# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OHDV
Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245148**

2. STATE VENDOR OR MEDICAID NO. (L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **04/01/2006**

6. DATE OF SURVEY **09/23/2014** (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 **208** (L18)

13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 208 | | | |
| (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):

Facility's request for a temporary waiver involving K103 (replacement of wood studs in a corridor wall) is approved; last day in effect is 11/07/14.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 09/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/23/2014 (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 **03/01/1968** (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. **00450** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/19/2014** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5148

September 23, 2014

Mr. Timothy Johnson, Administrator
Golden LivingCenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

Dear Mr. Johnson:

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

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

Effective September 17, 2014 the above facility is certified for or recommended for:

208 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 208 skilled nursing facility beds.

Your request for waiver of Life Safety Code Requirement: K103 (replacement of wood studs in a corridor wall) has been approved. It is effective through November 7, 2014.

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

September 23, 2014

Mr. Timothy Johnson, Administrator
Golden LivingCenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

RE: Project Number S5148023

Dear Mr. Johnson:

On August 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 8, 2014. 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 September 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2014 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 August 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 8, 2014, effective September 17, 2014 and therefore remedies outlined in our letter to you dated August 25, 2014, will not be imposed.

Correction of the Life Safety Code deficiencies cited under K103 (replacement of wood studs in a corridor wall) at the time of the August 8, 2014 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of November 7, 2014, has been approved.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

## 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 |
|---|---|---|
| 245148 | A. Building<br>B. Wing | 9/23/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH<br>SAINT LOUIS PARK, MN 55426 |

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 Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix **F0246**<br>Reg. # **483.15(e)(1)**<br>LSC | **09/17/2014** | ID Prefix **F0247**<br>Reg. # **483.15(e)(2)**<br>LSC | **09/17/2014** | ID Prefix **F0253**<br>Reg. # **483.15(h)(2)**<br>LSC | **09/17/2014** |
| ID Prefix **F0278**<br>Reg. # **483.20(g) - (j)**<br>LSC | **09/17/2014** | ID Prefix **F0364**<br>Reg. # **483.35(d)(1)-(2)**<br>LSC | **09/17/2014** | ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | **09/17/2014** |
| ID Prefix **F0463**<br>Reg. # **483.70(f)**<br>LSC | **09/17/2014** | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| **State Agency** | GD/AK | 09/23/2014 | 18623 | 09/23/2014 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 8/8/2014 | | | |

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit |
|---|---|---|
| 245148 | 01 - MAIN BUILDING 01 | 9/18/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH<br>SAINT LOUIS PARK, MN 55426 |

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 Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0072 | 09/10/2014 | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
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| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PS/AK | 09/23/2014 | 28120 | 09/18/2014 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
|---|---|
| 8/5/2014 | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: OHDV
Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245148**
2. STATE VENDOR OR MEDICAID NO.
(L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**
6. DATE OF SURVEY **08/08/2014** (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 **208** (L18)
13.Total Certified Beds 208 (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 |
|---|---|---|---|---|
| | **208** | | | |
| (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):

Facility's request for a temporary waiver involving K103 (replacement of wood studs in a corridor wall) is recommended; last day in effect is 11/07/14.

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**03/01/1968**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00450**
(L31)

30. REMARKS
TW LSC K103 sent to CMS 09/19/2014 Co.
Posted 09/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 4646

August 25, 2014

Mr. Timothy Johnson, Administrator
Golden LivingCenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

RE: Project Number S5148023 and Complaint Numbers H5148142, H5148143, H5148144, and H5148145

Dear Mr. Johnson:

On August 8, 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. In addition, at the time of the August 8, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5148142, H5148143, H5148144, and H5148145. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 8, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5148142, H5148143, H5148144, and H5148145, that were 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:

> **<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;**

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

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

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

**DEPARTMENT CONTACT**

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 17, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**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.

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

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 November 8, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting 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.

