m. explained nursing staff are mandated to work overtime "a lot." LPN-E explained there was no RN available to work on the floor. If there was an admission, whoever the nurse on duty was responsible for doing assessment. LPN-E explained there was no RN coverage on the weekends "unless the director of nursing services (DNS) or assistant director of nursing was scheduled to be here, which was very rare." On 3/3/16, at 11:06 a.m. an interview with the DNS, staffing coordinator and human resources manager stated they worked very hard to fill shifts, and mandated shifts (staff were forced to stay) as little as possible, usually they were able to get someone to pick up a shift, or to stay on for the next shift without mandating. The facility also offered bonuses for some shifts, but not all open shifts. The facility did verify that not all shifts had enough staff to fill the staffing plan. In addition, the facility did not meet the requirement of a RN eight consecutive hours a day, seven days a week. There was a manager on duty (MOD) every weekend, but the MOD was not always a nurse. The DON, ADON and the MDS	F 354		

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F 354	Continued From page 34 coordinator were the only RNs in the building.	F 354		
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 maintain a clean and sanitary environment in the kitchen. This had the potential to affect 30 of 44 residents. Findings include: On 2/29/16, at 6:30 p.m. an initial tour of the facility kitchen was conducted with the dietary manager (DM). The following concerns were observed: -The coffee maker was observed with piled dust to the top and sides. The metal support strips holding the water softener that was attached to the coffee maker was rusted with paint peeled, and was also covered with thick dust build-up. The two Metal strips supporting the water softener were loosely attached to the wall and there was a hole measuring approximately 1.5 inches on the wall. The DM verified the residents	F 371	F371 -Facility Dietary Manager and Maintenance has replaced metal support strips and changed out to brand new parts to coffee maker, with wall patched up. Toaster knobs and fan in dry storage room were cleaned. -Daily documentation and schedule for kitchen cleaning has been put into place. -DM or designee to complete weekly kitchen audit. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 371	Continued From page 35 drank coffee from the machine. -The toaster had crumbs and debris all over. The two toaster knobs were covered with brown, thick sticky buildup. -In the dry storage room in the basement, the vent above the canned food was covered with dust and the fan was blowing the dust on the food. On 3/2/16, at 2:00 p.m., a revisit tour to the kitchen was conducted with the DM and the registered dietician (RD). All of the above conditions were again observed. Both the DM and RD confirmed the coffee maker and toaster were dirty and verified residents were served food from them. During an interview at 2:15 p.m. DM explained the coffee maker and toaster are supposed to be wiped down after use. DM explained the "Farm Brothers" company was in charge of the coffee maker maintenance and that "I will get on the phone with them after this to get them come and take care of it." DM explained that "maintenance" was in charge of cleaning the vents, "but I'm the one ultimately responsible for it. I guess I didn't think about it." A review of the cleaning schedule for the month of February provided by DM indicated that the coffee maker is to be cleaned inside and out every week. However, there was no indication that it was cleaned on week three and four of that month; it was indicated on the schedule that it wasn't completed. On 3/3/16, at around 11:00 a.m. DM approached surveyor and reported that the toaster knobs have been cleaned. DM stated "I never thought of	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

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F 371	Continued From page 36 those knobs before." DM also explained that the vent in dry storage has been cleaned and that "Farm Brothers" would be in to clean the coffee maker. A facility's Cleaning Kitchen Areas policy dated 2/17/16, directed to, "Wash shelf surfaces with warm water and a detergent solution. Assure that edges, lips and cracks are clean and free of food buildup.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R15) who was identified with intellectual disabilities. Findings include: On 2/29/16, at approximately 7:30 p.m. facility was asked to provide a list of residents who had level II PASSR.	F 406	F406 -PASSR Level 2 was completed on R15. -Facility will have PASSR Level 2 in hand prior to admitting any further resident that meets this requirement. -ED or designee to audit PASSR Level 2 are complete prior to admissions and placed in chart monthly. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 406	Continued From page 37 On 3/1/16, the executive director provided a list which identified R15 with a developmental disability and had been identified as requiring level II. On 3/2/15, at 6:59 a.m. to 10:30 a.m. R15 was observed lying in bed in the room awake. During the entire time several staff went into the room provided care and a family member came and assisted R15 with breakfast and left. When approached R15 was able to converse but was hard to understand. On 3/3/16, at 2:20 p.m. an activity was observed in the main dining room and resident was observed lying in his bed awake. -At 2:38 p.m. when asked if resident attended activities the director of activities stated resident this week on Tuesday had attended an activity on Tuesday morning music and otherwise she did 1:1 round with him daily. R15's quarterly Minimum Data Set (MDS) dated 2/7/16, indicated R15 had severely impaired cognition, had psychomotor retardation and had both short and long term memory issues. R15's diagnoses included cerebral palsy, depression, convulsions and depression obtained from the MDS. The MDS also indicated R15 had no mood symptoms, no behavioral symptoms and no psychosis, hallucinations or delusions. The MDS further indicated R15 required total dependence to extensive assistance of one to two staff assistance with all activities of daily living (ADL's)	F 406		

