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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OFIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **03/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 03/30//2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 07/01/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/31/2014
(L33)

DETERMINATION APPROVAL

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

CCN:24-5348

On March 17, 2014, a Post Certification Revisit (PCR) was completed by review of the facility's plan of correction. Based on the plan of correction, it has been deteremined that the facility has corrected the deficiencies issued pursuant to the January 30, 2014 standard survey, effective March 11, 2014. Refer to the CMS 2567b for the results of this revisit.

Effective March 11, 2013, the facility is certified for 49 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5348

May 15, 2014

Ms.. Sharon Wooten, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Dear Ms.. Wooten:

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 March 11, 2014 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2014

Mr. Ernest Gershone, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348023

Dear Mr. Gershone:

On February 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 11, 2014 and therefore remedies outlined in our letter to you dated February 10, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5348r14.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing	3/17/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/11/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/11/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	03/30/2014	12835	03/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OFIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**

2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - RUSH CITY**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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 **01/30/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Ann Hyrkas, HFE NEII — 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: MPM
Mark Meath, Enforcement Specialist — 03/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 03/31/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OFIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

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(L1) **245348**

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(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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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 **03/17/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
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Patricia Halverson, Unit Supervisor 03/30//2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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07/01/1986
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 07/01/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/31/2014
(L33)

DETERMINATION APPROVAL

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

CCN:24-5348

On March 17, 2014, a Post Certification Revisit (PCR) was completed by review of the facility's plan of correction. Based on the plan of correction, it has been deteremined that the facility has corrected the deficiencies issued pursuant to the January 30, 2014 standard survey, effective March 11, 2014. Refer to the CMS 2567b for the results of this revisit.

Effective March 11, 2013, the facility is certified for 49 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5348

May 15, 2014

Ms.. Sharon Wooten, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

Dear Ms.. Wooten:

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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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2014

Mr. Ernest Gershone, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348023

Dear Mr. Gershone:

On February 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 11, 2014 and therefore remedies outlined in our letter to you dated February 10, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5348r14.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245348	A. Building B. Wing	3/17/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/11/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/11/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	03/30/2014	12835	03/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2014			

CCN:24-5348

At the time of the January 30, 2014 standard survey survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8149

February 10, 2014

Mr. Ernest Gershone, Administrator
Golden LivingCenter - Rush City
650 Bremer Avenue South
Rush City, Minnesota 55069

RE: Project Number S5348023

Dear Mr. Gershone:

On January 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (218) 302-6151
Fax: (218) 723-2359

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 March 11, 2014, 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 March 11, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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
	245348	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	DK 2.26.14 PLH	
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 shaving and nail care for 1 of 1 residents (R36) reviewed for ADL's. Findings include: A Diagnosis Report dated 1/20/14, indicated R36's diagnoses included anemia, heart failure, and dementia. A significant change Minimum Data Set (MDS)	F 282	F282 -Resident R36 offered grooming per his care plan. -All residents requiring an assist with ADL's related to grooming have the potential to be affected by the deficient practice. -Nursing staff has been educated to offer grooming in accordance with the written plan of care while respecting the resident's right to choose.. -Random weekly audits will be conducted to ensure compliance. Audits will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 3/11/2014	

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

Administrator 2-19-14

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

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F 282	Continued From page 1 dated 1/23/14, indicated R36 had severe cognitive impairment and required extensive assistance with personal hygiene activities. A Care Area Assessment (CAA) dated 1/9/14, indicated R36 needed extensive assistance with ADL's. R36's Care Plan dated 12/18/13, directed staff assistance with shaving/hair needs. The undated Nursing Assistant Care Sheet indicated R36 received a bath on Friday afternoon with the assist of 1 and required the assist of 1 with ADL's. A Weekly Bath List (undated) indicated R36 was scheduled to receive a bath on Tuesday evening shift and Friday evening shift. On 1/28/14, at 9:41 a.m., on 1/29/14 at 9:20 a.m., and on 1/30/14, at approximately 9:00 a.m., R36 was observed with long facial whiskers and long, jagged and dirty fingernails. On 1/30/14, at approximately 11:15 a.m. licensed practical nurse (LPN)-B stated residents should be shaved as needed and nail care provided on bath days. On 1/30/14, at 1:30 p.m. the director of nursing (DON) stated she would expect assistance with shaving would be provided daily or as needed for residents who are dependent in ADL's. The DON further stated fingernails should be trimmed at least on bath day or more often as needed. On 1/30/14, at approximately 3:30 p.m. registered	F 282		