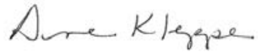
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

**Sheehan, Pat (DPS)**

---

**From:** Sheehan, Pat (DPS)
**Sent:** Monday, September 15, 2014 9:17 AM
**To:** Jan.Suzuki@cms.hhs.gov
**Cc:** robert.rexeisen@state.mn.us; 'Johnson, Timothy 20 [LC00871]'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
**Subject:** Golden Livingcenter St Louis Park (241480) K103 Temporary Waiver Request

This is to inform you that I am accepting GLC St Louis Park's request for a temporary waiver until 11-7-14 for K103, replacement of wood studs in a corridor wall. The exit date was 8-8-14.


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

**Name of Facility**

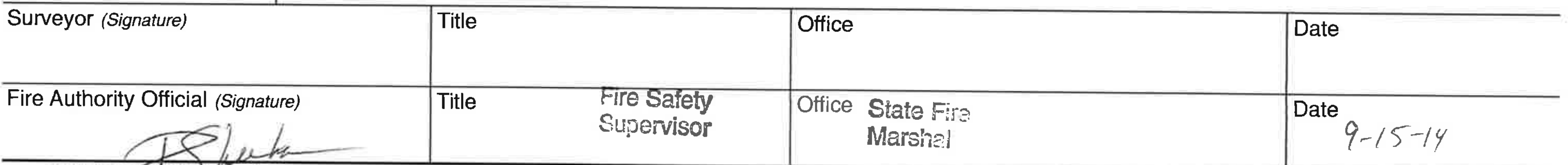
Golden Living Center - Saint Louis Park CMS Certification #245148 St. Louis Park, MN

**2000 CODE**

**PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS**

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

| PROVISION NUMBER(S) | JUSTIFICATION |
|---|---|
| K84<br>K 103<br>Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 | A temporary waiver for K103 is being requested until 11-7-14.<br><br>A. A temporary waiver for K 103 is needed because:<br>1. The facility had an architect in the facility on 8-27-14 and he indicated that the walls must be removed and rebuilt to meet the noncombustible requirement of K 103.<br>2. The drawings for issuing a permit will be completed, and it is estimated that a permit can be received in 1 weeks time.<br>3. The facility has contacted a general contractor, Outland Builders, for removal and rebuilding of the identified walls, and they estimate that they will need 4 weeks to complete the construction once the permit is received.<br>4. The start date of this project is still pending, and the facility needs time for the bidding process and securing capital, which could take up to 2 weeks time before a start date can be identified.<br>*The additional time needed is estimated at 7 weeks.<br><br>B. List of the additional safeguards that will be put into place until this deficiency is corrected.<br>1. The affected areas are areas not normally accessed by residents. Room 387 is storage and the door remains locked at all times. The areas on first floor near the Director of Nurses office are office spaces and are locked at times when not in use by those staff. |



| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title Fire Safety Supervisor | Office State Fire Marshal | Date 9-15-14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245148 | A. BUILDING ____ B. WING ____ | C 08/08/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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| F 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>Complaint investigations were also completed at the time of the standard survey for H5148142, H5148143, H5148144, and H5148145 and were unsubstantiated. | F 000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R109) reviewed for environmental concerns, had their call light readily accessible. | F 246 | F 246 a. The care plan for R109 was updated to reflect his preference/ habits for call light placement.<br>b. All residents preference/ habits for call light placement are observed and care planned as needed.<br>c. Addendum added to the Use of Call Light procedure to remove #11 call lights placed on the bed at all times, never on the floor or bedside stand. Revision: placement of call light within reach of resident when resident is in their room, unless otherwise individually care planned. All staff educated on addendum to procedure.<br>d. DNS or designee completes 15 random audits for call light placement weekly. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Executive Director | 9-10-2014 |

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 246 | Continued From page 1 | F 246 | | |

Findings include:

