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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: STQ0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245342**
2.STATE VENDOR OR MEDICAID NO.
(L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - GREELEY**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

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

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

6. DATE OF SURVEY **03/12/2012** (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 **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	70			
(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 :
Susanne Reuss, Unit Supervisor — 04/04/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Susan N. Leppke, Program Specialist — 04/18/2012 (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
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 4/24/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on January 26, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2012, effective March 6, 2012. Therefore remedies outlined in our letter dated February 3, 2012, will not be imposed. Please see attached CMS-2567b forms from the revisit.

Documentation supporting the facility's request for a temporary waiver involving K67 with a date of completion of November 1, 2012 is not verified. This facility's plan of correction for this deficiency, including their request for a temporary waiver with a date of completion of November 1, 2012, is approved.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 18, 2012 CMS Certification Number (CCN): 245342

Ms. Jennifer Schoenecker, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

Dear Ms. Schoenecker:

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 6, 2012 the above facility is recommended for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

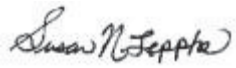
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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.

Sincerely,



Susan N. Leppke, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4121 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 4, 2012

Ms. Jennifer Schoenecker, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

RE: Project Number S5342021

Dear Ms. Schoenecker:

On February 3, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 6, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2012, effective March 6, 2012 and therefore remedies outlined in our letter to you dated February 3, 2012, will not be imposed.

Correction of the Life Safety Code deficiency(ies) cited under K67 at the time of the January 26, 2012 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of November 1, 2012, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5342r12.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
245342	A. Building B. Wing	3/12/2012

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

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 **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/06/2012**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/06/2012**
ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/06/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/06/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/06/2012**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/06/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/SNL	04/04/2012	20810	03/12/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/26/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: STQ0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245342**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - GREELEY**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **01/26/2012** (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 **70** (L18)

13.Total Certified Beds **70** (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
	70			
(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 :
Robyn Woolley, HFE-NEII 04/03/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/05/2012 (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
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
TW LSC K67 Waiver in ACO. CO.
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: 24-5342
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on January 26, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) 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.

The facility¿s request for temporary waiver involving the deficiency cited at K67 until November 1, 2012 is recommended for approval. Refer to the CMS-2567, CMS-2786R; Provision Number K84 Justifications, and email dated April 3, 2012 from Patrick Sheehan, Department of Public Safety.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4754

February 3, 2012

Ms. Jennifer Schoenecker, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

RE: Project Number S5342021

Dear Ms. Schoenecker:

On January 26, 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 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;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
PO Box 64900, St Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 6, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 6, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 26, 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 July 26, 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,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5342s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 253 SS=D	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 maintain a sanitary resident bathroom for four residents sharing a bathroom in rooms 229 and 231. Findings include: During observation on 1/23/12, the bathroom between rooms 229 and 231 had a strong urine odor, the floor was stained yellow near the toilet, and the baseboard behind the toilet contained yellow stains. Four residents shared this bathroom. On environmental tour at 8:00 a.m. on 1/25/12, the administrator and director of maintenance	F 253	**F253** • The bathroom floor between rooms 229 and 231 was immediately cleaned. The tile floor and baseboard will be replaced with new laminate floor. • All resident bathrooms will be audited for odor and deep cleaned if necessary. All resident bathrooms will be audited for stained baseboard and tile floor and will be replaced if necessary. • Each resident bathroom is cleaned daily and more often as needed, which is the policy to address cleaning of resident bathrooms.	2/21/12 SER

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

Executive Director 2-14-12

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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	245342	A. BUILDING _____ B. WING _____	01/26/2012

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F 253	Continued From page 1 verified the bathroom shared by rooms 229 and 231 had a strong urine odor and stated the baseboard behind the toilet may be the source. Both acknowledged the room needed to be deep cleaned because of the odor. The administrator and director of maintenance also confirmed that the facility did not have a policy to address cleaning of resident bathrooms. They went on to explain that the facility system is for staff discovering a problem in a resident room to complete a maintenance request slip. The maintenance director stated he would ensure the bathroom odor for rooms 229 and 231 would be eliminated.	F 253	• All staff will be educated on the policy of cleaning resident bathrooms. • ED/Designee will conduct random audits to monitor for compliance. ED will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on compliance noted. • ED is responsible. • Completion date: March 6, 2012.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not accurately and comprehensively assess one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11,	F 276	**F276** • R89's comprehensive assessment has been updated to accurately reflect current bladder status. • All residents' comprehensive assessments have been audited to ensure documentation is accurately reflected to residents current bowel and bladder status. • Nurse managers will be educated on process to complete comprehensive assessment in conjunction with the MDS.	

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F 276	Continued From page 2 that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes for R89, outside of the MDS assessment period, on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Note entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A)stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator	F 276	• The DNS/Designee will conduct random audits in conjunction with quarterly schedule to monitor for compliance. DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible. • Completion date: March 6, 2012	

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LICENSE AND CERTIFICATION

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F 276	Continued From page 3 share responsibility of updating resident care. The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change."	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive plan of care for 1 of 2 residents (R18) in the sample who had pressure ulcers.	F 279	**F279** • R18's mattress was replaced with an air mattress immediately to meet comprehensive care plan intervention. • An audit was done on all residents that are care planned t o have an air mattress to ensure air mattress is in place. • Nurses will be educated to check to ensure air mattresses are in place, daily, and will document this on Treatment Record. • The DNS/Designee will conduct random audits in conjunction with quarterly schedule to monitor for compliance. DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible. • Completion date: March 6, 2012	

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F 279	Continued From page 4 Findings include: R18 had a stage IV (a full thickness of skin and subcutaneous tissue is lost exposing muscle or bone) sacral pressure ulcer and lacked interventions based on the comprehensive assessment to promote wound healing. The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer and multiple sclerosis (MS). The admission Minimum Data Set (MDS) completed on 10/3/11 indicated the resident was cognitively intact and required extensive assistance of two with bed mobility, transfers, toileting and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers and currently had a stage IV pressure ulcer measuring 3.3 cm (centimeters) x 1.7 cm x 2.8 cm. A Pressure Ulcer Care Area Assessment dated 10/3/11 indicated the resident had risk factors for pressure ulcer development including immobility, altered mental status, cognitive loss, incontinence, poor nutrition, MS, peripheral vascular disease, limitations in range of motion an indwelling catheter, and being wheelchair bound. The resident's care plan initiated 10/6/11 indicated the resident required repositioning every hour and the resident had a pressure reduction/relieving mattress. A Quarterly Comprehensive Assessment dated 12/29/11 identified the resident's continued pressure ulcer risk and the presence of a stage four pressure ulcer on the sacrum. The	F 279		

