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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: URDS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **12/19/2013** (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 **69** (L18)

13.Total Certified Beds **69** (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)
X 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,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(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 :
Gloria Derfus, Unit Supervisor 02/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN-24-5222

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 7, 2013. On December 19, 2013, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on December 12, 2013, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 7, 2013, effective December 12, 2013. Refer to the CMS-2567B for both health and life safety code. Documentation supporting the facility's request for a continuing waiver involving K067 has been forwarded. Approval of the waiverrequest was recommended.

Effective December 12, 2013, the facility is certified for 69 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5222

March 12, 2014

Mr. Ryan Onstad, Administrator
Golden LivingCenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

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 December 12, 2013, the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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

February 5, 2014

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, MN 55404

RE: Project Number S5520024

Dear Mr. Onstad:

On November 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. 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 December 19, 2013, 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 November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013 and therefore remedies outlined in our letter to you dated November 26, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K-0067 at the time of the November 7, 2013 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. 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,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

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
245222	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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 **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **12/17/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/17/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/17/2013**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **12/17/2013**
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	Date:	Signature of Surveyor:	Date:
	GD/AK	02/05/2014	18623	12/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/7/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RGJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **12/05/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **69** (L18)

13.Total Certified Beds **69** (L17)

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

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
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
	69			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver at K067 is recommended.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 12/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/30/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5222

Electronically Delivered: December 15, 2014

Mr. Ryan Onstad, Administrator
Golden LivingCenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Onstad:

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 December 2, 2014 the above facility is certified for:

69 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: 067.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare 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 about this electronic notice.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 12, 2014

Mr. Ryan Onstad, Administrator
Golden Livingcenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222024

Dear Mr. Onstad:

On October 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective December 2, 2014 and therefore remedies outlined in our letter to you dated October 31, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the October 23, 2014 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245222	A. Building B. Wing	12/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	12/02/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	12/02/2014	ID Prefix F0428 Reg. # 483.60(c) LSC	12/02/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/KJ	12/12/2014	18623	12/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/23/2014

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: RGJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00937

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245222**
2.STATE VENDOR OR MEDICAID NO.
(L2) **543433500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - CHATEAU**
(L4) **2106 SECOND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **10/23/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **69** (L18)
13.Total Certified Beds **69** (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)
X 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: B,5 * (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver at K067 is recommended.

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 11/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 31, 2014

Mr. Ryan Onstad, Administrator
Golden LivingCenter - Chateau
2106 Second Avenue South
Minneapolis, Minnesota 55404

RE: Project Number S5222024

Dear Mr. Onstad:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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:

Gloria Derfus, Gayle Lantto, and Sue Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793

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 December 2, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (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 January 23, 2015 (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 April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

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

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure a clean and odor-free environment for residents and visitors reviewed for environmental concerns. This had the potential to affect the 24 residents who resided on the 3rd floor of the facility, family, and/or visitors. Findings include: On 10/20/14, at 2:30 p.m. a strong pervasive urine odor was detected on the 3rd floor in the hallway near resident rooms 301, 302, 303 and 304. On 10/21/14, at 9:00 a.m. urine odors were noted on the 3rd floor in the hallway and could not be detected if it was generated from one of the	F 253	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F253 - The floors in rooms 301, 302, 303, and 304 will be stripped and waxed by	12/2/14