On 8/5/14, at 10:53 a.m. during R109's room observation, the call light was observed to be coiled on the floor under the foot of the bed. R109 was observed to be laying in bed with his head to the foot board and his feet to head board of the bed. R109 stated he did not use the call light because "it takes two hours to respond to the white light [the call light over the door of the room in the hallway]" and further stated, "I go to the bath room to use that call light, the red one, because I get a better response." When asked about the average response time, R109 stated the average staff response time was "two hours" for the light by the bed and "under two hours" for the call light in the bathroom. R109 reported he usually used the call light to get assistance with loose stools in his "pull ups." R109 stated this happened about "2-3 times per week."

On 8/8/14, at 10:00 a.m. the call light was observed to remain on the floor under the foot of the bed.

On 8/8/14, at 12:30 p.m. during the environment tour, the call light was observed remain under the foot of the bed on the floor. When the observation was pointed out during the tour of the environment, the administrator then grabbed the call light and set the call light on top of the bedding at the foot of the bed. When asked what his expectation was, the administrator stated the call light was supposed to be in reach if it was care planned to be at reach. The administrator further stated if the call light was not care planned the call light should be where the resident preferred it to be.

RECEIVED
SEP 11 2014
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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| F 246 | Continued From page 2<br>R109's annual Minimum Data Set (MDS) dated 7/9/14, indicated R109's Brief Interview for Mental Status (BIMS-tool used to measure cognition) score was fourteen, indicating intact cognition. In addition, the MDS indicated R109 used a walker for locomotion.<br><br>R109's fall care plan dated 1/10/11, identified R109 was at risk for falls and directed staff to ensure R109's, "Call light or personal items [were] available and [within] easy reach..." In addition, the undated Nursing Assistant Assignment Care Guide identified, "[R109] self transfers, please remind to use call light."<br><br>In addition R109's Comprehensive Assessment dated 7/9/14, indicated call light was to be in reach when in room.<br><br>The undated Call Light, Use of policy directed, "Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand." | F 246 | | |
| F 247 SS=D | 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE<br><br>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the appropriate notice of a new roommate for 2 of 2 residents (R175, R176) who got new roommates reviewed for admission, transfer and discharge. | F 247 | F 247<br>a. R175 and R176 were informed of the facility process for roommate notification.<br>b. All residents or their legal representative are notified of new roommates according to facility policy and procedure.<br>c. All staff educated on facility policy and procedure for roommate notification. Staff educated to document roommate notification in medical record.<br>d. ED or designee will complete random audits of 5 roommate notifications, or room relocations weekly. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

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| F 247 | Continued From page 3<br>Findings include:<br><br>R176<br>When interviewed on 8/4/14, at 5:15 p.m. R176 stated he was not given notice before a change in roommate.<br><br>Review of the computerized census record revealed R178 moved into the same room as R176 on 3/19/14. On 8/8/14, at 10:30 a.m. the business office director verified this information.<br><br>The quarterly Minimum Data Set (MDS) dated 7/17/14, indicated R176 was cognitively intact.<br><br>Review of the Progress Notes and the medical record lacked evidence R176 was notified of a new roommate on or before 3/19/14.<br><br>R175<br>When interviewed on 8/5/14, at 1:37 p.m. R175 stated he was not given notice before a change in roommate.<br><br>Review of the computerized census record revealed R161 moved into the same room as R175 on 1/16/14. On 8/8/14, at 10:30 a.m. the business office director verified this information.<br><br>The quarterly MDS dated 6/30/14, indicated R175 was cognitively intact.<br><br>Review of the Progress Notes and the medical record lacked evidence R176 was notified of a new roommate on or prior to 1/16/14.<br><br>When interviewed on 8/8/14, at 10:07 a.m. licensed social worker (LSW)-A stated she normally gave notices of new roommates to | F 247 | | |

