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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTQ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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)

6. DATE OF SURVEY **04/02/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Edith Hasskamp - HFE-NEII 04/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 04/17/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5298
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 15, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On April 2, 2012, the Minnesota Department of Health completed a Post Certification Revisit and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on February 15, 2012, effective March 23, 2012. Therefore, the remedies outlined in our letter dated February 24, 2012 will not be imposed. See attached CMS-2567B for the results of the April 2, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5298

April 10, 2012

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

Dear Mr. Gershone:

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

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

Effective March 23, 2012 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2012

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

RE: Project Number S5298023

Dear Mr. Gershone:

On February 24, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 2, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2012, effective March 23, 2012 and therefore remedies outlined in our letter to you dated February 24, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5298R12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245298	A. Building B. Wing	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/23/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/23/2012**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/23/2012**
ID Prefix **F0458** Reg. # **483.70(d)(1)(ii)** LSC	Correction Completed **03/23/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PH/NCS	**Date:** 4/10/12	**Signature of Surveyor:** 12831	**Date:** 4/2/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/15/2012

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2012

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

Re: Enclosed Reinspection Results - Project Number S5298023

Dear Mr. Gershone:

On April 2, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 15, 2012, with orders received by you on February 29, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

S5298023

AH Form Approved
4/10/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00866	A. Building B. Wing	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20540 Reg. # MN Rule 4658.0400 Subp. LSC	Correction Completed 03/23/2012	ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. : LSC	Correction Completed 03/23/2012	ID Prefix 20915 Reg. # MN Rule 4658.0525 Subp. (LSC	Correction Completed 03/23/2012
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PH/NCS	Date: 4/10/12	Signature of Surveyor: 12831	Date: 4/2/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/15/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTQ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - TWIN RIVERS**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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)

6. DATE OF SURVEY **02/15/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds **56** (L17)

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

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	IMR
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE-NEII 03/13/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/04/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 4/5/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5298
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 15, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0428

February 24, 2012

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

RE: Project Number S5298023

Dear Mr. Gershone:

On February 15, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 26, 2012, 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 May 15, 2012 (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 August 15, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5298S12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	305 FREMONT STREET ANOKA, MN 55303

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	Golden Living Center Twin Rivers objects to the allegations of non-compliance in this Statement of Deficiency with both the findings of non-compliance and the level of deficiency cited. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the administrator of any employees, agents or other individuals who draft or may be discussed in this Response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, GLC Twin Rivers has prepared and submitted this Plan of Correction solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten days of the survey as a Condition of Participation in Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the facility.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	3-13-12 JPM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director — TITLE — (X6) DATE: 3-6-12

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 272	Continued From page 1 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility did not provide comprehensive assessment of range of motion services for 1 of 1 residents (R38) reviewed for range of motion. Findings included: R38's diagnoses included Parkinson's disease and contracture of the right hand. The annual Minimum Data Set (MDS) dated 1/17/2012, indicated R38 was moderately cognitive impaired and required the extensive assistance of one to two staff for all activities of daily living (ADL's). The MDS identified R38 had functional limitation in range of motion of both upper extremities. The MDS indicated R38 was not on a restorative nursing program, not provided ROM services and did not have a splint	F 272	F 272 It is the Policy of Golden Living Center Twin Rivers that each resident has the right to be assessed for range of motion services. To assure continued compliance the following plan has been implemented. Resident # 38 is presently on Occupational Therapy case load. Therapy is working on appropriate range of motion and splinting program for R wrist and hand. New admissions will be screened by Physical and occupational therapy for range of motion needs. Other residents range of motion needs will be screened by Occupational and Physical Therapy quarterly. Licensed nurses will address functional range of motion at time of admission and quarterly. Clinical health status section C will be completed on admission Interdisciplinary resident review section H will be completed quarterly. Licensed nurses will be in-serviced on completion of section C and H on nursing forms. Occupational and physical therapy staff will be in-serviced on screening for functional deficits.	

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F 272	Continued From page 2 or brace. The ADL functional and rehabilitation needs Care Area Assessment (CAA) dated 1/20/2012, indicated R38 was at risk to maintain current level of functioning. There was no evidence of assessment to determine if restorative ROM was appropriate. The Occupational Therapist (OT) Progress Report dated 8/19/11, indicated active assistant (AA)ROM to the right wrist extension was at -20 degrees. (The lower the number the greater the muscle contraction). Following skilled OT services for ROM, the OT Progress Report dated 9/16/11, indicated the right wrist extension improved to -40 degrees. The OT Progress Report and Discharge Summary dated 10/05/11, indicated that ROM goals for the right upper extremity/wrist had been met with right wrist extension at -50 degrees. OT services were discontinued on 10/05/2011. The MDS nurse, interviewed by phone on 2/17/2012, at 11:40 a.m., stated there was no annual assessment of R38's maintenance ROM needs. The MDS nurse verified the MDS identified the functional limitation of right wrist ROM.	F 272	The DNS or designee will conduct weekly audits to assure continued compliance. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/23/12	3/23/12
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311	F 311 It is the Policy of Golden Living Center Twin Rivers that each resident will receive appropriate treatment and services to maintain or improve his or her abilities. To assure continued compliance the following plan has been implemented: Resident # 60 was evaluated by physical therapy for independent walking program. He was determined to be independent with ambulation and discharged from therapy. Nurses will complete section C for daily activities on clinical health status form at time of admission. Nurses will complete section H - balance during transitions and walking on interdisciplinary resident review form quarterly.	

