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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QQJ5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245306**

2. STATE VENDOR OR MEDICAID NO. (L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **02/06/2017** (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 **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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):

Documentation supporting the facility's request for a continuing waiver involving LSC K521 has been recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 03/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/27/2017 (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 **01/01/1986** (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) **00**
VOLUNTARY
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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245306

March 23, 2017

Ms. Tianna Bagley, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

Dear Ms. Bagley:

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 January 31, 2017 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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 this deficiency 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,

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 23, 2017

Ms. Tianna Bagley, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306027

Dear Ms. Bagley:

On January 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 22, 2016. 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 February 6, 2017, 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 December 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 22, 2016, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 6, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the December 22, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245306		2/6/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242 Reg. # 483.10(f)(1)-(3) LSC	Correction Completed 01/31/2017	ID Prefix F0329 Reg. # 483.45(d)(e)(1)-(2) LSC	Correction Completed 01/31/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/31/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 3/23/2017	SIGNATURE OF SURVEYOR 10160	DATE 2/6/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QQJ5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00941

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245306**

2. STATE VENDOR OR MEDICAID NO. (L2) **307113800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER WEST**
(L4) **2215 HIGHWAY 52 NORTH**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **12/22/2016** (L34)

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**	

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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):

Documentation supporting the facility's request for a continuing waiver involving LSC K521 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE — Date :
Christina Smith, HFE NE II — 01/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 01/31/2017 (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 **01/01/1986** (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) **00**

VOLUNTARY
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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 6, 2017

Ms. Tianna Bechly, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

RE: Project Number S5306027 and Complaint Number H5306035

Dear Ms. Bechly:

On December 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5306035 that was found to be unsubstantiated.

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

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

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 January 31, 2017, 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 January 31, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 22, 2017 (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 June 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and a complaint investigation were also completed at the time of the standard survey." An investigation of complaint H5306035 was completed and found not to be substantiated.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 242		1/31/17

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

Electronically Signed | 01/16/2017

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
	245306	A. BUILDING _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(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 242	Continued From page 1 facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate preferences for bathing for 1 of 3 residents (R20) reviewed for choices. Findings include: R20's family member (FM)-A had been interviewed on 12/19/16, at 2:59 p.m. concerning bathing preferences. FM-A answered, she was concerned the facility was not bathing R20 two times a week per the bathing schedule. FM-A stated she was concerned the facility was not using hair shampoo, as she had not needed to replace the shampoo for a very long time. R20's care conference progress note dated 12/6/16, included, "Care conference was held with residents [sic] spouse, as resident chose to not participate...Residents spouse stated his shampoo has not been getting used, staff stated that resident has refused showers on occasion. DNS [director of nursing services] stated that she added a shower on Sunday during the day shift, to try an accommodate [R20's] shower schedule. Residents spouse did not state any other concerns. SS [social services] will remain available and assist as needed." R20's Bathing Type Detail Report revealed from 10/21/16 to 12/19/16, R20 had showers on the following days: 10/27/16 11/3/16 11/10/16 11/17/16	F 242	F242 It is the policy of Golden Living Rochester West that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care, interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. Resident R20 has two showers scheduled weekly per their request/choice. Resident will be interviewed and assessed for bathing preferences including time of day and frequency of bathing. Care plans and bathing schedule will be updated to match these preferences. All staff will be educated on the meaning of F242 and the importance of following resident preference and choices. The DNS or designee will conduct weekly audits for four weeks and then monthly for six months to ensure compliance and that bathing is being completed per the plan of care and bathing schedule. Results of the audits will be reported at the QAPI meeting. The QAPI Committee will provide direction or change when necessary and will dictate the continuation	