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

Electronically Signed | 11/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 1 resident rooms. On 10/22/14, at 7:15 a.m. urine odors were noted on the 3rd floor in the hallway near the resident rooms 301, 302, 303 and 304, at 2:30 p.m. the urine odor was still noticeable. On 10/23/14, at 9:00 a.m. urine odor was observed in the same area. The housekeeping staff was observed cleaning the resident rooms, hallway and wiping down the surfaces on a daily basis. During the environmental tour on 10/23/14, at 9:15 a.m. the administrator, the maintenance director (MD) and housekeeping director (HD) verified an odor in the hallway located by the surrounding rooms 301, 302, 303 and 304. The MD demonstrated and verified the ventilation system was in working order. The administrator did state there are a few residents that are non-compliant with their incontinence. The Housekeeping director verified and provided a daily room cleaning and deep cleaning schedule. On 10/23/14, at 9:50 a.m. registered nurse (RN)-B verified she could smell the pervasive urine odors in the hallway. She also verified the odor could be coming from resident room 301 as the residents are not always compliant with their incontinence needs. RN-B stated the residents bedding was changed and wiped down on a daily basis. There was no cleaning policy provided as requested.	F 253	housekeeping staff. - Housekeeping staff will perform weekly deep cleans in rooms 301, 302, 303, and 304. - The carpet on 3rd floor corridor and day room will be cleaned weekly. - The equipment, wheelchairs, and other items will be deep cleaned. - Bathing schedules of the residents in room 301, 302, 303, and 304 will be reviewed and revised as necessary. - Incontinence care plans of the residents in room 301, 302, 303, and 304 will be reviewed and revised as necessary. - Audits will be completed by different members of the IDT team to evaluate odor on 3rd floor. - Audits will be completed by different members of the IDT team to evaluate the odor on each floor/unit that could affect all residents. - The QAPI committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QAPI will dictate the continuation or completion of this monitoring process based on the compliance noted. - Executive Director responsible. - Completion date: December 2 2014.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		12/2/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 2 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for side effects of psychotropic medications for 2 of 5 residents (R44, R53) reviewed for unnecessary meds. Findings include: R44 was admitted to the facility on 1/24/12, with Admission Record diagnosis of alcohol induced persisting amnesic disorder (loss of memory caused by long-term alcohol abuse), dementia with behavioral disturbances, anxiety, alcohol induced persisting dementia, chronic pancreatitis	F 329	F 329 " Resident R44 and R53 orthostatic BP have been obtained and reviewed. " All other residents on Anti psychotic medications have had their electronic medication records reviewed for orthostatic blood pressures and changes made as needed " Licensed staff and TMAs will be educated on requirements for orthostatic blood pressure monitoring for residents. " Random audits will be completed monthly for Orthostatic blood pressure	

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F 329	Continued From page 3 (inflammation of the pancreas- an organ involved in digestion and insulin production in the body). On 10/22/14, at 7:35 a.m. R44 was in the main dining room at a table for four, visiting with neighbors. On 10/23/14, at 8:10 a.m. R44 was woken to go to breakfast in the main dining room, he was very quiet, stern faced with a flat affect and monotone voice. R44 agreed to accept medications, but then immediately got on the elevator to leave for breakfast without waiting for medication. Registered nurse (RN)-D stated, "I guess I'll give his meds when he gets back." R44's care plan dated 2/2/12, included: At risk for falls-related to medication- observe for side effects of medications, Seroquel (an anti-psychotic medication) and as needed Ativan (an anti-anxiety medication). Potential for drug related complications associated with use of psychotropic medications, anti-anxiety medication, and anti-psychotic medication. Monitor for side effects and report to physician: anti-anxiety/Hypnotic medications-drowsiness, morning, hand over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal Symptoms (EPS) (uncontrollable facial or body movements), weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. R44's care plan included: Behaviors which include shouting and cursing. A history of yelling at staff and pounding fists, altercation with peers, multiple resident to	F 329	completion for residents receiving anti psychotic medication. " Director of Nursing Services (DNS) will report results of audits to the QAPI committee. " The QAPI committee will review results of audits and decide if audits need to be continued weekly, less than weekly or more than weekly. QAPI will dictate the continuation or completion of this monitoring process based on the compliance noted. " Director of Nursing Services (DNS) is responsible. " Completion date: December 2 2014.	

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F 329	Continued From page 4 resident altercation and required a private room. R44 did not like to be called derogatory names. R44 did retaliate physically against people. R44's had physician ordered medications of: Seroquel (an anti-psychotic medication), 100 milligrams (mg) twice a day on 8/20/12, and Ativan (an anti-anxiety medication) 0.5 mg in the morning, 1 mg at 3:00 p.m. and 1 mg as needed after 3:00 p.m. on 11/7/12. R44 also had orthostatic blood pressure (BP) ordered by the physician on 11/7/12. The BPs were to be completed monthly. In addition, the Physician Orders dated 6/17/14, directed the staff to monitor for side effects from the anti-psychotic medication. The side effects included tardive dyskinesia, lethargy, orthostatic hypotension, fall episodes, stroke etc. Review of Orthostatic BP recorded in the record from 1/7/14, going forward noted: - 1/7/14: Lying (L) 140/70, sitting (S)130/65, standing (ST) 130/65 - 2/7/14: A note documented off unit not returning for BP check. The orthostatic BP was not completed per the Physician Order nor was the BP taken to monitor for potential side effects. - 3/7/14: L 130/75, S 130/75, ST 120/70 - 4/7/14: L 130/80, S 115/75, ST 110/70 - 5/7/14: A note refused BP monitoring. The Ativan dose was reduced. The orthostatic BP was not completed per the Physician Order nor was the BP taken to monitor for potential side effects. - 6/7/14, A note refused BP monitoring. The Ativan was discontinued on 6/5. The orthostatic BP was not completed per the Physician Order nor was the BP taken to monitor for potential side effects. - 7/7/14: L 105/65, S 115/70, ST 125/75	F 329		