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F 282	Continued From page 2 nurse (RN)-B stated the facility did not have a policy on nail care.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure shaving and nail care were provided for 1 of 1 residents (R36) reviewed for activities of daily living (ADL's). Findings include: A Diagnosis Report dated 1/20/14, indicated R36's diagnoses included anemia, heart failure, and dementia. A significant change Minimum Data Set (MDS) dated 1/23/14, indicated R36 had severe cognitive impairment and required extensive assistance with personal hygiene activities. A Care Area Assessment (CAA) dated 1/9/14, indicated R36 needed extensive staff assistance with ADLs. R36's Care Plan dated 12/18/13, directed staff to offer to assist with shaving/hair needs as needed.	F 312	F312 -Resident R36 has been offered grooming per his care plan. -All residents requiring an assist with ADL's related to grooming have the potential to be affected by the deficient practice. -Nursing staff has been educated to offer grooming in accordance with the written plan of care while respecting the resident's right to choose. -Direct Care observation audits will be conducted to ensure compliance. Audits will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 3/11/2014	

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F 312	Continued From page 3 An undated Nursing Assistant Care Sheet indicated R36 received a bath on Friday afternoon with the assist of 1 and required the assist of 1 with ADL's. A Weekly Bath List (undated) indicated R36 was scheduled to receive a bath on Tuesday evening shift and Friday evening shift. On 1/28/14, at 9:41 a.m. R36 was observed seated in a wheelchair in the facility's front lobby area. R36's face had many long whiskers present, and several of R36's fingernails were observed to be long and jagged with dark material under several of the fingernail tips. On 1/29/14, at 8:29 a.m. R36 was observed seated in a wheelchair in the hallway outside of the main dining room. R36's face and fingernails were noted to be the same as the previous day. On 1/30/14, at approximately 9:00 a.m. R36 was observed seated in a wheelchair in the front lobby area, still with long facial hair and dirty fingernails. On 1/30/14, at 9:39 a.m. nursing assistant (NA)-C stated R36 was already up for the day when she arrived at 5:30 a.m. NA-C reported she did notice R36 was in need of shaving. NA-C reported resident fingernails were usually trimmed and cleaned on bath day. On 1/30/14, at approximately 11:15 a.m. licensed practical nurse (LPN)-B stated residents should be shaved as needed and nail care provided on	F 312		

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F 312	Continued From page 4 bath days. On 1/30/14, at 1:30 p.m. the director of nursing (DON) stated she would expect assistance with shaving would be provided daily or as needed for residents who are dependent in ADL's. The DON further stated fingernails should be trimmed at least on bath day or more often as needed. A Shaving the Resident procedure (undated) was provided by the facility and directed removal of facial hair was to improve the residents' appearance and morale and did not specify frequency of hair removal. On 1/30/14, at approximately 3:30 p.m. registered nurse (RN)-B stated the facility did not have a policy on nail care.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		

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F 329	Continued From page 5 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, assess and/or monitor clinical indicators for ongoing use of medications for 2 of 5 residents (R10, R40) in the sample reviewed for unnecessary medications. Findings include: The package insert on Seroquel (antipsychotic medication) from the makers of the medication, AstraZeneca, indicate Seroquel is an atypical antipsychotic indicated for the treatment of schizophrenia, bipolar disorder manic episodes, and bipolar disorder depressive episodes. The insert includes the following warning: "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. SEROQUEL is not approved for elderly patients with dementia-related psychosis." R10 was sent to a geriatric psych unit on 5/14/13, because of agitation, paranoia and combativeness. R10 returned to the facility on	F 329	F329 -Res. #'s R10 and R40 have had there anti-psychotic medication use assessed, target behaviors and clinical indicators identified and GDR initiated. -All residents receiving anti-psychotic medication have the potential to be affected by the deficient practice. -Social Service and Nursing Administration have been educated regarding the requirements for gradual dose reduction, appropriate Diagnosis and documentation of target behaviors, non-pharmacologic interventions attempted and clinical rationale documented by the MD. -Random weekly audits will be conducted to review resident MD orders for use of anti-psychotic medication and appropriate Diagnosis, documentation of targeted behaviors, non-pharmacologic interventions attempted and clinical rationale. Audits will be reviewed at QAPI and action planned as needed. -Director of Social Service is the responsible party. -Corrective action will be completed by 3/11/2014	