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F 311	Continued From page 3 by: Based on interview and documentation review the facility did not provide ambulation assistance for 1 of 1 residents (R60) in the sample reviewed for ambulation services. Findings include: R60, interviewed on 2/12/2012 at 6:58 p.m., stated that he was suppose to walk twice a day but it was not happening. R60's diagnosis included depression, anemia, congestive heart failure, and COPD. The quarterly Minimum Data Set (MDS) dated 1/03/12, indicated R60 had good short and long term memory, was cognitively intact and had no behaviors. The nursing assistant (NA) work sheet used on 2/15/12, indicated R60 was on an ambulation program. The schedule sheet for February indicated R60 was to be ambulated 50 to 100 feet, two times a day. The care conference summary dated 1/6/12 indicated R60 would walk with staff and use the exercise bike. The Comprehensive Narrative Summary dated 1/3/12, indicated R60's short and long term memory were ok and indicates he ambulated with limited assist of one staff. Review of the walking schedule, from February 1 - 13, 2012, with the nurse manager (NM-A) indicated that R60 was to walk twice a day with assistance. The schedule indicated that R60 did not walk at all in February, with 11 refusals out of 24 opportunities. The schedule indicated he stated he was busy one time and there was no documented explanation of other refusals.	F 311	Physical Therapy will screen residents for functional deficits at time of admission and quarterly Residents on walking programs will be reviewed monthly and as needed for progress and appropriateness of program Nursing staff will be in-serviced to re-approach resident if they refuse and to document re-approach and if resident continues to refuse. The explanation of refusal will be documented. Physical therapy staff will be in-serviced on completing screen on admission and quarterly. Physical therapy will complete therapy to nursing communication form when discharging resident on functional maintenance program. The DNS or designee will conduct weekly audits to assure continued compliance. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/23/12	3-23-12

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F 311	Continued From page 4 R60 was interviewed on 2/15/12 at 9 a.m. and stated he wanted to walk but had not been regularly asked. R60 said that sometimes he declined the staff request if he was busy (on the phone) or doing something else. He stated staff did not return so he could walk later. Interview with nurse manager (NM-A) on 2/15/12 at 9:05 a.m. indicated that they were going to discontinue R60's walking program because he refused to walk all of the time. Review of the walking schedule with her confirmed that it was recorded R60 had refused 11 out of the 24 opportunities to walk in February. When asked what the NAs were supposed to do when a resident refuses to walk, NM-A stated that staff are suppose to re-approach residents if they refuse to do something. Review of the walking list indicated there was no record of staff re-approaching R60 in February 2012. Interview with the NM-A at 11:45 a.m. on 2/15/12 indicated that R60 was on a functional maintenance program and should be assisted with walking twice a day.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	F 318 It is the Policy of Golden Living Center Twin Rivers that each resident with limited range of motion receives appropriate treatment and services to	

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F 318	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not provide maintenance range of motion services for 1 of 1 residents (R38) reviewed for range of motion. Findings included: R38 was not provided maintenance ROM for a contracture of the right hand and wrist. R38's diagnoses included Parkinson's disease and contracture of the right hand. The annual Minimum Data Set (MDS) dated 1/17/2012, indicated R38 was moderately cognitive impaired and required the extensive assistance of one to two staff for all activities of daily living (ADL's). The MDS identified R38 had functional limitation in range of motion of both upper extremities. The MDS indicated R38 was not on a restorative nursing program, not provided ROM services and did not have a splint or brace. The Occupational Therapist (OT) Progress Report dated 8/19/11, indicated active assistant (AA)ROM to the right wrist extension was at -20 degrees. (The lower the number the greater the muscle contraction). Following skilled OT services for ROM, the OT Progress Report dated 9/16/11, indicated the right wrist extension improved to -40 degrees. The OT Progress Report and Discharge Summary dated 10/06/11, indicated that ROM goals for the right upper extremity/wrist had been met with right wrist extension at -50 degrees. OT services were discontinued on 10/06/2011. Restorative ROM services were not addressed.	F 318	increase range of motion and/or prevent further decrease in range of motion. To assure continued compliance the following plan has been implemented Resident # 38 is presently on Occupational Therapy case load. Therapy is working on appropriate range of motion and splinting program for R wrist and hand. Other residents range of motion needs will be screened by Occupational and Physical Therapy on admission and quarterly. Licensed nurses will complete section C (Activities of daily living) on Clinical Health Status form at time of admission. Licensed nurses will complete section H (balance during transitions and walking) on interdisciplinary resident review form quarterly. Licensed nurses will be in-serviced on completion of section C and H on nursing forms. Occupational and physical therapy staff will be in-serviced on screening for functional deficits The DNS or designee will conduct weekly audits to assure continued compliance. The QA&A Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of completion: 3/23/12	3-23-12