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	245306	A. BUILDING _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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F 242	Continued From page 2 12/1/16 12/8/16 R20 was scheduled on the Rochester West Bath Schedule to receive two baths a week, one on Thursday during the evening shift and another on Sunday during the day shift. R20's progress notes were reviewed from 10/8/16 to 12/17/16, there was no documentation to indicate R20 refused bathing. R20's care plan did not include required assistance with bathing, bathing preference or frequency. On 12/21/16, at 10:01 a.m. nursing assistant (NA)-B stated R20 gets a bath once a week, on Thursday in the evening. NA-B stated R20 used to be scheduled two times a week for a shower, but refused at times. NA-B stated at this time R20 was scheduled to receive a bath once a week. On 12/21/16, at 10:35 a.m. nursing assistant (NA)-A stated R20 had a shower once a week. NA-A stated evening staff provided R20 his showers. On 12/21/16, at 2:58 p.m. the director of nursing (DON) stated R20 refused showers a lot. The DON stated she reviewed R20's documentation and verified there was no documentation to support R20 refused bathing services. The DON stated staff should document if R20 refused to shower. The DON stated following the care conference held on 12/6/16, R20 was scheduled to receive two baths a week and the bathing schedule was changed to reflect this. The DON verified per the documentation on R20's Bathing	F 242	or completion of this monitoring process based on the compliance noted for audits. DNS or designee is responsible for monitoring compliance.	

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F 242	Continued From page 3 Type Detail Report R20 had only received two showers starting December 1, to the 22, 2016, one on 12/1/16 and the second one on 12/8/16 in the month of December 2016. The DON stated there should have been follow-up on the concern to ensure bathing was being completed two times a week. On 12/22/16, at 9:30 a.m. the administrator stated she was unaware of the concern related to R20's bathing. The administrator stated she would have expected staff to follow-up to see if the two baths were being completed per the bath schedule, as this was the intervention implemented to addresses FM-A's concern with bathing. The administrator stated if follow-up was completed the facility would have been able to address the concern that two baths were not being completed and a grievance would have been implemented to ensure FM-A's concern with bathing was addressed.	F 242		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		1/31/17

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F 329	Continued From page 4 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to ensure non-pharmacological interventions were attempted and documented before medication was used as well as specific symptoms identified for anxiety and antipsychotic medications were administered for 2 of 5 residents (R11 and R5) who were reviewed for unnecessary medications. Findings include: R11's diagnosis found on the Admission Record dated 9/6/13 and 8/22/08, identifies other specified anxiety disorders and Major Depressive disorder. R11's orders found on the Order Summary Report dated 11/10/16, include Ativan 0.5 mg give one tablet by mouth every eight hours as needed for Anxiety related to other specified Anxiety Disorders. Targeted behaviors of restlessness, fidgeting, and repetitive questions/concerns. Document non-pharmacological interventions attempted prior to administration. R11's Medication Administration Record for the month of November 2016, identifies R11 received as needed (PRN) Ativan on 17 different occasions. The month of December 2016, identifies PRN Ativan was administered on 15 different occasions. Reviewed electronic medication administration record progress notes from November 2016, and December. The month of November non pharmacological interventions were not	F 329	F329 For residents R5 and R11, non-pharmalogical interventions will be identified and documented prior to the administration of "as needed" PRN medication. Residents who receive "as needed" medications and/or psychoactive medications could be affected. Licensed nursing staff will be educated that non-pharmalogical interventions must be attempted prior to the administration of a PRN medication and documented in the clinical record. Weekly audits for four weeks and then monthly audits for 6 months of PRN medication administration will be conducted to ensure non-pharmalogical interventions are documented prior to the administration of the medication. Results of the audits will be reported at the QAPI meeting. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from	