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F 329	Continued From page 6 5/29/13. The discharge summary directed follow-up management of psychotropic medications and, "If behaviorally indicated a gradual taper off of Seroquel could potentially be attempted." R10's physician's orders dated 1/7/14, included Seroquel 50 mg by mouth BID (start 5/29/13) for agitation and paranoia related to dementia with behavioral disturbances. The physician's orders did not include clinical indications for ongoing use of Seroquel for dementia with behavioral disturbance. The care plan dated 9/20/12, indicated R10 displayed behaviors that included confusion, pushing/cursing at staff when assisted, paranoia, agitation, combativeness and refusing cares. The care plan directed staff to attempt interventions before R10's behavior escalated, build on R10's strengths of reading and music and to invite to participate in those kinds of activities, seat R10 separate from others in the dining room, re-direct with a slow approach, re-approach when refused cares, offer quiet settings, and provide 1 on 1 time. The nursing assistant care sheet directed staff to re-approach when R10 was non-compliant with cares and to offer choices of care times when possible. The quarterly Minimum Data Set (MDS) dated 1/20/14, indicated R10 had moderate cognitive impairment and had no behaviors in the look back period of the previous seven days.	F 329		

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F 329	Continued From page 7 The Care Area Assessment (CAA) dated 7/19/13, indicated R10 triggered for alteration in behavior related to a diagnosis of dementia, a recent hospital stay for mental illness evidenced by delusional thought, throwing her plate of food, and negative comments to staff. The CAA further indicated since the recent hospital stay, R10's cognitive level appeared to have declined further, and R10 often told fabricated stories R10 believed to be true. The CAA did not indicate the frequency or content of delusional thoughts/fabricated stories or if the delusional thoughts/fabricated stories caused distress for R10. R10's behavior monitoring record for the past 30 days indicated 14 incidents of rejection of care and 1 incident of threatening staff. There was no monitoring for incidents of delusions, fabricated stories or paranoid behavior/statements. On 1/29/14, at 1:38 p.m. nursing assistant (NA)-A stated R10 has had behaviors of refusing to get up in the morning or being combative and refusing cares. NA-A further stated when she offers R10 a cup of coffee and comes back later, R10 will be ready to get up and out of bed. On 1/29/14, at 2:20 p.m. licensed practical nurse (LPN)-B verified R10 has had behaviors of refusal of cares and being combative with staff. On 1/30/14, at 1:34 p.m. the director of nursing and RN-B were interviewed. RN-B stated an attempted gradual dosage reduction (GDR) for	F 329		

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F 329	Continued From page 8 antipsychotic medication would be resident-specific, situational, and based on the resident's behaviors with a quarterly review. RN-B further stated behaviors for use of an antipsychotic would include those behaviors which are directed at others or self and have the potential to cause harm to self or others. RN-B further reported if a resident had been on an antipsychotic for 7 months for behaviors related to dementia, the expectation would be to attempt a GDR with the antipsychotic medication. On 1/20/14, at 3:20 p.m. the consultant pharmacist stated a potential GDR of Seroquel was not discussed with the physician. The facility was unable to provide a policy and procedure on the use of antipsychotic medications. R40's physician's orders dated 1/21/14, included Seroquel 50 mg TID for dementia with behavioral disturbances. The care plan dated 11/15/13, indicated R40 received an antipsychotic for agitation and hitting/pushing at staff during cares. The care plan interventions were to invite to activities, offer coffee and treats, offer pet visit when able, offer picture book, reassure resident is safe, offer 1:1 as needed, redirect from others as needed, and offer quiet environment with dim lighting, aromatherapy and soft music. The nursing assistant care sheet directed staff to offer reassurance, resident can be resistive with cares, transfers. Likes to hold a baby doll or a stuffed animal, and watch so she does not bite staff or herself.	F 329		