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F 329	Continued From page 5 - 8/7/14: A note refused BP monitoring. Seroquel dose was reduced. The orthostatic BP was not completed per the Physician Order nor was the BP taken to monitor for potential side effects. - 9/7/14: L 135/75, S 130/70, ST 130/70 - 10/7/14: No documentation was present on the chart. The orthostatic BP was not completed per the Physician Order nor was the BP taken to monitor for potential side effects. - 10/23/14: L 123/71, S 108/58, ST 116/70 was completed at the direction of the director of nursing (DON), after the issue was recognized by the survey team. The orthostatic BPs were not consistently completed as ordered by the physician nor were the BPs taken to determine if R44 had adverse side effects from the medication. The annual Care Area Assessment (CAA) dated 1/22/14, indicated R44 had delirium, impaired insight and judgment of the world around him, required assistance in structuring the day's activities and maintaining safety, and recent hallucinations (not described). R44 cognitive deficit was described as progressive in nature, along with a behavioral component. R44's behavioral symptoms included: physical and verbal aggression towards staff when refused entrance into smoking room. R44 was assessed at having socially disruptive qualities. The CAA also indicated R44 was at risk for falls due to diagnoses, visual impairment, poor judgment and medication. The Minimum Data Set (MDS) dated 7/23/14, indicated R44 had moderate cognitive impairment, minimal depression, and delusions of still owning a farm. In addition, the MDS noted R44 rejected cares and required moderate set up	F 329		

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F 329	Continued From page 6	F 329		

assistance of one for cares. The MDS noted R44 had not fallen in the past 180 days.

On 10/22/14, at 9:00 a.m. RN-A verified the orthostatic BP's were not consistently being done on a monthly basis as required for anti-psychotic medication use. RN-A suspected that the October 2014 documentation was missed completely because the Seroquel had been discontinued at some point and restarted in August 2014. RN-A further stated she would assign a date for the orthostatic BP to be completed on the treatment record (TAR), so it would not be missed again. A review of the physician orders and medication sheets indicated the Seroquel had not been discontinued, but had been reduced in August.

On 10/22/14, at 10:00 a.m. the DON, had reviewed the vital sign charting, progress notes and Medication administration records (MAR) and TARs; The DON verified the monthly orthostatic BPs for psychotropic medication monitoring were not completed if the resident refused on the date the orthostatic BP was scheduled. The DON further stated her expectation would be if the resident refused, the staff would re-approach later or the next day until a monthly orthostatic BPs were recorded. The DON verified if orthostatic BP was not obtained because the resident refused, or was not on the unit, the staff had the option to reset the orthostatic BP task for another time, or to just leave it unfulfilled, and that in February, May, June, August, and October 2014 the task was left unfulfilled.

The undated Admission Record revealed R53 was admitted to the facility on 1/16/14, and was readmitted on 6/6/14. The undated Diagnosis

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F 329	Continued From page 7	F 329		

Information sheet indicated R53 had diagnoses including dementia with behavioral disturbances, antisocial personality disorder, adjustment disorder mixed with emotional disturbance, and epilepsy with recurrent seizures.

Review of R53's Physician's Order history from January 2014 to present indicated R53 was taking anti-psychotic medication continuously since admission.

The admission MDS dated completed on 1/28/14, indicated R53 had moderate cognitive impairment, delirium (manifested through inattention, disorganized thinking). The admission MDS also indicated R53 rejected cares. The admission CAA dated 1/28/14, noted R53 "had behaviors of inattention and disorganized thinking that were present and fluctuated", and that R53 was started on Risperdal (anti-psychotic medication) during recent hospitalization for psychosis and paranoid symptoms. The CAA also indicated R53 was "at moderate risk for falls due to diagnoses, medication, mentation and history of falls."