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F 406	Continued From page 38 The Pre-Admission Screening Assessment (PAS/OBRA Level 1) dated 4/29/15, indicated resident had a diagnosis of mental retardation or related condition, resident was considered to have a mental retardation or related condition in the past, resident had a condition that presented a mental retardation or related condition and had been referred for nursing or boarding care facility placement. The screening indicate "If you answered yes to any of the previous questions, refer the person to the county offices for persons with developmental disabilities or related conditions for evaluation and determination of need for specialized services." On 3/2/16, at 7:44 a.m. licensed practical nurse (LPN)-F stated resident required physical extensive assistance with everything and was pretty much dependent on staff for all his needs due to the diagnoses and all the cares he required which included catheter cares, toileting. LPN-F indicated resident was able to communicate at times and when asked if he was able to follow the commands LPN-F stated at times but staff anticipated all his needs. LPN-F stated resident family was very involved in his care and family came daily in the morning. LPN-F stated resident did come out of room at times but spent most of the time in the room. On 3/2/16, at 8:18 a.m. when asked if there was any special assessments that were completed for residents with MI/MR the director of social services (DSS) stated the executive director (ED) completed the senior link assessments as she had background experience in those. DSS stated she had been working at the facility for about three and a half months and directed the surveyor to ED.	F 406		

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F 406	Continued From page 39 -At 8:36 a.m. ED went through the chart verified the chart did not have a level II screening. ED stated she thought R15's insurance company had done one and indicated would be look through another chart to find it. -At 8:54 a.m. ED approached stated she had put a call out to Dakota County and left a message to provide the information as the county had done the screening. ED indicated on the Level I it had been indicated R15 required nursing home care however still, no level II had been completed. On 3/2/16, at 2:48 p.m. ED approached stated she had gotten a call back from the county and had been informed the county was responsible to have done both level I and II screening and the contact person indicated the county was responsible for completing the screenings. ED also stated R15 had not been admitted from the hospital but rather had come from home, where family had cared for him and thought both the family and the county agreed for R15 to be admitted to the facility. When asked what the facility policy was for ensuring Level II was completed for resident identified as developmental disability (DD), ED stated, "the county was supposed to have done the screenings." On 3/3/16, at 10:47 a.m. ED approached stated she had completed an application today at the Senior LinkAge site requesting a screening to be done. When asked who was ultimately responsible to ensure level II screening had been completed, ED stated she was but with that case, the resident had been admitted from home and Dakota County was supposed to have completed all the necessary documentation. ED was not able to answer or provide documentation if follow	F 406		

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F 406	Continued From page 40 up had been done.	F 406		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 -Insulin pen labels were replaced and expired medications were removed. Medication refrigerator's were cleaned and defrosted. -Education will be provided to staff regarding policy and proper procedure for destruction of Fentynl patches. Cleaning schedule in place for medication refridgerator's. -DNS or designee to audit labeling and expiration of medications and cleaning of medication refridgerator's weekly. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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F 431	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin flexpen's for 2 of 2 (R54, R55) had a pharmacy label with a resident's name and directions, failed to ensure expired medications were discarded, failed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 1 of 1 resident (R23). In addition, the facility failed to ensure 2 of 2 medication storage refrigerators were cleaned and defrosted. These practices had the potential to affect all 44 residents. Findings include: ACU Unit On 2/29/16, at 6:46 p.m. licensed practical nurse (LPN)-D provided access to the ACU unit medication room. During the tour the following were observed stored in either the medication cabinet or the medication refrigerator: -100 tablets quantity house stock Acid Gone antacid with expiration date 9/15 was observed stored in the medication cabinet -R30's Lorazepam (anti-anxiety liquid medication) 0.75 milligrams (mg) was observed stored on the door of the refrigerator with discard 12/28/15 -R54's two Lantus flexpen's were observed stored on the bottom shelve of the refrigerator and on the cap noted resident name written with a black marker no pharmacy label on either pen. Upon taking the cap off LPN-D verified one of the pens had been used yet did not have date opened. LPN-D stated R54 received the insulin twice daily. LPN-D indicated she did not know why the pens did not have a pharmacy label and verified the used pen did not have a date when it was opened.	F 431		