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GOLDEN LIVINGCENTER - RUSH CITY	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 329	Continued From page 9 The admission Minimum Data Set (MDS) dated 11/11/13, indicated R40 had short and long term memory problems and had severely impaired decision making skills (rarely/never made decisions). The MDS also indicated R40 had behaviors towards others 4-6 days (in the look back period of the past seven days), and had verbal behavioral symptoms directed towards others 1-3 days (in the look back period of the past seven days). The Care Area Assessment (CAA) dated 11/11/13, indicated R40 triggered for behavioral symptoms due to resisting cares and physical episodes towards staff. Staff were directed to anticipate needs of resident and provide for her as necessary. Assistance of two staff when needed, explain what is going on or needing to be done before doing so. Staff administer medications per orders, monitor for side effects and observe her mood and behavior on a daily basis to ensure she is receiving the lowest possible therapeutic dose. Behavior monitoring records for the past 30 days indicated 12 episodes of behaviors such as attempting to bite staff, threw a doll at staff, hit, pinched, slapped and screamed at staff, spit at staff and grabbed staff glasses. Nursing assistant (NA)-D was interviewed, on 1/29/14, at 9:05 a.m., and stated R40 had episodes of slapping staff, pulling hair, biting, pushing away and screaming during cares. NA-D	F 329		

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F 329	Continued From page 10 stated R40 usually cooperates with cares because NA-D takes her time and re-approached later if R40 does not accept care. NA-D further stated some staff are in a hurry, and R40 resists care if staff was in a hurry. On 1/30/14, at 10:14 a.m. the director of nursing (DON) was interviewed and verified R40 resisted care. The facility was unable to provide a policy and procedure on the use of antipsychotic medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the consultant pharmacist failed to identify medication irregularities for 1 of 5 residents (R10) in the sample reviewed for unnecessary medications. Findings include:	F 428	F428 -The consultant pharmacist has identified irregularities regarding the use of anti-psychotic medication for resident #'s R10 and R40. -All residents receiving anti-psychotic medication have the potential to be affected by the deficient practice. -Consultant Pharmacist has been educated on the requirements to review and identify irregularities in the use of anti-psychotic medication. -Monthly reviews of medication will be conducted by the consultant pharmacist and recommendations forwarded to the primary MD for clinical rationale for continued use or initiation of GDR. -Consultant Pharmacist is the responsible party. -Corrective action will be completed by 3/11/2014	

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F 428	Continued From page 11 The package insert on Seroquel (antipsychotic medication) from the makers of the medication, AstraZeneca, indicate Seroquel is an atypical antipsychotic indicated for the treatment of schizophrenia, bipolar disorder manic episodes, and bipolar disorder depressive episodes. The insert includes the following warning: "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. SEROQUEL is not approved for elderly patients with dementia-related psychosis." R10 was sent to a geriatric psych unit on 5/14/13, because of agitation, paranoia and combativeness. R10 returned to the facility on 5/29/13. The discharge summary directed follow-up management of psychotropic medications and, "If behaviorally indicated a gradual taper off of Seroquel could potentially be attempted." R10's physician's orders dated 1/7/14, included Seroquel 50 mg by mouth BID (start 5/29/13) for agitation and paranoia related to dementia with behavioral disturbances. The physician's orders did not include clinical indications for ongoing use of Seroquel for dementia with behavioral disturbance. The care plan dated 9/20/12, indicated R10 displayed behaviors that included becoming confused, pushing/cursing at staff when assisted, paranoia, agitation, combativeness and refusing cares. The care plan directed staff to attempt interventions before R10's behavior escalated, build on R10's strengths of reading and music	F 428		

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F 428	Continued From page 12 and to invite to participate in those kinds of activities, seat R10 separate from others in the dining room, re-direct with a slow approach, re-approach when refused cares, offer quiet settings, and provide 1 on 1 time. The nursing assistant care sheet directed staff to re-approach when R10 was non-compliant with cares and to offer choices of care times when possible. The quarterly Minimum Data Set (MDS) dated 1/20/14, indicated R10 had moderate cognitive impairment and had no behaviors in the look back period of the previous seven days. The Care Area Assessment (CAA) dated 7/19/13, indicated R10 triggered for alteration in behavior related to a diagnosis of dementia, a recent hospital stay for mental illness evidenced by delusional thought, throwing her plate of food, and negative comments to staff. The CAA further indicated since the recent hospital stay, R10's cognitive level appeared to have declined further, and R10 often tells fabricated stories R10 believed to be true. The CAA did not indicate the frequency or content of delusional thoughts/fabricated stories or if the delusional thoughts/fabricated stories caused distress for R10. R10's behavior monitoring record for the past 30 days indicated 14 incidents of rejection of care and 1 incident of threatening staff. There was no monitoring for incidents of delusions, fabricated stories or paranoid behavior/statements.	F 428		