R53's care plan dated 1/28/14, also indicated risk for falls related to medication use, and directed staff to observe for side effects.

The current physician's orders dated 10/23/14, indicated R53 took Seroquel (an Anti-psychotic medication) 75 mg three times a day for schizophrenia. The physician's order dated 1/16/14, indicated "ANTI-PSYCHOTIC MEDICATION- OBSERVE FOR SIGNIFICANT SIDE EFFECT & REPORT TO MD [physician]" which included: postural hypotension. The Physician's Order dated 6/6/14, directed staff to

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GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 329	Continued From page 8 take orthostatic blood pressure monthly. Review of R53's electronic Treatment Administration Record (eTAR) from admission to present revealed direction for staff "ANTI-PSYCHOTIC MEDICATION- OBSERVE FOR SIGNIFICANT SIDE EFFECT & REPORT TO MD [physician]" and included postural hypotension, however R53's orthostatic blood pressure was not consistently monitored. The following was noted: In January, February, March, April, June, July, August, September, and October 2014 the orthostatic BPs were not completed per the Physician Order nor was the BP taken to monitor for potential side effects. May 2014: Lying (L) 141/94, Sitting (S) 149/87, Standing (ST) 137/87 June 2014:Lying (L) 110/80, Sitting (S) 178/100, Standing (ST) 115/82 On 10/22/14, at 8:16 a.m. R53 was observed eating breakfast in his room. R53 was very talkative, related events from his past, and did not answer interview questions. R53 did not carry on the conversation. The Registered Nurse (RN)-A, also program manager was interviewed on 10/22/14, at 1:03 p.m. The RN-A reviewed R53's medical record and verified R53's monthly orthostatic blood pressures were not consistently monitored, and explained staff were expected to take the monthly orthostatic blood pressure for all residents who took anti-psychotic medication. The facility's Behavior Management Guidelines undated policy provided by the DON indicated staff to monitor side effects including "Orthostatic hypotension every month" for anti-psychotic	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHATEAU	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 329	Continued From page 9 medication use. Adverse side effect monitoring was not completed for residents who were identified by the facility for being at risk for falls.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for side effects of psychotropic medications for 2 of 5 residents (R44, R53) reviewed for unnecessary meds. Findings include: R44 was admitted to the facility on 1/24/12, with Admission Record diagnosis of alcohol induced persisting amnesic disorder (loss of memory caused by long-term alcohol abuse), dementia with behavioral disturbances, anxiety, alcohol induced persisting dementia, chronic pancreatitis (inflammation of the pancreas- an organ involved in digestion and insulin production in the body). On 10/22/14, at 7:35 a.m. R44 was in the main dining room at a table for four, visiting with	F 428	F428 " Pharmacist will review the charts of all resident who are on anti psychotic medication for the presence of orthostatic blood pressures and make recommendations as needed. " Pharmacist will review the charts of all residents in the facility monthly and report on any irregularities to the attending physician and the Director of Nursing Services. " DNS/Designee will complete random audits of pharmacist reports to ensure review has been completed and ensure follow up on recommendations and will report progress of audits to the QAPI committee. " The QAPI committee will provide	12/2/14

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F 428	Continued From page 10 neighbors. On 10/23/14, at 8:10 a.m. R44 was woken to go to breakfast in the main dining room, he was very quiet, stern faced with a flat affect and monotone voice. R44 agreed to accept medications, but then immediately got on the elevator to leave for breakfast without waiting for medication. Registered nurse (RN)-D stated, "I guess I'll give his meds when he gets back." R44's care plan dated 2/2/12, included: At risk for falls-related to medication- observe for side effects of medications, Seroquel (an anti-psychotic medication) and as needed Ativan (an anti-anxiety medication). Potential for drug related complications associated with use of psychotropic medications, anti-anxiety medication, and anti-psychotic medication. Monitor for side effects and report to physician: anti-anxiety/Hypnotic medications-drowsiness, morning, hand over, ataxia, dry mouth, constipation, blurred vision, urinary retention, headache, vertigo, nausea, hypotension, tachycardia, weakness, sedation, lethargy, confusion, memory loss and dependence, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal Symptoms (EPS) (uncontrollable facial or body movements), weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. R44's care plan included: Behaviors which include shouting and cursing. A history of yelling at staff and pounding fists, altercation with peers, multiple resident to resident altercation and required a private room. R44 did not like to be called derogatory names. R44 did retaliate physically against people. R44's had physician ordered medications of:	F 428	direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. " Director of Nursing Services (DNS) is responsible " Completion date: December 2 2014.	