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| F 247 | Continued From page 4<br>residents verbally and documented in the progress notes. LSW-A stated she was not able to find documentation of R176 and R175 being notified of receiving new roommates.<br><br>On 8/8/14, at 10:48 a.m. a licensed social worker (LSW)-A provided the facility Resident Room Relocation policy revised October 2009 which directed, "Providing resident and his or her legal representative or interested family member with a verbal notice and documenting in the medical record." and "Informing a resident or his or her legal representative when he or she is receiving a new roommate." LSW-A again verified there was no documentation regarding R176 and R175 being notified of receiving a new roommate.<br><br>The administrator was interviewed on 8/8/14, at 11:11 a.m. and stated he expected residents to be given notice before receiving a new roommate. The administrator stated he did not think the notification needed to be documented and he would have to "check the policy." | F 247 | | |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure resident rooms were kept in good repair and sanitary manner for 5 of 7 resident (R109, R169, R258, R53, R72) reviewed for environmental concerns. | F 253 | F 253<br>a. Identified repairs or cleaning have been or will be completed.<br>b. The environment is assessed for comfort, needed repairs, and sanitary interior by the Executive Director, Housekeeping Supervisor, and Maintenance Supervisor.<br>c. All staff educated on how to report needed environmental repairs or cleaning.<br>d. ED or designee will audit 7 rooms weekly for comfort, needed repairs, and sanitary interior. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

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| F 253 | Continued From page 5<br><br>Findings include:<br><br>A tour of the facility was conducted on 8/8/14, beginning at 11:50 a.m. through 1:00 p.m. with the maintenance supervisor, administrator and the housekeeping supervisor present throughout the tour. The following concerns were identified. R109's air conditioning was in ill repair.<br><br>On 8/5/14, 10:18 a.m. during interview with R109, when asked about any problems with the temperature, lighting, noise or anything else in the building that affected his comfort, R109 stated he would like it to be "a little cooler." R109 stated the air conditioning (AC) did not work "great." AC was observed to be on the highest and coldest setting. R109 stated warm air came out of AC unit and further indicated AC had been running that way since he came to the room eight months ago. The air blowing from AC unit at the time of the interview was observed to feel warm to the hand. At 10:48 a.m. the temperature in the room was observed to feel warmer than hallway and more humid. During room observation the thermostat was observed next to the AC unit (directly to the left of the unit on the wall over the bed). The thermostat appeared to be broken. R109 stated the thermostat "doesn't work" and staff were aware.<br><br>R109's annual Minimum Data Set (MDS) dated 7/9/14, indicated R109 was cognitively intact. In addition, the MDS indicated R109 used a walker for locomotion.<br><br>At the time of the tour, the maintenance supervisor checked and verified the room temperature was 76.5 degrees Fahrenheit and | F 253 | | |

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| F 253 | Continued From page 6<br>verified the AC was blowing warm air. When asked if the AC was broken, he stated, "I will fix it!" as he walked out of the room.<br><br>R169's water faucet and bathroom door were in ill repair.<br><br>On 8/4/14, at 7:15 p.m. during room observation the bathroom faucet was very loose and a splintered gouge was observed in the veneer, exposing splintered wood beneath. The gouge was observed at the level of the door knob and slightly to the side.<br><br>R169's annual MDS dated 6/27/14, indicated R169 had intact cognition. In addition, the MDS indicated R169 required supervision oversight of one staff with activities of daily living (ADL's).<br><br>During the environmental tour the maintenance director and house-keeping supervisor both verified the faucet was loose and the maintenance supervisor verified the gouge on the door.<br><br>R258's privacy curtain not kept in a sanitary condition.<br><br>On 8/5/14, at 12:53 a.m. during room observation the privacy curtain in R258's room by his bed had multiple brown stains.<br><br>R258's admission MDS dated 2/3/14, indicated R258 had intact cognition. In addition, the MDS indicated R258 required extensive physical assist with ADL's.<br><br>On 8/8/14, during the environmental tour the house-keeping supervisor verified the brown | F 253 | | |