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F 428	Continued From page 13 On 1/29/14, at 1:38 p.m. nursing assistant (NA)-A stated R10 has had behaviors of refusing to get up in the morning or being combative and refusing cares. NA-A further stated when she offers R10 a cup of coffee and comes back later, R10 will be ready to get up and out of bed. On 1/29/14, at 2:20 p.m. licensed practical nurse (LPN)-B verified R10 has had behaviors of refusal of cares and being combative with staff. On 1/30/14, at 1:34 p.m. the director of nursing and RN-B were interviewed. RN-B stated an attempted gradual dosage reduction (GDR) for antipsychotic medication would be resident-specific, situational, and based on the resident's behaviors with a quarterly review. RN-B further stated behaviors for use of an antipsychotic would include those behaviors which are directed at others or self and have the potential to cause harm to self or others. RN-B further reported if a resident had been on an antipsychotic for 7 months for behaviors related to dementia, the expectation would be to attempt a GDR with the antipsychotic medication. The consultant pharmacist monthly medication regimen review summaries from 6/11/13, to 1/15/14, did not address the lack of clinical indicators for the ongoing use of Seroquel or and evaluation for a GDR. On 1/20/14, at 3:20 p.m. the consultant pharmacist stated a potential GDR of Seroquel was not discussed with the physician. The facility was unable to provide a policy and procedure on the use of antipsychotic medications.	F 428		

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F 428	Continued From page 14 On 1/30/14, at 2:01 p.m. the administrator indicated there was no policy on the consultant pharmacist duties, a consultant pharmacist would be required to follow regulations.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 44	F441 -Infection control standards are being maintained during dressing changes on resident R9. -All residents requiring dressing changes have the potential to be affected by the deficient practice. -Licensed staff have been educated in the appropriate way to maintain infection control standards during the performance of dressing changes. -Wound Care observation audits will be conducted to ensure maintenance of infection control standards during dressing changes. Audits will be reviewed at QAPI and action planned as needed. -DNS or designee is the responsible party. -Corrective action will be completed by 3/11/2014	

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F 441	Continued From page 15 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control standards were maintained during a dressing change procedure for 1 of 1 residents (R9) reviewed for pressure ulcers Findings include: P9 was admitted on 6/28/13. The care plan dated 7/12/13, indicated P9 was admitted with two stage 4 pressure ulcers, one on the ischial tuberocity and one on the sacrum. Physician's orders dated 1/21/14, direct R9 to receive daily wet to dry dressings for wound care. A quarterly Minimum Data Set (MDS) dated 12/27/13, indicated R9 had moderate cognitive impairment and had 2 stage 4 pressure ulcers. On 1/29/14, at 10:51 a.m. registered nurse (RN)-A was observed to provide a dressing change and ulcer care for R9's pressure ulcers. R9 was positioned on the left side in bed. RN-A washed her hands in R9's bathroom and assembled the dressing change supplies on R9's overbed table. RN-A donned disposable gloves and provided fecal incontinence care. Without handwashing or glove change, RN-A removed the	F 441		