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F 279	Continued From page 5 assessment indicated the resident would "continue with Q1h (every hour) repositioning as patient will allow and low air loss mattress to her bed." The assessment indicated the resident had an electric wheelchair and was able to and does offload independently when in the chair. Weekly skin progress notes dated 9/28/11 through 1/18/12 identified a low air loss mattress on the resident's bed as an intervention for a pressure ulcer management. Although the assessment and progress notes identified the use of a low air loss mattress as an intervention to prevent the development of pressure ulcers and promote healing of the resident's current pressure ulcer, at 10:17 a.m. on 1/25/12, the resident's bed was noted to have a foam mattress on it. At 10:30 a.m. on 1/25/12, the director of nursing and clinical manager (CM-A) verified the resident's bed did not have the low air loss mattress as indicated in the medical record. At 10:34 a.m. on 1/25/11, CM-A stated the resident should have a low air loss mattress on her bed. CM-A verified the care plan did not identify the need for a low air loss mattress only a pressure relieving/reduction mattress.	F 279		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	**F314** • R18's mattress was replaced with an air mattress immediately in order to promote healing. • An audit was done on all residents that are care planned t o have an air mattress to ensure air mattress is in place.	

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F 314	Continued From page 6 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents with pressure ulcers received the necessary care and treatment to promote healing and prevent further development of pressure ulcers for 1 of 2 residents (R18) in the sample who had a pressure ulcer. Findings include: R18 had a stage IV (a full thickness of skin and subcutaneous tissue is lost exposing muscle or bone) sacral pressure ulcer and lacked interventions to promote wound healing . The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer and multiple sclerosis (MS). The admission Minimum Data Set (MDS) completed on 10/3/11 indicated the resident was cognitively intact and required extensive assistance of two with bed mobility, transfers, toileting and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers and currently had a stage IV pressure ulcer measuring 3.3 cm (centimeters) x 1.7 cm x 2.8 cm. A Pressure Ulcer Care Area Assessment dated 10/3/11 indicated the resident had risk factors for pressure ulcer development including immobility, altered mental status, cognitive loss, incontinence, poor nutrition, MS, peripheral	F 314	• Nurses will be educated to check to ensure air mattresses are in place, daily, and will document this on Treatment Record. • The DNS/Designee will conduct random audits in conjunction with quarterly schedule to monitor for compliance. DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible. • Completion date: March 6, 2012	

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F 314	Continued From page 7 vascular disease, limitations in range of motion, an indwelling catheter, and being wheelchair bound. The resident's care plan initiated 10/6/11 indicated the resident required repositioning every hour and the resident had a pressure reduction/relieving mattress. A Quarterly Comprehensive Assessment dated 12/29/11 identified the resident's continued pressure ulcer risk and the presence of a stage four pressure ulcer on the sacrum. The assessment indicated the resident would "continue with Q1h (every hour) repositioning as patient will allow and low air loss mattress to her bed." The assessment indicated the resident had an electric wheelchair and was able to and does offload independently when in the chair. Weekly skin progress notes dated 9/28/11 through 1/18/12 identified a low air loss mattress on the resident's bed as an intervention for a pressure ulcer management. At 10:17 a.m. on 1/25/12, the resident's bed was observed and noted to have a foam mattress on it. At 10:30 a.m. on 1/25/12 the director of nursing and clinical manager (CM-A) verified the resident's bed did not have the low air loss mattress as indicated in the quarterly assessment and progress notes. At 10:34 a.m. on 1/25/11, CM-A stated the resident should have a low air loss mattress on her bed. CM-A verified the care plan did not identify the use of a low air loss mattress only a pressure relieving/reduction mattress.	F 314		

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F 314	Continued From page 8 At 8:21 a.m. 1/26/12, the resident's foam mattress had been replaced with a low air loss mattress.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide accurate and comprehensive assessment or an accurate plan of care regarding urinary incontinence for one of one resident (R89) reviewed for urinary incontinence who was not accurately and comprehensively assessed . Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11, that read, " Bowel/Bladder: After review of the 3	F 315	**F315** • R89's comprehensive assessment and CNA assignment sheet has been updated to accurately reflect current bladder status. • All residents' comprehensive assessments have been audited to ensure documentation is accurately reflected to residents current bowel and bladder status. • Nurse managers will be educated on process to complete comprehensive assessment in conjunction with the MDS. • The DNS/Designee will conduct random audits in conjunction with quarterly schedule to monitor for compliance. DNS will report progress of audits to the QA committee.	

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F 315	Continued From page 9 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes, outside of the MDS assessment period, for R89-on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Notes entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A) stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. Page twelve of the resident's current care plan contained a goal, dated 3/12, that read, " I will maintain my current level of (always continent bladder continence and occasional bowel incontinence) continence. " The current assignment sheet for nursing	F 315	• The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible. • Completion date: March 6, 2012	

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F 315	Continued From page 10 assistant care directed only that R89 receive assistance of one staff with toileting and gave no further direction for care. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care. The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change," and "Observation of care provided matches the plan of care."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug 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	F 329	F329 • R18: Resident's Trimethoprim is currently on hold while receiving other antibiotics • Consulting pharmacist to review and ensure no other residents in the facility have antibiotics without specific indications identified in the chart • Consultant pharmacist to receive education on prophylactic antibiotic use and identifying potentially inappropriate medications related to such therapy. • Consultant pharmacist to provide information to nursing regarding the use of prophylactic antibiotics and multiple antibiotics.	