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F 428	Continued From page 11 Seroquel (an anti-psychotic medication), 100 milligrams (mg) twice a day on 8/20/12 and Ativan (an anti-anxiety medication) 0.5 mg in the morning, 1 mg at 3:00 p.m. and 1 mg as needed after 3:00 p.m. on 11/7/12. R44 also had orthostatic blood pressure (BP) ordered by the physician on 11/7/12. The BPs were to be completed monthly. In addition, the Physician Orders dated 6/17/14, directed the staff to monitor for side effects from the anti-psychotic medication. The side effects included tardive dyskinesia, lethargy, orthostatic hypotension, fall episodes, stroke etc. Review of Orthostatic BP recorded in the record from 1/7/14, going forward noted: - 1/7/14: Lying (L) 140/70, sitting (S)130/65, standing (ST) 130/65 - 2/7/14: A note documented off unit not returning for BP check. The orthostatic BP was not completed per the Physician Order not was the BP taken to monitor for potential side effects. - 3/7/14: L 130/75, S 130/75, ST 120/70 - 4/7/14: L 130/80, S 115/75, ST 110/70 - 5/7/14: A note refused BP monitoring. The Ativan dose was reduced. The orthostatic BP was not completed per the Physician Order not was the BP taken to monitor for potential side effects. - 6/7/14, A note refused BP monitoring. The Ativan was discontinued on 6/5. The orthostatic BP was not completed per the Physician Order not was the BP taken to monitor for potential side effects. - 7/7/14: L 105/65, S 115/70, ST 125/75 - 8/7/14: A note refused BP monitoring. Seroquel dose was reduced. The orthostatic BP was not completed per the Physician Order not was the BP taken to monitor for potential side effects. - 9/7/14: L 135/75, S 130/70, ST 130/70	F 428		

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F 428	Continued From page 12	F 428		

- 10/7/14: No documentation was present on the chart. The orthostatic BP was not completed per the Physician Order not was the BP taken to monitor for potential side effects.
- 10/23/14: L 123/71, S 108/58, ST 116/70 was completed at the direction of the director of nursing (DON), after the issue was recognized by the survey team. The orthostatic BPs were not consistently completed as ordered by the physician nor were the BPs taken to determine if R44 had adverse side effects from the medication.

The annual Care Area Assessment (CAA) dated 1/22/14, indicated R44 had delirium, impaired insight and judgment of the world around him, required assistance in structuring the day's activities and maintaining safety, and recent hallucinations (not described). R44 cognitive deficit was described as progressive in nature, along with a behavioral component. R44's behavioral symptoms included: physical and verbal aggression towards staff when refused entrance into smoking room. R44 was assessed at having socially disruptive qualities. The CAA also indicated R44 was at risk for falls due to diagnoses, visual impairment, poor judgment and medication.

The monthly medication review (MMR) from May 2014 going forward indicated: May, Ativan gradual dose reduction (GDR) started. June, Ativan to PRN (as needed). July, Ativan discontinued. August, Seroquel decreased to 100 mg every day. September, no new labs.

The Minimum Data Set (MDS) dated 7/23/14, indicated R44 had moderate cognitive impairment, minimal depression, and delusions of

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F 428	Continued From page 13 still owning a farm. In addition, the MDS noted R44 rejected cares and required moderate set up assistance of one for cares. The MDS noted R44 had not fallen in the past 180 days. On 10/22/14, at 9:00 a.m. RN-A verified the orthostatic BP's were not consistently being done on a monthly basis as required for anti-psychotic medication use. RN-A suspected that the October 2014 documentation was missed completely because the Seroquel had been discontinued at some point and restarted in August 2014. RN-A further stated she would assign a date for the orthostatic BP to be completed on the treatment record (TAR), so it would not be missed again. A review of the physician orders and medication sheets indicated the Seroquel had not been discontinued, but had been reduced in August. On 10/22/14, at 10:00 a.m. the DON, had reviewed the vital sign charting, progress notes and Medication administration records (MAR) and TARs; The DON verified the monthly orthostatic BPs for psychotropic medication monitoring were not completed if the resident refused on the date the orthostatic BP was scheduled. The DON further stated her expectation would be if the resident refused, the staff would re-approach later or the next day until a monthly orthostatic BPs were recorded. The DON verified if orthostatic BP was not obtained because the resident refused, or was not on the unit, the staff had the option to reset the orthostatic BP task for another time, or to just leave it unfulfilled, and that in February, May, June, August, and October 2014 the task was left unfulfilled. On 10/22/14, at 1:00 p.m. the consultant pharmacist (CP) stated he began with the facility	F 428		