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F 441	Continued From page 16 dressings from both pressure ulcers and removed the gloves. RN-A washed her hands, returned to the bedside and applied clean gloves. RN-A washed and dried R9's back side area. With the same gloves on, RN-A sprayed one of the ulcers with wound cleanser spray and wiped the wound with a 4 inch by 4 inch gauze. Still wearing contaminated gloves, RN-A sprayed and wiped the second ulcer, using clean gauze to wipe the wound. RN-A removed the gloves, washed hands and applied new gloves. RN-A measured each of the wounds using disposable tape measures. RN-A then sprayed skin barrier/prep spray onto the skin skin surrounding both ulcers. Without hand hygiene or glove change, RN-A saturated 4 inch by 4 inch gauze with sterile normal saline solution and placed the gauze in R9's ulcers, firmly pressing the saturated gauze dressings into each wound. RN-A covered the wet dressings with 4 inch by 4 inch gauze sponges and along with a Tegaderm dressing to hold the sponge into each ulcer. RN-A noticed feces on R9's rectal area and cleansed the area with a disposable wipe. R9 wore the contaminated gloves to apply a disposable brief, pull up R9's blankets, and to return several unused dressings and supplies to a storage area in R9's room. With the contaminated gloves still on, RN-A lowered R9's bed and pushed the red treatment cart containing some of the dressing change supplies into the hallway. RN-A then re-entered R9's room with the same contaminated gloves on and spoke to nursing assistant (NA)-A who had entered R9's room with RN-A. RN-A removed the contaminated gloves and returned to the treatment cart. RN-A gathered supplies for changing the dressing around R9's catheter from the treatment cart, returned to R9's room and then washed hands.	F 441		

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F 441	Continued From page 17 On 1/29/14, at 1:30 p.m. RN-A stated she should have removed the gloves and washed her hands after completing incontinence care. RN-A verified hands should be washed after removing gloves. RN-A confirmed she wore contaminated gloves when she pushed the treatment cart out of the room, when she returned to the room, and while removing supplies from the treatment cart. On 1/30/14, at 2:20 p.m. the director of nursing (DON) stated re-gloving and hand washing should be done after removing old dressings from a wound and before applying new dressings. The DON further stated gloves should be removed and hands washed after providing care to a resident and before leaving the resident's room. A Clean Dressing Change Audit procedure (undated) directed staff to wash hands and apply a clean pair of gloves between steps of the dressing change procedure as well as when the procedure is complete.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain woodwork in resident rooms; ensure the dining room furniture was intact; and	F 465		

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F 465	Continued From page 18 to clean the kitchen. This had the potential to affect all 36 residents as well as visitors passing through the hallways or using the dining room. Findings include: During tour of the facility with the with the administrator and the maintenance director on 1/29/14, at approximately 9:30 a.m. the following was observed. The main dining room was observed 1/29/14, to have a drawer front missing from a cabinet and another drawer had hardware hanging by one screw. The door from the dining room to the kitchen had stain and varnish worn off in an area 20 by 21 inches exposing bare wood. A wood door leading to the out side had molding hanging loose on one side. The rest of the molding was held two inches away from the door frame by pieces of unfinished wood spacers allowing observation of the inside of the door framing with a copper water pipe running through the space. The wood door going into the Alzheimer's Care Unit dining room was scraped from side to side at the level of wheel chairs wheels hitting the door. R36's bedroom door knob was dented and the stain and varnish around the doorknob was worn off to expose raw wood. The bath room door had missing veneer measuring 1 X 0.5 inches at the level of the latch. R27's room had a TV cord draped across the front of the bulletin board on top of the over head	F 465	F465 -The two sinks and the stove exhaust hood have been cleaned. Main Dining Room areas identified in the 2567 have been repaired. The identified areas requiring maintenance will be repaired. -All residents have the potential to be affected by the deficient practice. -Dietary and Maintenance staff have been educated to perform required cleaning and routine maintenance as needed. -Weekly audits will be conducted to assure cleaning and routine maintenance is completed in a timely manner. Audits will be reviewed at QAPI and action planned as needed. -DSM and Facility Administrator are the responsible parties for identified kitchen. Maintenance Director and Facility Administrator are the responsible parties for repair and replacement identified maintenance items. - Corrective action will be completed by 3/11/2014	