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F 329	Continued From page 11 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 1 resident (R18) in the sample who received ongoing antibiotics for neurogenic bladder. Findings include: R18 received Trimethoprim (an antibiotic) and lacked indications for continued use. The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer, osteomyelitis, neurogenic bladder and multiple sclerosis (MS). The physician's orders printed 1/3/12 and signed by the MD (no date), indicated the resident had an indwelling catheter and received Trimethoprim 100 mg by mouth daily at bedtime for neurogenic bladder. A hospital Discharge Summary dated 8/15/11 indicated the resident had been on long term Trimethoprim and has had no issues with urinary tract infections. A physician's progress note dated 12/30/11 and a urology consult note dated 1/2/12 failed to address the continued use of Trimethoprim. The medical record lacked evidence of a physician	F 329	• DNS/Designee to monitor for compliance on antibiotic use in the facility with random audits. DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on compliance. • Completion date: March 6, 2012.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 documented clinical rationale for the ongoing use for Trimethoprim. During the month of January 2012, in addition to Trimethoprim, the resident received multiple antibiotics for the treatment of poliomyelitis including: Meropenm one gram IV three times a day (started 12/20/11 and discontinued on 1/11/12), Vancomycin HCl 1250 to 1700 mg (milligrams) IV every 48 hours (started 12/29/11 and discontinued 1/11/12), Doxycycline Hyclate 100 mg by mouth twice daily for 30 days (started 1/11/12) and Levaquin 750 mg by mouth daily for 30 days (started 1/11/12). In the afternoon on 1/25/12, the clinical manager (CM-A) was interviewed regarding the history of and rationale for the continued use of Trimethoprim. CM-A requested an opportunity to review the medical record prior to responding to the questions asked. At 8:31 a.m. on 1/26/12, CM-A verified the medical record lacked a physician documented clinical rationale for the ongoing use of Trimethoprim and it's concurrent use with IV and oral antibiotics that were prescribed for the treatment of osteomyelitis. CM-A stated the resident has had no urinary tract infections since admission. CM-A stated the medication was ordered by the urologist and she contacted the physician's office on 1/25/12 regarding this medication. The physician put the Trimethoprim on hold while the resident was receiving Doxycyline Hyclate and Levaquin	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	01/26/2012

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F 364	Continued From page 13 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide meals at a palatable temperature, potentially affecting 21 of 67 residents in the facility. Findings include: During stage one interviews at 4:30 p.m. and 6:00 p.m. on 1/23/12, two out of ten residents complained about food temperatures. A review of the resident council minutes for October 2011 and November 2011 revealed resident complaints about the food temperatures. No specific wing or unit was mentioned in the minutes. The assembly of trays for the 21 north wing residents started at 12:15 p.m. on 1/25/12, and was completed at 12:22 p.m. During this tray assembly, plates were retrieved from a plate warmer and the plates were cool enough to be handled without a hot pad. The plates were then put on insulated underbases, food taken from a steam table placed on the plates, the plates topped with insulated dome plate covers that were not heated, and the plates with underbases and covers placed in an closed cart. These food carts were then delivered to the north resident	F 364	F364 • Food will be prepared according to the facility guideline to ensure it is cooked to the proper temperature and held to proper temperature range throughout the serving time. • Dietary staff will be educated on how to serve food to ensure adequate food temperature. • The Dietary Services Manager/Designee will conduct random audits for food temperature to ensure compliance. Dietary Services Manager will report progress of audits to the QA committee. • The Dietary Services Manager/Designee will conduct random audits to determine how the temperature is perceived by the resident. Dietary Services Manager will report progress of audits to the QA committee. • The Dietary Services Manager will attend resident council meetings to ensure residents are satisfied with the temperature of the food being served.	

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F 364	Continued From page 14 unit. At 12:14 p.m., the temperature of the food on the steam table had been taken by the registered dietitian (RD) and the certified dietary manager (CDM) with the following findings: ground chicken 155 degrees fahrenheit (F) , chicken breast 160 degrees F, potatoes 170 degrees F, mixed vegetables 137 degrees F. The last tray was passed to a resident on the north unit at 12:35 p.m. and at that time, a test tray was temped by the RD and CDM. The ground chicken was 126 degrees F, the chicken breast was 123 degrees F, the scalloped potatoes were 130 degrees F, and the pears were 60 degrees F. At 8:00 a.m. on 1/26/12 dietary staff found temperatures of fortified oatmeal temped at 180 degrees F, regular oatmeal 176 degrees F, and egg bake at 190 degrees F in the steam table before these foods were plated. A test tray was the last plated at 8:34 a.m. and tested for temperature at 8:41 a.m. by the RD and CDM. The oatmeal was 136 degrees F with good flavor but pasty texture and not hot, and the egg bake was 112 degrees F. with good flavor but barely warm. When interviewed at 1:15 p.m. on 1/25/12, the CDM stated that there is no facility policy for auditing of serving temperature of food to the residents and she is not aware of any regulation for serving temperatures of food to the residents. The RD and the CDM acknowledged the pears should have been served colder, and the hot foods hotter. A review of page 5.45 in the facility's Dining	F 364	• The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • Dietary Services Manager is responsible is responsible. • Completion date: March 6, 2012	