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F 329	Continued From page 5 documented as well as specific symptoms for reason for administration on 14 out of the 17 occasions. The month of December 2016, non-pharmacological interventions were not documented as well as specific symptoms for reason for administration on 15 out of 15 occasions. Documentation identifies reason for administration was often, "per request [not a valid reason to give]," "complaints of anxiety [lack of specific symptom/signs of what "anxiety" is for R11] and "anxiety due to having pain [again lack of what "anxiety" was for resident]." R5's diagnosis found on the Admission Record dated 1/26/16, identifies major depressive disorder recurrent and unspecified anxiety disorder. R5's orders found on the Order Summary Report dated 7/5/16, Ativan 0.5 mg give every eight hours as needed for muscle spasms/tremors related to anxiety disorder unspecified. Order dated 7/20/16, Seroquel (antipsychotic medication used out of class) 50 mg every one hour as needed for agitation and anxiety total of two doses in 24 hours; may give repeat dose one hour after previous PRN dose if unable to sleep. R5's Medication Administration Record for the month of November 2016, identifies R5 received PRN Ativan on nine different occasions and PRN Seroquel on seven different occasions. The month of December 2016, identifies R5 received PRN Ativan on 14 different occasions and PRN Seroquel on two occasions. Reviewed progress notes from November and December 2016. The month of November non-pharmacological interventions were not documented as well as identifying specific resident centered anxiety symptoms for reason for administration of Ativan on 6 out of the 9 occasions and 7 out of 7 occasions for Seroquel.	F 329	audits. DNS or designee is responsible for monitoring compliance.	

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F 329	Continued From page 6 The month of December non-pharmacological interventions were not documented as well as specific symptoms for reason for administration of Ativan 7 out of 14 occasions and 2 out of 2 occasions for Seroquel. Documentation identifies reason for administration of Ativan as, "per request [not a valid symptom]" and reason for Seroquel as, "unable to sleep." Interview on 12/21/16, at 9:52 a.m. with registered nurse (RN)-B stated when documenting PRN medications the specific symptoms the resident is experiencing and at least two non-pharmacological interventions should be documented before each PRN medication is administered. Interview on 12/21/16, at 10:26 a.m. with director of nursing (DON) stated all PRN medication should have non-pharmacological interventions documented before the medication is administered. DON stated if a resident is refusing non-pharmacological interventions then the nurse should be documenting the refusals as well. Policy titled, Administration Procedures for all Medications dated 6/15, identifies, when administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record effectiveness. Policy does not identify the use of non-pharmacological interventions prior to the administration of PRN medications.	F 329		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		1/31/17

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F 441	Continued From page 7 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 441		

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F 441	Continued From page 8 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to ensure glucometer meter was properly cleaned and disinfected between multi-resident use for 2 of 11 residents (R40 and R92) who utilized the glucometer for testing routine blood glucose readings. Findings include: R40 had been observed to have a blood glucose check on 12/19/16, at 12:25 p.m. by registered nurse (RN)-B. RN-B after completing blood glucose check cleaned the glucometer with a bleach wipe. RN-B stated the glucometers are cleaned for 30 seconds and all the glucometers are used for more than one resident use R92 had been observed to have a blood glucose check on 12/19/16, at 7:10 p.m. with RN-A. RN-A after completing blood glucose check removed a Clorox wipe from a bag and wiped the exterior	F 441	F441 Residents receiving blood sugar monitoring using the glucometer have the potential to be affected. Licensed nursing staff will received training and a competency will be completed on the cleaning of disinfecting of glucometers to reduce the spread of infections. DNS or designee will visually complete weekly random audits of glucometer cleaning and disinfecting. Results of the audits will be reported at the QAPI meeting. The QAPI Committee	

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F 441	Continued From page 9 surface of the glucometer for 30 seconds. RN-A then placed the glucometer back in to the community basket. RN-A stated glucometers are shared for all residents in the building who require blood glucose checks. RN-A stated facility protocol was to clean the glucometer with the Clorox wipe for 30 seconds. Interview on 12/22/16, at 7:15 a.m. with director of nursing (DON) stated glucometer should be disinfected between each resident use. DON stated the glucometer should be wiped off with a Clorox wipe then wrapped in the wipe and then placed in a baggie for one minute. DON stated nursing staff had received training on how to properly disinfect the glucometer in either February or March of this year. DON was asked to provide training documentation. DON provided training documents. Training provided to staff on 6/17/15, titled, "Glucometer Disinfection", identifies RN-B having attended the training. The other staff, RN-A had not attend the training offered. The training provided included, "Glucometers-after each resident you must wipe them down with bleach wipes, wrap in wipe and place in plastic bag for one minute." Interview on 12/22/16, at 9:25 a.m. with DON stated if staff don't attend the training then spot corrections are completed for those individual staff but aren't documented anywhere. DON stated all staff should receive their annual competencies and the expectation is for new hires to have competencies completed upon hire. Facility provided the manufacturer's guidelines for the Clorox Bleach wipes that are used for disinfecting the glucometers. According to guidelines to disinfect, "allow surface to remain wet for 30 seconds. To kill viruses, allow surface to remain wet for 1 minute." Policy titled, Blood Glucose Monitor	F 441	will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS or designee is responsible for monitoring compliance.	