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| F 253 | Continued From page 7<br>stains on the privacy curtain to the left of the room. The house-keeping supervisor stated the curtains were cleaned once a month and as needed; the supervisor verified nursing or house-keeping were responsible to put in a work order or let house-keeping know the curtain needed to be cleaned.<br><br>R53's bathroom door was in ill repair.<br><br>On 8/5/14, at 2:39 p.m. during room observation outside of bathroom door was noted with splintered gouges in the veneer at the level of the door knob and slightly to the side at handle level.<br><br>R53's quarterly MDS dated 6/16/14, indicated R53 had intact cognition. In addition, the MDS indicated R53 required limited to extensive physical assist with ADL's.<br><br>During the environmental tour the maintenance supervisor and administrator verified the gouge on the door. The maintenance supervisor stated the preventative work was done every three months and anybody could put a work order in if they noted a concern.<br><br>R72's bathroom door was in ill repair.<br><br>On 8/5/14, at 2:44 p.m. during room observation a punched dent in the bathroom door was noted in the center of the door. The punched dent appeared to line up with the knob from entrance door to the room.<br><br>R72's quarterly MDS dated 5/2/14, indicated R72 had intact cognition. In addition, the MDS indicated R53 required extensive physical assist with ADL's including toilet use and personal | F 253 | | |

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| F 253 | Continued From page 8<br>hygiene.<br><br>On 8/8/14, during the environmental tour both the administrator and maintenance verified the dent.<br><br>Review of the Curtain Cleaning for June and July 2014, revealed the curtains had been cleaned on 6/9/14, and 7/9/14.<br>The undated Preventative Maintenance Manual Program Overview policy indicated, "It is the policy of this facility to properly maintain the building, it's fixtures, systems, equipment, and furnishings to ensure that the entire facility is in good repair at all times in order to provide quality patient care, protect capital investment, ensure life safety codes, exceed governmental inspection standards and provide a safe environment for residents, associates, and visitors." | F 253 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is | F 278 | F 278<br>a. The MDS for R105 was modified for pressure ulcer assessment.<br>b. MDS Coordinator ensures accurate assessments and documentation on MDS for all residents.<br>c. All nursing staff is educated on accurate assessment and documentation.<br>d. DNS or designee will complete 4 MDS audits for accuracy weekly. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245148 | A. BUILDING ______ B. WING ______ | C 08/08/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

| (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 |
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| F 278 | Continued From page 9 | F 278 | | |

Continued From page 9
subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on document review and interview, the facility failed to accurately assess and document a chronic stage 4 pressure ulcer for 1 of 3 residents (R105) reviewed for pressure ulcer assessment.

Findings include:

R105 was admitted to the facility on 11/1/13, with admission diagnoses of panhypopituitarism (a condition of inadequate or absent production of the anterior pituitary hormones), personality disorder, dementia, and dysphagia (difficulty swallowing).

The admission Minimum Data Set (MDS) dated 11/8/13, indicated R105 did not have a stage 1 or great pressure ulcer, but was at risk for pressure ulcers. The assessment lacked documentation in areas of unhealed or healed pressure ulcer.

The quarterly MDS dated 5/20/14, had a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated R105 had no cognitive impairment, and had rejected care 1-3 times in

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| | 245148 | A. BUILDING ______ B. WING ______ | C 08/08/2014 |

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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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| F 278 | Continued From page 10 | F 278 | | |

F 278 Continued From page 10

the look back period. R105 required extensive assistance of one staff for bed mobility, toileting, personal hygiene, dressing, and eating; and limited assistance of one staff for transfers. The MDS indicated R105 did not have a stage 1 or great pressure ulcer, but was at risk for pressure ulcers. The assessment lacked documentation in areas of unhealed or healed pressure ulcer.

The Care Area Assessments (CAAs) dated 11/8/13, indicated R105 was at risk of pressure ulcer, but noted the skin was intact.