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F 364	Continued From page 15 Services Policies and Procedures, dated 2011, instructed staff to discard any hot food items that are not at 140 degrees F or above at the end of meal service, and to discard any cold food product that is not at 41 degrees F or below.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure food was stored, prepared, and served under sanitary conditions to prevent food borne illness, which had the potential to affect 66 of 67 residents in the facility. Findings include: During the initial kitchen tour at 12:05 p.m. on 1/23/12, with the director of dietary services (DDS) present, the coat, shoes, tote bag and purse of a cook (Cook-A) were stored in the kitchen's food preparation area. Cook-A stated, "I was never told we cannot have personal belongings in the kitchen, and we've always done it as long as I have been here, everyone does." When immediately interviewed, the DDS verified	F 371	**F371** • Cook-A's belongings were immediately removed and was educated that personal belongings can not be kept in the kitchen. • All Dietary staff will be educated on not storing any personal items in the kitchen. • Dietary staff educated on proper way of washing hands and glove wearing. • Dietary staff educated on proper way to hold bowls or plates for plating food to avoid bare hand contact. • The Dietary Services Manager/Designee will conduct random audits to monitor for compliance. Dietary Services Manager will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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F 371	Continued From page 16 employees are not to keep personal items in the food preparation area of the kitchen. When reviewed, page 5.10 of the facility's Dining Policies and Procedures, dated 2011, directed, "Personal items (such as purses and coats) must be placed in a designated area away from food-preparation, service and storage areas." At 8:00 a.m. on 1/25/12, another cook (Cook-B) plated food without wearing gloves and her bare fingers had contact with the plate surfaces that would contain food. She proceeded to pick up a rack of bowls and another serving spoon out of a drawer without washing her hands before continuing to plate food. The registered dietitian (RD) intervened and instructed Cook-B to don gloves for both hands. Cook-B then stated, "Are we going back to wearing gloves again?" Page 5.10 of the facility's Dining Policies and Procedures, dated 2011, indicated, "Dining Service employees should wash their hands before putting on gloves. Wash hands when changing gloves if hands have been contaminated...After obtaining additional supplies, equipment, or utensils."	F 371	• Dietary Services Manager is responsible is responsible. • Completion date: March 6, 2012	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	**F425** • Resident # 89 has had a new vial of insulin ordered to reflect the proper dosage of insulin she is to receive, No ill effects were found for this resident due to the label on her insulin vial not matching the MD order. Resident # 89 received the proper dose of insulin via electric MAR.	

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F 425	Continued From page 17 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility did not ensure the accuracy of 1 of 2 insulin vial labels observed during medication administration. Findings include: The insulin vial label for R89 did not accurately reflect the current physician orders. Observation of medication administration for resident (R89) on 1/24/12 at 11:55 a.m. included Novolog insulin. Registered nurse (RN)-A administered 9 units of the insulin subcutaneously to R89. The resident had also been observed to receive 9 units of Novolog insulin at 8 a.m.1/24/12. The label on the vial of insulin indicated 9 units to be administered daily. RN-A stated the physician's order had changed to include 9 units of insulin every a.m. and every noon. RN-A placed a change of direction sticker on the vial of insulin and stated "that should have been done."	F 425	• All residents at this facility have the potential to be effected by this practice. LN and TMA's will receive education related to the policy "medications and medication labels". • DNS/Designee will complete weekly audits of MARs matching labels of medication. Nurses/TMA found to be deficient in this practice will receive reeducation and possible discipline action if not corrected. • DNS/Designee to monitor for compliance with random audits. DNS will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on compliance. • Completion date: March 6, 2012.	

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F 425	Continued From page 18 Record review for R89 revealed a physician's order dated 9/27/11 indicating the change of insulin orders to 9 units every a.m. and every noon. Review of the facility policy for medication labels indicated "medication labels are not altered, modified, or marked in any way by nursing personnel." The policy directed "the nurse may place a direction change label on the medication container." The policy further directed "if directions for use change, the provider pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the medication regimen for 1 of 10 residents (R18) in the sample was free of medication irregularities.	F 428	**F428** • R18: Resident's drug in questions, Trimethoprim, is currently on hold while receiving additional antibiotics for osteomyeletis • Consulting pharmacist will contact prescribing urologist for additional information regarding continued need for Timethoprim. • Consulting pharmacist will continue to review drug regimen of all resident's monthly and report irregularities to attending physician and DNS. • Random audits will be completed on consulting pharmacist to ensure that residents are not receiving inappropriate multiple antibiotics therapy. • Completion date: March 6, 2012	

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F 428	Continued From page 19 Findings include: R18 received Trimethoprim (an antibiotic) and lacked indications for continued use. The facility's consulting pharmacist failed to report this medication irregularity to the director of nursing and physician The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer, osteomyelitis,neurogenic bladder and multiple sclerosis (MS). The physician's orders printed 1/3/12 and signed by the MD (no date), indicated the resident had an indwelling catheter and received Trimethoprim 100 mg by mouth daily at bedtime for neurogenic bladder. A hospital Discharge Summary dated 8/15/11 indicated the resident had been on long term Trimethoprim and has had no issues with urinary tract infections. A physician's progress note dated 12/30/11 and a urology consult note dated 1/2/12 failed to address the continued use of Trimethoprim. The medical record lacked evidence of a physician documented clinical rationale for the ongoing use for Trimethoprim. During the month of January 2012, in addition to Trimethoprim, the resident received multiple antibiotics for the treatment of osteomyelitis including: Meropenem one gram IV three times a day (started 12/20/11 and discontinued on 1/11/12), Vancomycin HCl 1250 to 1700 mg (milligrams) IV every 48 hours (started 12/29/11 and discontinued 1/11/12), Doxycyline Hyclate 100 mg by mouth twice daily for 30 days (started 1/11/12) and Levaquin 750 mg by mouth daily for 30 days (started 1/11/12).	F 428		

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F 428	Continued From page 20 The Clinical Pharmacist Medication Regimen Review Summary form dated 10/12/11 through 1/5/12 indicated the consulting pharmacist made no recommendations regarding the ongoing use of Trimethoprim. At 9:03 a.m. on 1/26/12, the facility's consulting pharmacist was contacted via phone. The pharmacist stated neurogenic bladder is not an indication for the use of Trimethoprim. The pharmacist stated, the resident "has multiple practitioners and perhaps we need to try a little more coordination of care." She added, the resident has been on multiple antibiotics since her admission and the use of the antibiotics increases the resident's risk for developing C. difficile (a bacterial infection in the GI tract that causes severe diarrhea). The pharmacist stated she had not addressed the use of the Trimethoprim with the director of nursing or the resident's physician and this is worth following up on.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F441** • RN-A has ben educated on proper hand washing guidelines. • Licensed nurses will be educated on infection control and hand washing guidelines. • The DNS/Designee will conduct random audits to monitor for compliance. DNS will report progress of audits to the QA committee.	