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F 428	Continued From page 14 in May, and spent three days in the facility, making sure everything was on the right track. He had checked to make sure that orthostatic BP monitoring was in place, but did not specifically check to see if orthostatic BP's were always recorded in the chart. CP stated that each resident on anti-psychotic medications should be monitored for side effects of the medications including monthly orthostatic blood pressures. The undated Admission Record revealed R53 was admitted to the facility on 1/16/14, and was readmitted on 6/6/14. The undated Diagnosis Information sheet indicated R53 had diagnoses including dementia with behavioral disturbances, antisocial personality disorder, adjustment disorder mixed with emotional disturbance, and epilepsy with recurrent seizures. Review of R53's Physician's Order history from January 2014 to present indicated R53 was taking anti-psychotic medication continuously since admission.	F 428		

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F 428	Continued From page 15 The admission MDS dated completed on 1/28/14, indicated R53 had moderate cognitive impairment, delirium (manifested through inattention, disorganized thinking). The admission MDS also indicated R53 rejected cares. The admission CAA dated 1/28/14, noted R53 "had behaviors of inattention and disorganized thinking that were present and fluctuated", and that R53 was started on Risperdal (anti-psychotic medication) during recent hospitalization for psychosis and paranoid symptoms. The CAA also indicated R53 was "at moderate risk for falls due to diagnoses, medication, mentation and history of falls." R53's care plan dated 1/28/14, also indicated risk for falls related to medication use, and directed staff to observe for side effects. The current physician's orders dated 10/23/14, indicated R53 took Seroquel (an Anti-psychotic medication) 75 mg three times a day for schizophrenia. The physician's order dated 1/16/14, indicated "ANTI-PSYCHOTIC MEDICATION- OBSERVE FOR SIGNIFICANT SIDE EFFECT & REPORT TO MD [physician]" which included: postural hypotension. The Physician's Order dated 6/6/14, directed staff to take orthostatic blood pressure monthly. Review of R53's electronic Treatment Administration Record (eTAR) from admission to present revealed direction for staff "ANTI-PSYCHOTIC MEDICATION- OBSERVE FOR SIGNIFICANT SIDE EFFECT & REPORT TO MD [physician]" and included postural hypotension, however R53's orthostatic blood pressure was not consistently monitored. The	F 428		

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F 428	Continued From page 16 following was noted: In January, February, March, April, June, July, August, September, and October 2014 the orthostatic BPs were not completed per the Physician Order nor was the BP taken to monitor for potential side effects. May 2014: Lying (L) 141/94, Sitting (S) 149/87, Standing (ST) 137/87 June 2014:Lying (L) 110/80, Sitting (S) 178/100, Standing (ST) 115/82 On 10/22/14, at 8:16 a.m. R53 was observed eating breakfast in his room. R53 was very talkative, related events from his past, and did not answer interview questions. R53 did not carry on the conversation. The Registered Nurse (RN)-A, also program manager was interviewed on 10/22/14, at 1:03 p.m. The RN-A reviewed R53's medical record and verified R53's monthly orthostatic blood pressures were not consistently monitored, and explained staff were expected to take the monthly orthostatic blood pressure for all residents who took anti-psychotic medication. The Consultant Pharmacist (CP) was interviewed on 1/22/14, at 1:55 p.m. and stated when he reviewed resident's records he looked to make sure there was an order for the monthly orthostatic blood pressures, but he did not necessarily looked to see if staff completed them or not. The CP reviewed R53's medical record, and stated he missed to identify irregularity. The facility's Behavior Management Guidelines undated policy provided by the DON indicated staff to monitor side effects including "Orthostatic hypotension every month" for anti-psychotic medication use. Adverse side effect monitoring	F 428		

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F 428	Continued From page 17 was not completed for residents who were identified by the facility for being at risk for falls." The facility's Consultant Pharmacist Services Provider Requirements policy dated revised November 2011, indicated the CP helped to identify, communicate, address, and resolves concerns and issues related to the provision of pharmaceutical services. This included "Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information."	F 428		