The care plan dated 11/2013, indicated R105 had a history of an open area behind the right ear and current pressure ulcer behind the right ear.

R105's Weekly Wound Care notes indicated a stage IV pressure ulcer was located behind the right ear, the ulcer was packed with Hydrofera bacteriostatic foam. R105 was seen in the wound clinic weekly. Wound clinic notes indicated R105 had a history of removal of Astrocytoma (brain tumor), and multiple surgeries to the right ear as the potential cause of the chronic pressure ulcer behind the right ear.

On 8/6/14, at 1:33 p.m. the MDS coordinator was interviewed and MDS's were reviewed. The MDS coordinator verified the quarterly MDS on 5/20/14, was inaccurate and lacked mention of a stage IV pressure ulcer. The MDS coordinator further verified the admission MDS dated 11/8/13, also did not identify a pressure sore, or history of pressure sore and was inaccurate.
The registered nurse (RN)-C and wound care nurse was interviewed on 8/6/14, at 1:53 p.m. and stated she suspected the wound was there on admission, but it was not documented. RN-C

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|---|---|
| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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| F 278 | Continued From page 11<br>stated the facility "called it [the pressure ulcer] facility acquired [admitted 11/4/13]." RN-C stated R105's father reported R105 had a chronic wound behind her ear for many years. | F 278 | | |
| F 364 SS=E | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to maintain food temperatures at a safe level. This had the potential to affect 5 of 5 residents (R36, R92, R115, R148, R199) in the Advanced Alzherimer's Care Unit (AACU) on pureed diet, and the remaining 19 of 19 residents in the AACU not on pureed diet.<br><br>Findings include:<br><br>On 8/4/14, at 6:14 p.m. in the AACU dietary aide (DA)-A was observed to check the temperatures of the food in the portable steam table. DA-A verified the temperatures of pureed lettuce 60 degrees Fahrenheit (F), tomato soup 110 degrees F, and lasagne 190 degrees F. DA-A did not reheat, re-chill, nor replace any of these foods. R36, R92, R115, R148, R199 were served pureed lettuce. The other 19 residents in AACU were served lasagne. None of the residents chose tomato soup (option 2) in place of the lasagne. | F 364 | F 364<br>a. Dietary staff is trained on ensuring food is maintained and served at safe temperatures according to facility policy.<br>b. Food is maintained at safe temperatures according to facility policy.<br>c. All staff educated on maintaining food at safe temperatures according to facility policy.<br>d. DDS or designee completes random audits of 5 temperature logs weekly for accuracy. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

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| F 364 | Continued From page 12 | F 364 | | |

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On 8/8/14, at 1:50 p.m. the dietary director stated the dietary staff checked the temperature of the food at point of service, and if temperatures were out of range, the dietary staff should have done something to get the foods at proper temperature before serving. The dietary director stated the goal temperatures were 41 degrees F and below for cold food, and 150 degrees F and above for hot food.
The facility's undated policy on Holding and Serving instructed staff to hold hot foods at a continuous temperature of 135 degrees F or above on the serving line. Avoid holding foods above 180 degrees F for safety and to avoid destroying nutrient value. Reheat immediately to 165 degrees F for 15 seconds any hot food that falls below 135 degrees F--discard any reheated food at the end of the service. Discard any hot food that was not at 135 degrees F or above at the end of the meal service. The policy instructed for cold foods, to hold potentially hazardous cold items on ice during service or remove only small amounts of the chilled items, such as pudding, assuring the temperature was maintained at 41 degrees F or below. The policy instructed dietary staff to take and record temperatures to assure all items are at 41 degrees F or below before returning to the refrigerator.