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F 441	Continued From page 21 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility did not ensure the implementation and maintenance of appropriate infection control practices for medication administration. Findings include: RN-A failed to implement effective infection control practices during a medication pass. On 1/24/12 at 8:05 a.m. registered nurse (RN)-A was observed to administer an injection of insulin to resident 52 (R52). Immediately following the	F 441	• The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • DNS is responsible. • Completion date: March 6, 2012	

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F 441	Continued From page 22 injection RN-A prepared and administered oral medications to R89. RN-A did not complete hand hygiene between the insulin injection for R52 and the oral medication set up and administration for R89. RN-A acknowledged the failure to follow infection control practices for medication administration. The facility policy for handwashing/hand hygiene with a revision date of 10/09 directed staff to perform hand hygiene (wash hands for ten to 15 seconds using antimicrobial or non-antimicrobial soap and water) before and after performing any invasive procedure. The hand hygiene procedure also indicated hand hygiene as recommended by the Centers for Disease Control (CDC) directing staff to decontaminate hands before and after direct contact with a patient's skin.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure that 9 of 21 residents observed had access to their overhead bed light. Findings include: During stage one resident interview at 7:00 p.m. on 1/23/12, two of ten residents expressed concern that they had to call a staff member to turn on the bed overhead light because they were	F 465	**F465** • All over the bed light cords for resident's noted on facility tour were replaced with a longer cord. • All over the bed light cords have been audited and those that were not long enough were replaced with a cord that is long enough. • All staff will be educated on steps to take in the event they find an over the bed light cord that is not long enough.	

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F 465	Continued From page 23 unable to reach the cord to turn on the light. On the environmental tour at 8:00 a.m. on 1/25/12, with the administrator and director of maintenance, 9 out of 21 overhead bed light cords were not accessible to the resident to use independently because the cords were either broken off or not long enough for the residents to reach. The administrator and director of maintenance confirmed that the facility did not have a policy to address overhead light cords. They went on to explain that the facility system is for staff discovering a problem in a resident room to complete a maintenance slip for repair. The maintenance director stated he would go through all resident rooms and make sure all residents had access to the overhead bed light cords.	F 465	• The ED/designee will conduct random audits to monitor for compliance. ED will report progress of audits to the QA committee. • The QA committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. • ED is responsible. • Completion date: March 6, 2012	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, April 03, 2012 9:10 AM
To: 'Brown, Tamika J. (CMS/MC)'
Cc: Linhoff, Tom (DPS); 'Schoenecker, Jennifer 54 [BH00876]'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Golden Living Center Greely (245342) L67 Temporary Waiver Request

This is to inform you that I am accepting GLC Greely's request for a temporary waiver until 11-1-12 to perform the work necessary to eliminate their K67 deficiency, corridors as a plenum. The exit date was 1-26-12.

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

Name of Facility	2000 CODE
CLC Greely	

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
K067	**A Temporary Waiver is requested for K067 for the following reasons:** **A. There will be no adverse effect on the health and safety of the facility's residents and staff since:** **1. The building is equipped with an approved corridor smoke detection system.** **2. The building has automatic shutdown of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system.** **3. Annual service and maintenance contracts exist to service all the facility's fire protection systems (for example; fire alarm, sprinkler system, portable extinguishers). An Additional Semi annual service for the fire sprinkler system is being conducted on the buildings sprinkler system by a licensed contractor.** **4. The building fire alarm system is monitored to provide automatic fire department notification.** **5. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.** **6. Fire drills are conducted quarterly on each shift, an additional drill will be completed each quarter.** **7. The facility is protected by a supervised automatic sprinkler system.** **B. The facility will arrange for the work to be completed by November 1, 2012, when it is feasible for the facility and contractor.**

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature]	Fire Safety Supervisor	State Fire Marshal	9-3-12

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

F 5342020

PRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREELEY	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

Dc: 03.06.12

Ext: 01.26.12

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 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Greeley Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 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 TO:

PATRICK SHEEHAN, SUPERVISOR
HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145
Pat.Sheehan@state.mn.us

POC ok
w/TW for K67
4-3-12

RECEIVED
MAR - 3 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

Executive Director | 2.14.12

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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K 000	Continued From page 1 *****DO NOT FAX***** 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. Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type 2(111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction.	K 000		
	The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. Also system smoke detection is in all resident rooms.			

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K 000	Continued From page 2 The facility has a licensed capacity of 70 beds and had a census of 67 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: Based on observation, the facility failed to ensure that the corridors of this 1-story, fully fire sprinklered building were not being used as a portion of a supply and return air system. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: During tour of the facility on 01/25/2012 between 09:00 AM and 01:00 PM, it was observed that the egress corridors throughout the 1964 building were being used as a portion of a supply, return or exhaust air system serving adjoining resident rooms. NFPA 90A (99), prohibits the use of Health Care Occupancies' egress corridors as an air plenum. An annual waiver has been approved in the previous survey. No changes have been made in the facility.	K 067	POC for K 067 Temporary Waiver Attached.	TW 11-1-12

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K 067	Continued From page 3 *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4754

February 3, 2012

Ms. Jennifer Schoenecker, Administrator
Golden Livingcenter - Greeley
313 South Greeley Street
Stillwater, Minnesota 55082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5342021

Dear Ms. Schoenecker:

The above facility was surveyed on January 23, 2012 through January 26, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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, Po Box 64900, St Paul, Minnesota 55164-0900. 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,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING _____ B. WING _____	01/26/2012

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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 January 23-26, 2012 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	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.	

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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	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 which 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.	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by:	2 550		

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2 550	Continued From page 2 Based on observation, interview, and document review, the facility did not accurately and comprehensively assess one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11, that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes for R89, outside of the MDS assessment period, on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Note entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that	2 550		

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2 550	Continued From page 3 she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A)stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care. The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change." Based on observation, interview, and document review, the facility did not accurately and comprehensively assess one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11,	2 550		

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2 550	Continued From page 4 that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes for R89, outside of the MDS assessment period, on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Note entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A)stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care. The facility's Incontinence Management/Bladder	2 550		

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2 550	Continued From page 5 Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure comprehensive assessments were conducted in a timely manner. 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. Based on observation, interview, and document review, the facility did not accurately and comprehensively assess one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11, that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet	2 550		

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2 550	Continued From page 6 been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes for R89, outside of the MDS assessment period, on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Note entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A)stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care. The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change."	2 550		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 7 Based on observation, interview, and document review, the facility did not accurately and comprehensively assess one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11, that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident	2 550		