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F 465	Continued From page 19 bed light. On 1/29/14 at 8:15 a.m. interview with the maintenance supervisor stated that whomever cleaned and waxed the floor must have draped the TV cord over things and never put it back on the floor. R29's bath room door had stain and varnish worn off measuring 11 by 14 inches exposing raw wood on the inside surface. R18's bathroom door knob was dented and the stain and varnish around the knob was worn to expose raw wood. The bath room door had missing veneer measuring 1.5 X 0.5 inches at the level of the latch. R21's bedroom door knob was dented and the stain and varnish was worn in an area measuring 11 X one inches to expose raw wood on the inside. The bath room door had stain and varnish worn off to expose raw wood in an area measuring 20 X three inches. The bathroom door had missing veneer, measuring 1 X 0.25 inches at the level of the latch. R40's bedroom door knob was dented and the door stain and varnish around the knob and down the side of the door was worn and exposed raw wood measuring 20 X one inches. Stain and varnish were worn off the door at the height of the door knob to expose raw wood measuring 7 X 1/2 inches. The wall in one corner of the room had paint and sheet rock paper missing intermittently for a 3 foot long, one half inch wide strip. There was a 2 x 2 inch unpainted square with two holes in it on one end of the missing sheet rock paper.	F 465		

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F 465	Continued From page 20 R63's bedroom door knob was dented and the door was missing veneer measuring 1 x 1.5 inches at the level of the latch. The bathroom door knob was also dented and missing veneer at the level of the latch. R63's bathroom door edge was worn to expose raw wood, measuring 2 x 17 inches. The bed side table was chipped and the cabinet was worn around the bottom 3 inches exposing the raw wood. R39's door had missing veneer, measuring 1 X 0.5 inches at the level of the latch. R24's bath room door had missing veneer, measuring 1 X 0.5 inches at the level of the latch. The door stain and varnish was worn to expose raw wood measuring 15 x 3 inches. R10's bedroom and bathroom doors had sanded edges with approximately 2 inches X 7 feet of raw wood exposed. R16's door stain and varnish around the door knob was worn to expose raw wood. The door had missing veneer on both sides, measuring 1.5 by 1/2 inch at the level of the latch. The double doors in the hall of the Alzheimer's Care Unit (ACU) had a hole that measured one by one inch square. Both doors had stain and varnish worn off around the knob. The maintenance director, interviewed on 1/29/14, at 9:45 a.m., stated staff tell him if something needs repair. The maintenance director verified the findings during the tour. On 1/27/14, at 3:10 p.m. during tour of the	F 465		

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F 465	Continued From page 21 kitchen with the dietary manager (DM), two sinks and the stove exhaust hoods were observed to have built up dust, grease, food and soiled grey substances on them. The hand washing sink was dirty and there was a bright brown substance one half inch beyond the grout line along the back of the sink. There was a thick gray brown substance about 6 inches wide on the top and side of the sink, down the wall, over the base board and two inches out unto the floor. The DM stated at that time the sinks were suppose to be cleaned daily by the cooks. The DM didn't know if there was a policy on cleaning the sinks but said she expected them to be clean daily and that included cleaning around to sinks also. Four of the eight exhaust vents above the stove were full of dust and grease to the point of approximately 75 % of the vent holes were closed with dust and grease. The DM stated that the exhaust vents should be cleaned monthly. The DM was responsible to clean the vents but she didn't remember when she last cleaned them. Behind the large mixing bowl on the counter was a large window air conditioner with dust pieces 1/4 inch long that would be blown into food in the mixer. The DM stated that they last used the air conditioner in the late fall. The sink in the dish washing area had a thick brown gray area along the outside edge. When it was touched by the DM what appeared to be drips were a solid thick substance measuring approximately one half inch wide. The policy for Cleaning Exhaust Hoods policy	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 22 was not dated. It indicated potential fire hazard and to keep hoods free of grease and dust at all times. Strictly enforce cleaning schedule because dirty exhaust hood filters pose a potentially high fire hazard. Monthly Cleaning of exhaust hoods and filters. It indicated the exhaust hoods and filters were to be cleaned monthly or more frequently if needed. Exhaust hood fans policy, indicated they would hire a commercial cleaning company to clean exhaust hood fans quarterly or per the facility's schedule. The policy indicated they would keep a record provided by the commercial cleaning company on file. The Policy for Cleaning Kitchen Areas was not dated indicated the hand sinks would be cleaned daily. The steps indicated to ensure area behind faucet base was clean and free of debris and build up. Instructions indicated to wipe down basin legs and drain pipe with damp cloth and mild soapy solution.	F 465		

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

F5348022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - RUSH CITY	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Golden Living Center-Rush City was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Golden Living Center-Rush City is a 1-story building with a partial basement. The building was constructed in 1967. The building is fully fire sprinkler protected. The facility has a complete 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 licensed capacity of 49 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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