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F 441	Continued From page 10 Decontamination dated 4/29/16, identifies the blood glucose monitor will be cleaned and disinfected with wipes following use for each resident. Policy identifies after completing a glucose test, the nurse will use a disposable wipe to clean all external parts of the monitor, will continue to leave monitor damp for maximal kill time indicated on product label.	F 441		

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	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/20/2016**

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Golden Living Center) 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/16/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. (Golden Living Center) is a 1-story building with a partial basement. The original building was constructed in 1961 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		1/31/17

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K 521	Continued From page 2 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Findings Include: On facility tour between 09:00 AM and 12:00 PM on December 20, 2016, based on documentation review and interview that the following include: Observation revealed, that the ventilation system utilizes the egress corridor as the supply air for the resident rooms. Date of building construction is 1961. There was no balance report available. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	K0521 Waiver requested January 16, 2017.	

Name of Facility

Golden Living Rochester West - 2215 Hwy 52 North, Rochester, MN 55901 - (507) 288-1818

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
K52.1 HVAC system shall comply with section 9.2 and NFPA 90A	A waiver is requested for the following reasons: 1. There are no adverse effects on the health or safety of residents or staff a. The building is equipped with an approved full-corridor smoke detection system b. The facility is fully protected by an automatic sprinkler system c. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building's fire alarm and/or sprinkler systems d. Annual service and maintenance contracts are in place to ensure proper service of all the facility's fire protection systems (fire alarm, sprinkler system, portable extinguishers) e. The building's fire alarm system is monitored to provide automatic notification to the fire department f. Fire safety training is provided for all new hires during orientation and for all employees annually g. Fire drills are conducted at least quarterly on each shift 2. Compliance with this provision would impose an unreasonable hardship on the facility: a. Compliance would cost an estimated $126,200 to upgrade the facility's HVAC system to comply with NFPA 90a b. The required work would be a hardship as residents would need to be relocated and the associated dust from this work could lead to infection control issues.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 01-20-2017

HiMEC
MECHANICAL

1400 7th Street NW
Rochester, MN 55901
Phone: (507) 288-7713
Fax: (507) 281-5206
www.himec.com

April 15, 2014

Golden Living Center
West 2215 HWY 52 N
Rochester, MN 55901

RE: Ducting Both Wings

- Fabricate all Return air ducting for both north and south wing
- Take down ceiling after hours and reinstall after work has been completed
- Provide and install all return air duct in hallway
- Provide and install return air for each room
- Provide and install supply air registers to the middle of each room
- Test and balance both rooftops/duct work and provide a copy to the owner and city as required
- Provide and install fire smoke dampers in each wall for supply and return
- Install balancing dampers in each run
- Provide moving of all pipes and electrical in the way above the ceiling
- Provide and install a fire rated wall in each corridor above the ceiling and all the way up to the deck with 5/8 gyp board and all fire caulking. This needs to be done through both wings above the ceiling
- Provide coned off work areas everyday with plastic enclosures
- Labor/Materials
- Start-up
- Permit
- Test and balance
- Engineered cost for plans are included in this price

Total.....$126,200.00

Please let me know if I can be of further assistance to you, or should you have any questions regarding this, please feel free to contact me at (507) 288-7713.