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F 431	Continued From page 42 -The freezer was observed with build-up of ice, approximately one inch in the inside, underneath, and around the freezer. Ice had fallen onto the shelves where medications were stored. LPN-D verified the built up ice and stated the night nurse was responsible for cleaning it. Central Cart On 2/29/16, at 7:14 p.m. during medication observation with LPN-B was observed to prep Lantus (insulin) flexpen for R55 which was dated as opened 2/6/16. The flexpen had R55's first name only and did not have the pharmacy label. LPN-B verified the flexpen did not have a label. R55's Physician Order printed 3/3/16, indicated resident had an order for Lantus (insulin) inject 12 units subcutaneously at bedtime related to diabetes type II without complication. During interview on 3/3/16, at 7:23 a.m. the director of nurses (DNS) stated, "Each insulin pen should be individually labeled." During interview on 3/3/16, at 11:15 a.m. Pharmacist stated, "Each insulin Flexpen should be individually labeled on the barrel of the pen to prevent the possibility of giving it to the wrong resident." Fentanyl patches On 3/3/16, at 6:45 a.m. LPN-C provided access for the narcotic box where a box of Fentanyl (pain patches) for R23 were stored with two patches left. When asked what the facility policy was for destroying used patches LPN-A stated two nurses were supposed to destroy the patch and had to sign in the narcotic book after.	F 431		

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F 431	Continued From page 43 R23's physician orders printed 3/3/16, indicated resident had the following order: -Fentanyl patch 72 hour 75 micrograms (mcg)/hour apply 1 patch transdermally one time a day every three day(s) for pain related to malignant neoplasm and remove per schedule. On 3/3/16, at 7:11 a.m. the DNS when asked what the facility policy was for the nurses documenting after destroying Fentanyl patches DNS stated both nurses were supposed to sign after in the narcotic book. DNS verified in page 76, 92 and 104 there was only one nurse signature. DNS stated as far as she knew Minnesota Department of Health (MDH) did not indicate how documentation was supposed to be done. On 3/3/16, at 11:25 a.m. the consultant pharmacist (CP) stated two nurses were supposed to sign off after each destruction in the narcotic book. CP acknowledged the patches had a high potential risk for diversion. During review of Individual Narcotic Record page 76, 92 and 104 it was revealed R23 had the patch removed nine times and at all times only one nurse signature was documented. In addition, review of electronic medication records (EMAR) for 1/1/16, through 3/3/16, revealed only one nurse had signed off removing the used patch and applying it. There was no second signature of nurse witnessing the destruction of the used patches. Guidance on Disposal of Transdermal Narcotic Patches dated 7/2/15, directed "Transdermal patches containing controlled substances present a unique situation with the potential for abuse,	F 431		

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F 431	Continued From page 44 misuse and diversion, and the substantial amount of controlled medication remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss of diversion, and provide for safe handling, distribution and disposition of the medications. Any state/local specific requirements should be kept with this guidance. Staff should dispose of controlled substance patches in a secure and safe method, so diversion and/or accidental exposure are minimized. Golden Living advocates using the disposal outlined in the manufacturer's product package insert, along with a documentation method that requires one person to render the patch unusable and another to witness the disposition unless state specific guidance calls for a different process... Step 3 In the presence of another licensed Golden Living employee, flush the folded patch down the toilet. Step 4 Document the disposal on the CERTIFICATE OF DESTRUCTION FOR USED CONTROLLED SUBSTANCE PATCHES." North Cart On 2/29/16, at 7:36 p.m. a medication cart tour was completed with LPN-A who provided access. During the tour R8's pill card with 29 tablets left of Morphine 2.5 mg was observed stored in the narcotic box with discard date 9/1/15. LPN-A verified the medication was expired and stated resident had been on liquid form as R8 was on hospice but had graduated recently. LPN-A stated	F 431		