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F 318	Continued From page 6 The OT Progress Report and Discharge Summary dated 12/29/11, indicated R38 continued to require staff assistance with all ADL's. There was a recommendation for a custom wrist/hand splint to increase ROM, reduce pain and prevent further contracture. Review of the Care Conference Summary dated 1/19/12 indicated that R38 was on an ambulation program for restorative rehabilitation. There was no plan to maintain ROM of the right wrist contracture. OT-G examined R38's right wrist contracture on 2/13/12 and stated the ROM was -40 with discomfort. The MDS nurse, interviewed by phone on 2/17/2012, at 11:40 a.m., verified the lack of ROM services or splinting for R38's right wrist.	F 318		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide 80 square feet of floor space per resident in 8 of 28 resident rooms (4, 7, 17, 20, 21, 29, 35, 36). Findings include: The following double resident rooms did not meet the required minimum square footage per	F 458	F458 Golden LivingCenter-Twin Rivers would like to request a waiver under F458 in regard to resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 29, 35, and 36. • These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase the size of the rooms without causing hardship on the facility. • Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The residents' health, treatments, comfort, safety and well-being will be maintained at the highest possible level. Currently there are no concerns or complaints from residents regarding their room size. • The Director of Maintenance is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	

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F 458	Continued From page 7 resident: Room 4 = 150 square feet, 75 square foot per resident Room 7 = 152.5 square feet, 76.2 square foot per resident Room 17 = 150 square feet, 75 square foot per resident Room 20 = 150 square feet, 75 square foot per resident Room 21 = 150 square feet, 75 square foot per resident Room 29 = 150 square feet, 75 square foot per resident Room 35 = 150 square feet, 75 square foot per resident Room 36 = 155 square feet, 77.5 square foot per resident There was no evidence these residents were negatively impacted by their room size. On 2/12/2012, at 3:15 p.m. during the entrance conference, the facility's executive director verified the above findings, and stated the facility would apply for a waiver for this requirement.	F 458		

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	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2012**

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GOLDEN LIVINGCENTER - TWIN RIVERS	**305 FREMONT STREET** **ANOKA, MN 55303**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Twin Rivers was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 1-story building was constructed in 1962 and was determined to be of Type II (111) construction. With an addition of the same type in 1977. It has a partial basement and is automatic sprinkler protected throughout. The facility has fire alarm detection in corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 56 and had a census of 52 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0428

February 24, 2012

Mr. Ernest Gershone, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, Minnesota 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5298023

Dear Mr. Gershone:

The above facility was surveyed on February 12, 2012 through February 15, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rulesl. 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 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.

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 this office at Minnesota Department of Health, 320 West Second St, Room 703, Duluth, Minnesota 55802-1402. 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,

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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	00866	A. BUILDING _____ B. WING _____	02/15/2012

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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: On 2/12/12 through 2/15/12, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program; 320 West 2nd Street, Duluth, MN 55802	2 000	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		

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	00866	A. BUILDING _____ B. WING _____	02/15/2012

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2 540	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility did not provide comprehensive assessment of range of motion services for 1 of 1 residents (R38) reviewed for range of motion. Findings included: R38's diagnoses included Parkinson's disease and contracture of the right hand. The annual Minimum Data Set (MDS) dated 1/17/2012, indicated R38 was moderately cognitive impaired and required the extensive assistance of one to two staff for all activities of daily living (ADL's). The MDS identified R38 had functional limitation in range of motion of both upper extremities. The MDS indicated R38 was not on a restorative nursing program, not provided ROM services and did not have a splint or brace. The ADL functional and rehabilitation needs Care Area Assessment (CAA) dated 1/20/2012, indicated R38 was at risk to maintain current level of functioning. There was no evidence of assessment to determine if restorative ROM was appropriate. The Occupational Therapist (OT) Progress Report dated 8/19/11, indicated active assistant (AA)ROM to the right wrist extension was at -20 degrees. (The lower the number the greater the muscle contraction). Following skilled OT services for ROM, the OT Progress Report dated 9/16/11, indicated the right wrist extension improved to -40 degrees. The OT Progress Report and Discharge Summary dated 10/05/11, indicated that ROM goals for the right upper extremity/wrist had been met with right wrist	2 540		