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	245222	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Chateau was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2014

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

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K 000	Continued From page 1 Marian.Whitney@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 Livingcenter Chateau is a 4-story building, with a partial basement. The facility was constructed in 1963 and was determined to be of Type II(222) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 69 beds and had a census of 58 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067		12/2/14

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K 067	Continued From page 2 Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 10:15 AM and 11:45 AM on 10/21/2014, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067	K067 - Waiver requested. Refer to justification on form Part IV Recommendation for waiver of Specific Life Safety Code Provisions.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, November 06, 2014 11:15 AM
To: rochi_lsc@cms.hhs.gov
Cc: robert.rexeisen@state.mn.us; 'ryan.onstad@goldenliving.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Golden Livingcenter Chateau (245222) 2014 K67 Annual Waiver - Preciously Approved - No Changes

This is to inform you that GLC Chateau is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 10-21-14.

I am recommending that CMS approve this waiver request.

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

Name of Facility **2000 CODE**

GGNSC Minneapolis Chateau dba: Golden Living Center - Chateau

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K67 The building Heating, Ventilation and Air Conditioning (HVAC) Equipment does not comply with the LIfe Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K-67. A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: The facility received an estimate on March 14, 2012 for the cost of upgrading the HVAC system to be in compliance with NFPA 90. The cost estimate for a complying HVAC is $432,250.00. This estimate does not include costs of major structural engineer work or major structural work related to the HVAC upgrade, which will be needed according to the estimate scope. Also, this cost does not include the cost of financing, which will need to be done in able to afford the project. Financing will add approximately $86,400 to $194,400 to the overall costs of the project. Under current CMS reimbursement rates, it is estimated to take approximately a minimum of 8 to 15 years to recoup the costs. This approximation will need to be extended when taking into account the costs of current facility projects that are under way such as air handler maintenance, tub/shower room renovations, flooring replacements, plus routine equipment and service projects and non routine emergency maintenance or services. A complying HVAC system has a large scope of work included at this particular facility. A project with a scope of this scale will force the a high degree of disruption to the facility residents. The estimate states that the work will able to be done in 4 resident rooms at the same time. This has the potential of displacing 8 - 10 residents at the same time. This is especially challenging when the medical, mental, and psychological states of our residents are taken into consideration. We have some residents who prefer to remain in their rooms and get agitated, aggressive, and abusive when disturbed in this capacity. The resident's rooms are located on 2nd, 3rd, and 4th floor. The dining room, the kitchen, and staff offices are located on the first floor. On an average day, there is about 35 staff members with about 66 residents for a ratio of 1:1.89. The facility staffs at a rate of 4.77 hours per patient, per day. The building is 50 years old and there are no known plans for the facility to be replaced and no end date has been determined for the buildings usable life. There are concerns of whether or not the new HVAC system would put the facility out of compliance due the the fact that the corridors will be less than 6 feet and 8 inches tall, which is not allowed against LSC. There are also concerns about whether the building electrical system is adequate to handle the additional HVAC equipment required or if the penetration of load bearing walls to install required duct work would adversely affect the structural integrity of the building. B. The waiver of such unmet provisions will not adversely affect the health and safety of the patients, occupants or staff because: The type of building and the way the building is outfitted and staffed to ensure compliance and maximum safety for our residents. The facility is a type II (222) type construction. The interior finishes are of Class A or Class B. The walls, floors, ceiling and vertical opening resist the passage of smoke. The facility's life safety features are an EST and Notifier fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification; complete supervised automatic wet standpipe sprinkler system throughout ; portable fire extinguishers are located on all units; pyrochem kitchen hood wet chemical system. Annual service and maintenance contracts are in place to keep all systems in effective operating condition. The facility also has a fire safety plan that is in accordance with LSC 19.7.2.2. The facility does operate under safe smoking policies and procedures, fire policies, fire watch, and housekeeping and laundry operate under safe dryer policies. Two smoke compartments on each floor, so there is a total of eight smoke compartments in the entire building. The closest fire department is .93 miles away and has an average response time of 2-4 minutes. The facility is in compliance with all other safety requirements and there were no other safety deficiencies that were cited. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	Fire Safety Supervisor	State Fire Marshal	11-6-14