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F 431	Continued From page 45 she would leave the card in the narcotic box and was going to let the director of nursing services know. LPN-A further stated the facility policy was to remove all expired medications and discard them except for the narcotics which the DNS and pharmacist destroyed which she thought was done very regularly and was not sure why this had not been removed or destroyed the last time the destruction was done. On 3/3/16, at 7:11 a.m. DNS stated she would expect expired medications to be removed and discarded by the nurses. DNS explained would expect the nurses to let her know when narcotics were expired and the nurses were supposed to keep the narcotic in the cart locked until it was destroyed. When asked about the insulin flexpen's not being dated and labeled DNS stated she had not worked with this pharmacy before but thought the pens should be individually labeled with resident name and directions and nurses were supposed to date the pens when opened. DNS indicated the flexpen's came in a box of six and the nurse were just taking them out and using a black marker to write the name of the resident "I will work with the pharmacy about this." Main Medication room On 3/3/16, at 9:00 a.m. LPN-A provided access to main medication room during the tour. The medication refrigerator freezer was observed to have three to four inches of built-up ice inside and all around the outside and reusable ice pack was embedded into the ice. On the shelves below were multiple influenza vials, intravenous medications, boxes of anti-anxiety medication, suppositories among others for several residents and house supply stock. When asked who was	F 431		

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F 431	Continued From page 46 responsible to clean the refrigerators LPN-A stated the night nurse was and stated she was going to notify the director. On 3/3/16, at 11:25 a.m. the consultant pharmacist (CP) stated he was not aware the facility had another medication room and refrigerator in the Alzheimer's Care Unit (ACU), and would not expect expired medications to have been stored in the carts or medication room. On 3/3/16, at 2:23 p.m. when asked who was responsible for making sure the refrigerators and freezer were cleaned, the DNS stated the night nurse was she was not aware of the concern and was going to check it herself. When asked who was ultimately responsible for making sure the areas were kept clean, DNS stated "me. I am the director of nursing." Storage of Medication policy dated 1/6/15, directed: 12. Insulin vials should be stored in the refrigerator until opened. Date insulin vials when first opened. May store opened vial in refrigerator or at room temperature. Do not freeze insulin. If insulin has been frozen, do not use... 13. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled. or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal... 15. Medication storage area are kept clean, well lit, and free of clutter. 16. Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. Recommendations are made for corrective action taken as problems are	F 431		

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F 431	Continued From page 47 identified."	F 431		

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	245332	F5332026 A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2016

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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, State Fire Marshal Division on March 1, 2016. At the time of this survey, Golden Living Center Excelsior 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	K 000	APPROVED By Tom Linhoff at 8:17 am, Apr 05, 2016 RECEIVED APR - 4 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 3-21-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	515 DIVISION STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 44 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 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050	RECEIVED APR - 4 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION K050 -Fire drills are completed on a monthly basis per fire regulations. -Maintenance Director and ED to prepare a log of dates/times for remainder of year for fire drills to ensure compliance with fire regulations. -Maintenance Director will report to ED completion of monthly fire drill with monthly audit of form completed. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	**515 DIVISION STREET** **EXCELSIOR, MN 55331**

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K 050	Continued From page 2 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 44 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on March 1, 2016, it was observed that the fire drills were not documented for the 3rd shift in the 3rd quarter and the 1st shift in the 4th quarter. This deficient practice was confirmed by the Administrator at the time of Inspection.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility's fire alarm system is not maintained in	K 052	K052 -Fire Alarm test was completed by Summit for yearly inspection. -Maintenance Director has contracted with Summit for yearly fire alarm test to be completed by Summit. -ED or Designee to audit monthly for compliance of annual fire alarm test and documentation. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

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K 052	Continued From page 3 accordance with NFPA 72, (99). This deficient practice could affect all 44 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on March 1, 2016, it was revealed that no annual fire alarm test was conducted. The last documented fire alarm test was done on November 11, 2014. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 44 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on March 1, 2016, It was revealed that a smoke detector sensitivity test has not been conducted for 6 years. The last documented smoke detector sensitivity test was done on November 13, 2009. This was confirmed by the Director of Environmental Services at the time of inspection.	K 054	K054 -Facility has completed Smoke Detectors and Sensitivities inspection and test with Summit. -Maintenance Director has contracted with Summit for yearly Smoke Detectors and Sensitivities inspection and test. -ED or Designee to audit monthly for compliance of annual smoke detector and sensitivity test and documentation. --The date of completion will be 4/12/16 -The facility QAPI committee will review the audits quarterly for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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