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2 540	Continued From page 3 extension at -50 degrees. OT services were discontinued on 10/05/2011. The MDS nurse, interviewed by phone on 2/17/2012, at 11:40 a.m., stated there was no annual assessment of R38's maintenance ROM needs. The MDS nurse verified the MDS identified the functional limitation of right wrist ROM. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the MDS addressed all pertinent care requirements. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 540		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.	2 895		

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2 895	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not provide maintenance range of motion services for 1 of 1 residents (R38) reviewed for range of motion. Findings included: R38 was not provided maintenance ROM for a contracture of the right hand and wrist. R38's diagnoses included Parkinson's disease and contracture of the right hand. The annual Minimum Data Set (MDS) dated 1/17/2012, indicated R38 was moderately cognitive impaired and required the extensive assistance of one to two staff for all activities of daily living (ADL's). The MDS identified R38 had functional limitation in range of motion of both upper extremities. The MDS indicated R38 was not on a restorative nursing program, not provided ROM services and did not have a splint or brace. The Occupational Therapist (OT) Progress Report dated 8/19/11, indicated active assistant (AA)ROM to the right wrist extension was at -20 degrees. (The lower the number the greater the muscle contraction). Following skilled OT services for ROM, the OT Progress Report dated 9/16/11, indicated the right wrist extension improved to -40 degrees. The OT Progress Report and Discharge Summary dated 10/05/11, indicated that ROM goals for the right upper extremity/wrist had been met with right wrist extension at -50 degrees. OT services were discontinued on 10/05/2011. Restorative ROM services were not addressed.	2 895		

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2 895	Continued From page 5 The OT Progress Report and Discharge Summary dated 12/29/11, indicated R38 continued to require staff assistance with all ADL's. There was a recommendation for a custom wrist/hand splint to increase ROM, reduce pain and prevent further contracture. Review of the Care Conference Summary dated 1/19/12 indicated that R38 was on an ambulation program for restorative rehabilitation. There was no plan to maintain ROM of the right wrist contracture. OT-G examined R38's right wrist contracture on 2/13/12 and stated the ROM was -40 with discomfort. The MDS nurse, interviewed by phone on 2/17/2012, at 11:40 a.m., verified the lack of ROM services or splinting for R38's right wrist. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop a system to ensure an ongoing program to maintain proper positioning of residents and range of motion services to maintain or prevent decline in the resident ' s range of motion. The Director of Nursing along with the physical therapist could educate appropriate staff on proper range of motion. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) Days	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 915		

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2 915	Continued From page 6 A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility did not provide ambulation assistance for 1 of 1 residents (R60) in the sample reviewed for ambulation services. Findings include: R60, interviewed on 2/12/2012 at 6:58 p.m., stated that he was suppose to walk twice a day but it was not happening. R60's diagnosis included depression, anemia, congestive heart failure, and COPD. The quarterly Minimum Data Set (MDS) dated 1/03/12, indicated R60 had good short and long term memory, was cognitively intact and had no behaviors. The nursing assistant (NA) work sheet used on 2/15/12, indicated R60 was on an ambulation program. The schedule sheet for February indicated R60 was to be ambulated 50	2 915		

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2 915	Continued From page 7 to 100 feet, two times a day. The care conference summary dated 1/5/12 indicated R60 would walk with staff and use the exercise bike. The Comprehensive Narrative Summary dated 1/3/12, indicated R60's short and long term memory were ok and indicates he ambulated with limited assist of one staff. Review of the walking schedule, from February 1 - 13, 2012, with the nurse manager (NM-A) indicated that R60 was to walk twice a day with assistance. The schedule indicated that R60 did not walk at all in February, with 11 refusals out of 24 opportunities. The schedule indicated he stated he was busy one time and there was no documented explanation of other refusals. R60 was interviewed on 2/15/12 at 9 a.m. and stated he wanted to walk but had not been regularly asked. R60 said that sometimes he declined the staff request if he was busy (on the phone) or doing something else. He stated staff did not return so he could walk later. Interview with nurse manager (NM-A) on 2/15/12 at 9:05 a.m. indicated that they were going to discontinue R60's walking program because he refused to walk all of the time. Review of the walking schedule with her confirmed that it was recorded R60 had refused 11 out of the 24 opportunities to walk in February. When asked what the NAs were supposed to do when a resident refuses to walk, NM-A stated that staff are suppose to re-approach residents if they refuse to do something. Review of the walking list indicated there was no record of staff re-approaching R60 in February 2012. Interview with the NM-A at 11:45 a.m. on 2/15/12	2 915		

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2 915	Continued From page 8 indicated that R60 was on a functional maintenance program and should be assisted with walking twice a day. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receive ambulation assistance as determined necessary by their individualized assessment. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 915		