The dietary director was interviewed on 8/8/14, at 10:10 a.m. and confirmed temperatures must be taken from the hot serving carts before food was served. The dietary director stated staff were trained on what to look for with hot and cold foods in the way of temperatures using, and the temperatures as outlined in the facility's policy. The dietary director stated the soup was tempted at 110 degrees F was low and should have been

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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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| F 364 | Continued From page 13 reheated before serving. The pureed lettuce which was tempted at 60 degrees F should not have been served to the residents. | F 364 | F 431<br>a. Medications not stored in a clean and sanitary manner or not labeled / expired were removed.<br>b. Every medication cart, medication storage room, and med fridge have been inspected for proper storage in a clean and sanitary manner and no non labeled/ expired meds present.<br>c. Education is provided to all Licensed Nurses and TMAs on policy and procedure for medication storage, medication labeling, and medication expiration. The cleaning procedure and checklist for medication storage is reviewed.<br>d. DNS or designee audits 2 medication rooms and 5 medication carts weekly. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>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.<br><br>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.<br><br>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 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH<br>SAINT LOUIS PARK, MN 55426 |

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| F 431 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 4 of 4 residents (R15, R43, R52, R198) reviewed for medication storage.<br><br>Findings include:<br><br>On 8/8/14, at 8:10 a.m. during observation of the 2 North medication room a Novolog Flexpen (used to treat diabetes) was noted for R15. The Novolog Flexpen had an open date of 6/26/14, and an expiration date of 7/24/14, written on it. Registered nurse (RN)-C verified the findings.<br><br>During observation of the 2 South medication room on 8/8/14, at 8:23 a.m. a pre-filled Heparin (used to thin blood) syringe had an expiration date of April 2014 for R43 and a Ventolin inhaler for R52 were observed in the room. Licensed practical nurse (LPN)- A verified the findings.<br><br>During observation of the 2 South medication cart on 8/8/14, at 8:32 a.m. two open multi-use vials of insulin were observed for R198. A vial of Humalog (used to treat diabetes) was dated as opened on 7/10/14, with a noted expiration date of 8/7/14. A vial of Levemir (used to treat diabetes) was dated as opened on 7/9/14, with a noted expiration date of 8/6/14. LPN-A verified the findings.<br><br>On 8/8/14, at 10:02 a.m. the pharmacy consultant stated she would not expect opened insulin to be put back in the refrigerator and expected expired | F 431 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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| F 431 | Continued From page 15<br>medications to be disposed of immediately.<br><br>The director of nursing was interviewed on 8/8/14, at 10:30 a.m. and stated she expected expired medications to be removed from storage areas immediately and the night shift was to check the medication storage areas nightly.<br><br>The facility Storage of Medications policy dated 05/12, directed, "Outdated, contaminated, or deteriorated medications...are immediately removed from inventory, disposed of according to procedures for medication disposal."<br><br>The NOC (night) SHIFT WEEKLY DUTIES form (undated) directed on Sunday to check the medication room refrigerator for expired medications and on Tuesday to check the medication and treatment cart for expired medications. | F 431 | | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R164) had a call light maintained in proper functioning order.<br><br>Findings include: | F 463 | F 463<br>a. The call light cord for R164 was replaced at the time of the survey.<br>b. All call lights are inspected for proper functioning order by the Maintenance Director.<br>c. All staff educated on how to report needed call light repairs.<br>d. ED or designee will audit 7 rooms weekly for call lights in proper functioning order. Audit results will be reviewed at monthly QAPI meeting and the frequency of audits will be changed depending on the results of the audits.<br>e. Completion Date: September 17, 2014 | |

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| | 245148 | A. BUILDING ______ B. WING ______ | C 08/08/2014 |

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| **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA** | **3201 VIRGINIA AVENUE SOUTH** **SAINT LOUIS PARK, MN 55426** |