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	00947	A. BUILDING _____ B. WING _____	01/26/2012

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2 550	Continued From page 8 Continence by Day Report revealed other urinary incontinence episodes for R89, outside of the MDS assessment period, on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Note entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A)stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care. The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change."	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced	2 560		

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2 560	Continued From page 9 by: Based on observation, interview and document review the facility failed to develop a comprehensive plan of care for 1 of 2 residents (R18) in the sample who had pressure ulcers. Findings include: R18 had a stage IV (a full thickness of skin and subcutaneous tissue is lost exposing muscle or bone) sacral pressure ulcer and lacked interventions based on the comprehensive assessment to promote wound healing. The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer and multiple sclerosis (MS). The admission Minimum Data Set (MDS) completed on 10/3/11 indicated the resident was cognitively intact and required extensive assistance of two with bed mobility, transfers, toileting and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers and currently had a stage IV pressure ulcer measuring 3.3 cm (centimeters) x 1.7 cm x 2.8 cm. A Pressure Ulcer Care Area Assessment dated 10/3/11 indicated the resident had risk factors for pressure ulcer development including immobility, altered mental status, cognitive loss, incontinence, poor nutrition, MS, peripheral vascular disease, limitations in range of motion an indwelling catheter, and being wheelchair bound. The resident's care plan initiated 10/6/11 indicated the resident required repositioning every hour and the resident had a pressure reduction/relieving mattress.	2 560		

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2 560	Continued From page 10 A Quarterly Comprehensive Assessment dated 12/29/11 identified the resident's continued pressure ulcer risk and the presence of a stage four pressure ulcer on the sacrum. The assessment indicated the resident would "continue with Q1h (every hour) repositioning as patient will allow and low air loss mattress to her bed." The assessment indicated the resident had an electric wheelchair and was able to and does offload independently when in the chair. Weekly skin progress notes dated 9/28/11 through 1/18/12 identified a low air loss mattress on the resident's bed as an intervention for a pressure ulcer management. Although the assessment and progress notes identified the use of a low air loss mattress as an intervention to prevent the development of pressure ulcers and promote healing of the resident's current pressure ulcer, at 10:17 a.m. on 1/25/12, the resident's bed was noted to have a foam mattress on it. At 10:30 a.m. on 1/25/12, the director of nursing and clinical manager (CM-A) verified the resident's bed did not have the low air loss mattress as indicated in the medical record. At 10:34 a.m. on 1/25/11, CM-A stated the resident should have a low air loss mattress on her bed. CM-A verified the care plan did not identify the need for a low air loss mattress only a pressure relieving/reduction mattress. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for pressure ulcer care. A monitoring program could be established in order to assure ongoing and effective care plan	2 560		

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2 560	Continued From page 11 interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents with pressure ulcers received the necessary care and treatment to promote healing and prevent further development of pressure ulcers for 1 of 2 residents (R18) in the sample who had a pressure ulcer. Findings include: R18 had a stage IV (a full thickness of skin and subcutaneous tissue is lost exposing muscle or	2 900		

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2 900	Continued From page 12 bone) sacral pressure ulcer and lacked interventions to promote wound healing . The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer and multiple sclerosis (MS). The admission Minimum Data Set (MDS) completed on 10/3/11 indicated the resident was cognitively intact and required extensive assistance of two with bed mobility, transfers, toileting and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers and currently had a stage IV pressure ulcer measuring 3.3 cm (centimeters) x 1.7 cm x 2.8 cm. A Pressure Ulcer Care Area Assessment dated 10/3/11 indicated the resident had risk factors for pressure ulcer development including immobility, altered mental status, cognitive loss, incontinence, poor nutrition, MS, peripheral vascular disease, limitations in range of motion, an indwelling catheter, and being wheelchair bound. The resident's care plan initiated 10/6/11 indicated the resident required repositioning every hour and the resident had a pressure reduction/relieving mattress. A Quarterly Comprehensive Assessment dated 12/29/11 identified the resident's continued pressure ulcer risk and the presence of a stage four pressure ulcer on the sacrum. The assessment indicated the resident would "continue with Q1h (every hour) repositioning as patient will allow and low air loss mattress to her bed." The assessment indicated the resident had an electric wheelchair and was able to and does offload independently when in the chair.	2 900		

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2 900	Continued From page 13 Weekly skin progress notes dated 9/28/11 through 1/18/12 identified a low air loss mattress on the resident's bed as an intervention for a pressure ulcer management. At 10:17 a.m. on 1/25/12, the resident's bed was observed and noted to have a foam mattress on it. At 10:30 a.m. on 1/25/12 the director of nursing and clinical manager (CM-A) verified the resident's bed did not have the low air loss mattress as indicated in the quarterly assessment and progress notes. At 10:34 a.m. on 1/25/11, CM-A stated the resident should have a low air loss mattress on her bed. CM-A verified the care plan did not identify the use of a low air loss mattress only a pressure relieving/reduction mattress. At 8:21 a.m. 1/26/12, the resident's foam mattress had been replaced with a low air loss mattress. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		

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2 910	Continued From page 14 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide accurate and comprehensive assessment or an accurate plan of care regarding urinary incontinence for one of one resident (R89) reviewed for urinary incontinence. Findings include: R89 was admitted 9/8/11 with diagnoses including diabetes, fractures of wrist and pelvis, chronic airway obstruction, and mild cognitive impairment. During morning observations on 1/24/12 and 1/25/12, R89 was independent with toileting. Record review revealed a Quarterly Comprehensive Assessment, dated 12/27/11, that read, " Bowel/Bladder: After review of the 3 day bowel and bladder record, she has no incontinence of bowel and bladder. She has been independent with her toileting tasks and has not been using an incontinence product. Her family reports history of some urinary incontinence upon admission, which has not yet been displayed. Plan will be to continue to toilet	2 910		