Sincerely,

Bryce Beckel
Project Manager Service Division

Acceptance_____ Date:_____

Proposal Guaranteed For 30 Days

Leadership through innovative and responsible solutions.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 6, 2017

Ms. Tianna Bechly, Administrator
Golden LivingCenter - Rochester West
2215 Highway 52 North
Rochester, MN 55901

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5306027 and Complaint Number H5306035

Dear Ms. Bechly:

The above facility was surveyed on December 19, 2016 through December 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5306035 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation 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 only a suggestion 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00941	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 19, 20, 21, 22, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. "In addition, complaint investigation were also completed at the time of the licensing survey." An investigation of complaint H5306035 was completed. The complaint was not substantiated.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, facility failed to ensure glucometer meter was properly cleaned and disinfected between multi-resident use for 2 of 11 residents (R40 and R92) who utilized the glucometer for testing routine blood glucose readings. Findings include: R40 had been observed to have a blood glucose check on 12/19/16, at 12:25 p.m. by registered nurse (RN)-B. RN-B after completing blood glucose check cleaned the glucometer with a bleach wipe. RN-B stated the glucometers are cleaned for 30 seconds and all the glucometers are used for more than one resident use R92 had been observed to have a blood glucose check on 12/19/16, at 7:10 p.m. with RN-A. RN-A	21375	Residents receiving blood sugar monitoring using the glucometer have the potential to be affected. Licensed nursing staff will received training and a competency will be completed on the cleaning of disinfecting of glucometers to reduce the spread of infections. DNS or designee will visually complete weekly random audits of glucometer cleaning and disinfecting. Results of the audits will be reported at the QAPI meeting. The QAPI Committee will	1/31/17

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21375	Continued From page 3 after completing blood glucose check removed a Clorox wipe from a bag and wiped the exterior surface of the glucometer for 30 seconds. RN-A then placed the glucometer back in to the community basket. RN-A stated glucometers are shared for all residents in the building who require blood glucose checks. RN-A stated facility protocol was to clean the glucometer with the Clorox wipe for 30 seconds. Interview on 12/22/16, at 7:15 a.m. with director of nursing (DON) stated glucometer should be disinfected between each resident use. DON stated the glucometer should be wiped off with a Clorox wipe then wrapped in the wipe and then placed in a baggie for one minute. DON stated nursing staff had received training on how to properly disinfect the glucometer in either February or March of this year. DON was asked to provide training documentation. DON provided training documents. Training provided to staff on 6/17/15, titled, "Glucometer Disinfection", identifies RN-B having attended the training. The other staff, RN-A had not attend the training offered. The training provided included, "Glucometers-after each resident you must wipe them down with bleach wipes, wrap in wipe and place in plastic bag for one minute." Interview on 12/22/16, at 9:25 a.m. with DON stated if staff don't attend the training then spot corrections are completed for those individual staff but aren't documented anywhere. DON stated all staff should receive their annual competencies and the expectation is for new hires to have competencies completed upon hire. Facility provided the manufacturer's guidelines for the Clorox Bleach wipes that are used for disinfecting the glucometers. According to guidelines to disinfect, "allow surface to remain wet for 30 seconds. To kill viruses, allow surface to remain wet for 1 minute."	21375	provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted from audits. DNS or designee is responsible for monitoring compliance.	

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21375	Continued From page 4 Policy titled, Blood Glucose Monitor Decontamination dated 4/29/16, identifies the blood glucose monitor will be cleaned and disinfected with wipes following use for each resident. Policy identifies after completing a glucose test, the nurse will use a disposable wipe to clean all external parts of the monitor, will continue to leave monitor damp for maximal kill time indicated on product label. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designated infection control officer could in-service all staff responsible for patient care equipment especially the multi-resident use glucometer to fully follow the the manufacturers directions to kill blood bourne disease. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	21535		1/31/17