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| F 463 | Continued From page 16<br>On 8/5/14, at 9:02 a.m. during R164's room observation, the call light at the bedside was observed to not be working when activated. The call light was observed to not light up outside the room. When the button of the call light was pushed, it clicked and did not push evenly. During the observation, the director of the dementia unit verified the finding and stated, "I will call maintenance." As she mentioned the maintenance director's name she further indicated, "We will take care of it right now."<br>During the environmental tour on 8/8/14, at approximately 12:30 p.m. the maintenance supervisor stated another staff in his department had fixed the call light. When asked if call light functioning audits were completed he stated "Yes" and further stated each time a call light had been noted as not working, his department would be notified through a work order and the staff would come immediately to fix it.<br><br>The fall care plan dated 8/19/11, identified R164 at risk for falls and had directed, "Keep hallways and rooms free of clutter and well lit; keep call light within reach while in room."<br>Undated Call Light, Use of policy directed, "To assure call system is in proper working order." In addition the policy directed, "Notify the maintenance department and enter defective call light location(s) in the maintenance log, if the facility has such a log." The policy lacked information on who was responsible to oversee if resident call lights were in proper function and how often they were monitored/audited to ensure proper function. | F 463 | | |

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

F5148022

PRINTED: 08/25/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245148 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 08/05/2014 |

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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH<br>SAINT LOUIS PARK, MN 55426 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter St. Louis Park 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>444 Cedar St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to: | K 000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>PoC ok<br>w/ TW for K103<br>PS 9-15-14<br><br> <br>RECEIVED<br>SEP 11 2014<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

Exit: 8-8-14   Dc: 9-17-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]   TITLE: Executive Director   (X6) DATE: 9-10-2014

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 |
|---|---|---|---|
| | 245148 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 08/05/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA | 3201 VIRGINIA AVENUE SOUTH<br>SAINT LOUIS PARK, MN 55426 |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Golden Livingcenter St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building.<br><br>The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 208 beds and had a census of 188 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 072 | NFPA 101 LIFE SAFETY CODE STANDARD | K 072 | | |

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|---|---|---|---|
| | 245148 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **08/05/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA** | **3201 VIRGINIA AVENUE SOUTH**<br>**SAINT LOUIS PARK, MN 55426** |

| (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 072<br>SS=E | Continued From page 2<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:30 PM on 08/05/2014, observation revealed that there is wheeled storage in several of the resident corridors. The facility does not have a categorical waiver for wheeled storage.<br><br>This deficient practice was verified by the Maintenance Director at the time of the inspection. | K 072 | K 072<br><br>The facility has reviewed the criteria for available categorical waiver for Capacity of Means of Egress which allows for wheeled equipment to be in access corridors for means of egress.<br><br>The facility meets the criteria and elects to use this categorical waiver as the PoC for this cited deficiency for Capacity of Means of Egress which allows for wheeled equipment to be in access corridors for means of egress. | 9-10-2014 |
| K 103<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 | K 103 | K 103<br>refer to attached temporary waiver requested for K 103 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245148 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | 08/05/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOLDEN LIVINGCENTER - ST LOUIS PARK PLAZA** | **3201 VIRGINIA AVENUE SOUTH**<br>**SAINT LOUIS PARK, MN 55426** |

| (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 103 | Continued From page 3<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility has combustible construction materials in the interior walls and partitions not in accordance with Life Safety Code Section 19.1.6.3. This deficient practice could affect some residents.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:30 PM on 08/05/2014, observation revealed that there are wood stud interior walls in room 387 and the main corridor wall near the first floor entrance and the Director of Nursing office.<br><br>This deficient practice was verified by the Maintenance Director at the time of the inspection. | K 103 | | |

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 4646

August 25, 2014

Mr. Timothy Johnson, Administrator
Golden LivingCenter - St Louis Park Plaza
3201 Virginia Avenue South
Saint Louis Park, Minnesota 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5148023 and Complaint Numbers H5148142, H5148143, H5148144, and H5148145

Dear Mr. Johnson:

The above facility was surveyed on August 4, 2014 through August 8, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5148142, H5148143, H5148144, and H5148145 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File