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2 910	Continued From page 15 herself with assist as needed with goal of continence of bowel and bladder. " The resident's quarterly Minimum Data Set (MDS), dated 12/14/11, described the resident as occasionally incontinent of bladder. When interviewed at 8:40 a.m. on 1/25/12, the facility's MDS coordinator stated that the data collected from the facility's Resident Continence by Day Report for the 12/14/11 quarterly MDS assessment period (14 days) showed that the resident had been incontinent of bladder on 12/10/11. Further review of the Resident Continence by Day Report revealed other urinary incontinence episodes, outside of the MDS assessment period, for R89-on 12/2/11, 12/6/11, 12/19/11, 12/20/11, 1/13/12, and 1/22/12. A Progress Notes entry in the record, dated 11/20/11, read, " Resident has had accidents of incontinence in the past 3 nights, she states that she would like to try a pull up at night. Will pass this to the next shift. " When interviewed at 9:50 a.m. on 1/25/12, the nursing assistant caring for R89 (NA-A) stated that R89 is completely continent of urine during the day, and incontinent of urine at times at night. Page twelve of the resident's current care plan contained a goal, dated 3/12, that read, " I will maintain my current level of (always continent bladder continence and occasional bowel incontinence) continence. " The current assignment sheet for nursing assistant care directed only that R89 receive assistance of one staff with toileting and gave no further direction for care. During interview at 1:55 p.m. on 1/25/12, the nurse manager for R89's unit (Clinical Manager-B) confirmed that she had completed the Quarterly Comprehensive Assessment dated 12/27/11, and she and the MDS coordinator share responsibility of updating resident care.	2 910		

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2 910	Continued From page 16 The facility's Incontinence Management/Bladder Function Guideline policy, dated January 2011, directed, "The resident will be assessed (evaluated) on admission and with MDS significant change," and "Observation of care provided matches the plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are comprehensively assessed for incontinence. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 910		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not provide meals at a palatable temperature, potentially affecting 21 of 67 residents. Findings include: During stage one interviews at 4:30 p.m. and 6:00 p.m. on 1/23/12, two out of ten residents complained about food temperatures.	2 960		

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2 960	Continued From page 17 A review of the resident council minutes for October 2011 and November 2011 revealed resident complaints about the food temperatures. No specific wing or unit was mentioned in the minutes. The assembly of room trays for the 21 north wing residents started at 12:15 p.m. on 1/25/12, and was completed at 12:22 p.m. During this tray assembly, plates were retrieved from a plate warmer and the plates were cool enough to be handled without a hot pad. The plates were then put on insulated underbases, food taken from a steam table placed on the plates, the plates topped with insulated dome plate covers that were not heated, and the plates with underbases and covers placed in an closed cart. These food carts were then delivered to the north resident unit. At 12:14 p.m., the temperature of the food on the steam table had been taken by the registered dietitian (RD) and the certified dietary manager (CDM) with the following findings: ground chicken 155 degrees fahrenheit (F) , chicken breast 160 degrees F, potatoes 170 degrees F, mixed vegetables 137 degrees F. The last tray was passed to a resident on the north unit at 12:35 p.m. and at that time, a test tray was temped by the RD and CDM. The ground chicken was 126 degrees F, the chicken breast was 123 degrees F, the scalloped potatoes were 130 degrees F, and the pears were 60 degrees F. At 8:00 a.m. on 1/26/12 dietary staff found temperatures of fortified oatmeal temped at 180 degrees F, regular oatmeal 176 degrees F, and egg bake at 190 degrees F in the steam table before these foods were plated. A test tray was the last plated at 8:34 a.m. and tested for	2 960		

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2 960	Continued From page 18 temperature at 8:41 a.m. by the RD and CDM. The oatmeal was 136 degrees F with good flavor but pasty texture and not hot, and the egg bake was 112 degrees F. with good flavor but barely warm. When interviewed at 1:15 p.m. on 1/25/12, the CDM stated that there is no facility policy for auditing of serving temperature of food to the residents and she is not aware of any regulation for serving temperatures of food to the residents. The RD and the CDM acknowledged the pears should have been served colder, and the hot foods hotter. A review of page 5.45 in the facility's Dining Services Policies and Procedures, dated 2011, instructed staff to discard any hot food items that are not at 140 degrees F or above at the end of meal service, and to discard any cold food product that is not at 41 degrees F or below. SUGGESTED METHOD FOR CORRECTION: The administrator with the dietary director could review and revise food production procedures to ensure adequate temperatures and palatability of meals . The dietary director could monitor food preparation schedules on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 960		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work	21000		

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21000	Continued From page 19 as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure food was stored, prepared, and served under sanitary conditions to prevent food borne illness, which had the potential to affect 66 of 67 residents in the facility. Findings include: During the initial kitchen tour at 12:05 p.m. on 1/23/12, with the director of dietary services (DDS) present, the coat, shoes, tote bag and purse of a cook (Cook-A) were stored in the kitchen's food preparation area. Cook-A stated, "I was never told we cannot have personal belongings in the kitchen, and we've always done it as long as I have been here, everyone does." When immediately interviewed, the DDS verified employees are not to keep personal items in the food preparation area of the kitchen. When reviewed, page 5.10 of the facility's Dining Policies and Procedures, dated 2011, directed, "Personal items (such as purses and coats) must be placed in a designated area away from food-preparation, service and storage areas." At 8:00 a.m. on 1/25/12, another cook (Cook-B) plated food without wearing gloves and her bare fingers had contact with the plate surfaces that would contain food. She proceeded to pick up a rack of bowls and another serving spoon out of a	21000		

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21000	Continued From page 20 drawer without washing her hands before continuing to plate food. The registered dietitian (RD) intervened and instructed Cook-B to don gloves for both hands. Cook-B then stated, "Are we going back to wearing gloves again?" Page 5.10 of the facility's Dining Policies and Procedures, dated 2011, indicated, "Dining Service employees should wash their hands before putting on gloves. Wash hands when changing gloves if hands have been contaminated...After obtaining additional supplies, equipment, or utensils." SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could develop a policy and procedure to ensure that food was served in a safe manner. Staff could receive training regarding handwashing and glove use to ensure knowledge of safe food handling while serving residents. Monitoring could occur to ensure food was served in a safe and sanitary manner. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21015		