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21535	Continued From page 5 Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, facility failed to ensure non-pharmacological interventions were attempted and documented before medication was used as well as specific symptoms identified for anxiety and antipsychotic medications were administered for 2 of 5 residents (R11 and R5) who were reviewed for unnecessary medications. Findings include: R11's diagnosis found on the Admission Record dated 9/6/13 and 8/22/08, identifies other specified anxiety disorders and Major Depressive disorder. R11's orders found on the Order Summary Report dated 11/10/16, include Ativan 0.5 mg give one tablet by mouth every eight hours as needed for Anxiety related to other specified Anxiety Disorders. Targeted behaviors of restlessness, fidgeting, and repetitive questions/concerns. Document non-pharmacological interventions attempted prior to administration. R11's Medication Administration Record for the month of November 2016, identifies R11 received as needed (PRN) Ativan on 17 different occasions. The month of December 2016, identifies PRN Ativan was administered on 15 different occasions. Reviewed electronic medication administration	21535	For residents R5 and R11, non-pharmalogical interventions will be identified and documented prior to the administration of "as needed" PRN medication. Residents who receive "as needed" medications and/or psychoactive medications could be affected. Licensed nursing staff will be educated that non-pharmalogical interventions must be attempted prior to the administration of a PRN medication and documented in the clinical record. Weekly audits for four weeks and then monthly audits for 6 months of PRN medication administration will be conducted to ensure non-pharmalogical interventions are documented prior to the administration of the medication. Results of the audits will be reported at the QAPI meeting. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process	

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21535	Continued From page 6 record progress notes from November 2016, and December. The month of November non pharmacological interventions were not documented as well as specific symptoms for reason for administration on 14 out of the 17 occasions. The month of December 2016, non-pharmacological interventions were not documented as well as specific symptoms for reason for administration on 15 out of 15 occasions. Documentation identifies reason for administration was often, "per request [not a valid reason to give]," "complaints of anxiety [lack of specific symptom/signs of what "anxiety" is for R11] and "anxiety due to having pain [again lack of what "anxiety" was for resident]." R5's diagnosis found on the Admission Record dated 1/26/16, identifies major depressive disorder recurrent and unspecified anxiety disorder. R5's orders found on the Order Summary Report dated 7/5/16, Ativan 0.5 mg give every eight hours as needed for muscle spasms/tremors related to anxiety disorder unspecified. Order dated 7/20/16, Seroquel (antipsychotic medication used out of class) 50 mg every one hour as needed for agitation and anxiety total of two doses in 24 hours; may give repeat dose one hour after previous PRN dose if unable to sleep. R5's Medication Administration Record for the month of November 2016, identifies R5 received PRN Ativan on nine different occasions and PRN Seroquel on seven different occasions. The month of December 2016, identifies R5 received PRN Ativan on 14 different occasions and PRN Seroquel on two occasions. Reviewed progress notes from November and December 2016. The month of November non-pharmacological interventions were not documented as well as identifying specific resident centered anxiety symptoms for reason	21535	based on the compliance noted from audits. DNS or designee is responsible for monitoring compliance.	

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21535	Continued From page 7 for administration of Ativan on 6 out of the 9 occasions and 7 out of 7 occasions for Seroquel. The month of December non-pharmacological interventions were not documented as well as specific symptoms for reason for administration of Ativan 7 out of 14 occasions and 2 out of 2 occasions for Seroquel. Documentation identifies reason for administration of Ativan as, "per request [not a valid symptom]" and reason for Seroquel as, "unable to sleep." Interview on 12/21/16, at 9:52 a.m. with registered nurse (RN)-B stated when documenting PRN medications the specific symptoms the resident is experiencing and at least two non-pharmacological interventions should be documented before each PRN medication is administered. Interview on 12/21/16, at 10:26 a.m. with director of nursing (DON) stated all PRN medication should have non-pharmacological interventions documented before the medication is administered. DON stated if a resident is refusing non-pharmacological interventions then the nurse should be documenting the refusals as well. Policy titled, Administration Procedures for all Medications dated 6/15, identifies, when administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record effectiveness. Policy does not identify the use of non-pharmacological interventions prior to the administration of PRN medications. SUGGESTED METHOD OF CORRECTION: The pharmacist could in-service staff responsible for psychoactive and psychotropic medication as to the need to identify resident centered target behaviors/medical symptoms and the use of nonpharmacological interventions to be attempted before as needed medications are	21535		

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21535	Continued From page 8 uses. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable	21830		1/31/17

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21830	Continued From page 9	21830		

efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and

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	00941	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(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) COMPLETE DATE
21830	Continued From page 10 the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate preferences for bathing for 1 of 3 residents (R20) reviewed for choices. Findings include: R20's family member (FM)-A had been interviewed on 12/19/16, at 2:59 p.m. concerning bathing preferences. FM-A answered, she was concerned the facility was not bathing R20 two times a week per the bathing schedule. FM-A stated she was concerned the facility was not using hair shampoo, as she had not needed to replace the shampoo for a very long time. R20's care conference progress note dated 12/6/16, included, "Care conference was held with residents [sic] spouse, as resident chose to not participate...Residents spouse stated his shampoo has not been getting used, staff stated that resident has refused showers on occasion.	21830	It is the policy of Golden Living Rochester West that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care, interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. Resident R20 has two showers scheduled weekly per their request/choice. Resident will be interviewed and assessed for bathing preferences including time of day and frequency of bathing. Care plans and bathing schedule will be updated to match these preferences. All staff will be educated on the meaning of F242 and the importance of following	

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21830	Continued From page 11 DNS [director of nursing services] stated that she added a shower on Sunday during the day shift, to try an accommodate [R20's] shower schedule. Residents spouse did not state any other concerns. SS [social services] will remain available and assist as needed." R20's Bathing Type Detail Report revealed from 10/21/16 to 12/19/16, R20 had showers on the following days: 10/27/16 11/3/16 11/10/16 11/17/16 12/1/16 12/8/16 R20 was scheduled on the Rochester West Bath Schedule to receive two baths a week, one on Thursday during the evening shift and another on Sunday during the day shift. R20's progress notes were reviewed from 10/8/16 to 12/17/16, there was no documentation to indicate R20 refused bathing. R20's care plan did not include required assistance with bathing, bathing preference or frequency. On 12/21/16, at 10:01 a.m. nursing assistant (NA)-B stated R20 gets a bath once a week, on Thursday in the evening. NA-B stated R20 used to be scheduled two times a week for a shower, but refused at times. NA-B stated at this time R20 was scheduled to receive a bath once a week. On 12/21/16, at 10:35 a.m. nursing assistant (NA)-A stated R20 had a shower once a week. NA-A stated evening staff provided R20 his	21830	resident preference and choices. The DNS or designee will conduct weekly audits for four weeks and then monthly for six months to ensure compliance and that bathing is being completed per the plan of care and bathing schedule. Results of the audits will be reported at the QAPI meeting. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted for audits. DNS or designee is responsible for monitoring compliance.	

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21830	Continued From page 12 showers. On 12/21/16, at 2:58 p.m. the director of nursing (DON) stated R20 refused showers a lot. The DON stated she reviewed R20's documentation and verified there was no documentation to support R20 refused bathing services. The DON stated staff should document if R20 refused to shower. The DON stated following the care conference held on 12/6/16, R20 was scheduled to receive two baths a week and the bathing schedule was changed to reflect this. The DON verified per the documentation on R20's Bathing Type Detail Report R20 had only received two showers starting December 1, to the 22, 2016, one on 12/1/16 and the second one on 12/8/16 in the month of December 2016. The DON stated there should have been follow-up on the concern to ensure bathing was being completed two times a week. On 12/22/16, at 9:30 a.m. the administrator stated she was unaware of the concern related to R20's bathing. The administrator stated she would have expected staff to follow-up to see if the two baths were being completed per the bath schedule, as this was the intervention implemented to addresses FM-A's concern with bathing. The administrator stated if follow-up was completed the facility would have been able to address the concern that two baths were not being completed and a grievance would have been implemented to ensure FM-A's concern with bathing was addressed. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise polices and procedures concerning bathing preferences in the facility, educate staff, and audit staff compliance.	21830		

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21830	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		