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21015	Continued From page 21 review, the facility did not ensure food was stored, prepared, and served under sanitary conditions to prevent food borne illness, which had the potential to affect 21 of 66 residents in the facility. Findings include: During the initial kitchen tour at 12:05 p.m. on 1/23/12, with the director of dietary services (DDS) present, the coat, shoes, tote bag and purse of a cook (Cook-A) were stored in the kitchen's food preparation area. Cook-A stated, "I was never told we cannot have personal belongings in the kitchen, and we've always done it as long as I have been here, everyone does." When immediately interviewed, the DDS verified employees are not to keep personal items in the food preparation area of the kitchen. When reviewed, page 5.10 of the facility's Dining Policies and Procedures, dated 2011, directed, "Personal items (such as purses and coats) must be placed in a designated area away from food-preparation, service and storage areas." At 8:00 a.m. on 1/25/12, another cook (Cook-B) plated food without wearing gloves and her bare fingers had contact with the plate surfaces that would contain food. She proceeded to pick up a rack of bowls and another serving spoon out of a drawer without washing her hands before continuing to plate food. The registered dietitian (RD) intervened and instructed Cook-B to don gloves for both hands. Cook-B then stated, "Are we going back to wearing gloves again?" Page 5.10 of the facility's Dining Policies and Procedures, dated 2011, indicated, "Dining Service employees should wash their hands before putting on gloves. Wash hands when	21015		

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21015	Continued From page 22 changing gloves if hands have been contaminated...After obtaining additional supplies, equipment, or utensils." SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: 15 (fifteen days)	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not provide meals at a palatable temperature, potentially affecting 21 of 67 residents. Findings include: During stage one interviews at 4:30 p.m. and 6:00	21025		

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21025	Continued From page 23 p.m. on 1/23/12, two out of ten residents complained about food temperatures. A review of the resident council minutes for October 2011 and November 2011 revealed resident complaints about the food temperatures. No specific wing or unit was mentioned in the minutes. The assembly of room trays for the north wing, 21 residents started at 12:15 p.m. on 1/25/12, and was completed at 12:22 p.m. During this tray assembly, plates were retrieved from a plate warmer and the plates were cool enough to be handled without a hot pad. The plates were then put on insulated underbases, food taken from a steam table placed on the plates, the plates topped with insulated dome plate covers that were not heated, and the plates with underbases and covers placed in an closed cart. These food carts were then delivered to the north resident unit. At 12:14 p.m., the temperature of the food on the steam table had been taken by the registered dietitian (RD) and the certified dietary manager (CDM) with the following findings: ground chicken 155 degrees fahrenheit (F) , chicken breast 160 degrees F, potatoes 170 degrees F, mixed vegetables 137 degrees F. The last tray was passed to a resident on the north unit at 12:35 p.m. and at that time, a test tray was temped by the RD and CDM. The ground chicken was 126 degrees F, the chicken breast was 123 degrees F, the scalloped potatoes were 130 degrees F, and the pears were 60 degrees F. At 8:00 a.m. on 1/26/12 dietary staff found temperatures of fortified oatmeal temped at 180 degrees F, regular oatmeal 176 degrees F, and	21025		

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21025	Continued From page 24 egg bake at 190 degrees F in the steam table before these foods were plated. A test tray was the last plated at 8:34 a.m. and tested for temperature at 8:41 a.m. by the RD and CDM. The oatmeal was 136 degrees F with good flavor but pasty texture and not hot, and the egg bake was 112 degrees F. with good flavor but barely warm. When interviewed at 1:15 p.m. on 1/25/12, the CDM stated that there is no facility policy for auditing of serving temperature of food to the residents and she is not aware of any regulation for serving temperatures of food to the residents. The RD and the CDM acknowledged the pears should have been served colder, and the hot foods hotter. A review of page 5.45 in the facility's Dining Services Policies and Procedures, dated 2011, instructed staff to discard any hot food items that are not at 140 degrees F or above at the end of meal service, and to discard any cold food product that is not at 41 degrees F or below. SUGGESTED METHOD FOR CORRECTION: The administrator with the director of food service could review the procedures for maintaining proper food temperatures for food served to residents, revise if necessary and the director of food service or designee could monitor food temperatures on an ongoing basis to ensure appropriate food temperatures are maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21025		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		

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21375	Continued From page 25 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and policy review, the facility did not ensure the implementation and maintenance of appropriate infection control practices for medication administration. Findings include: RN-A failed to implement effective infection control practices during a medication pass. On 1/24/12 at 8:05 a.m. registered nurse (RN)-A was observed to administer an injection of insulin to resident 52 (R52). Immediately following the injection RN-A prepared and administered oral medications to R89. RN-A did not complete hand hygiene between the insulin injection for R52 and the oral medication set up and administration for R89. RN-A acknowledged the failure to follow infection control practices for medication administration. The facility policy for handwashing/hand hygiene with a revision date of 10/09 directed staff to perform hand hygiene (wash hands for ten to 15 seconds using antimicrobial or non-antimicrobial soap and water) before and after performing any invasive procedure. The hand hygiene procedure also indicated hand hygiene as recommended by the Centers for Disease Control (CDC) directing staff to decontaminate hands before and after direct contact with a patient's skin.	21375		

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21375	Continued From page 26 Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending	21530		

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21530	Continued From page 27 physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the medication regimen for 1 of 10 residents (R18) in the sample was free of medication irregularities. Findings include: R18 received Trimethoprim (an antibiotic) and lacked indications for continued use. The facility's consulting pharmacist failed to report this medication irregularity to the director of nursing and physician The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer, osteomyelitis,neurogenic bladder and multiple sclerosis (MS). The physician's orders printed 1/3/12 and signed by the MD (no date), indicated the resident had an indwelling catheter and received Trimethoprim 100 mg by mouth daily at bedtime for neurogenic bladder. A hospital Discharge Summary dated 8/15/11 indicated the resident had been on long term Trimethoprim and has had no issues with urinary tract infections. A physician's progress note dated 12/30/11 and a urology consult note dated 1/2/12 failed to	21530		

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21530	Continued From page 28 address the continued use of Trimethoprim. The medical record lacked evidence of a physician documented clinical rationale for the ongoing use for Trimethoprim. During the month of January 2012, in addition to Trimethoprim, the resident received multiple antibiotics for the treatment of osteomyelitis including: Meropenem one gram IV three times a day (started 12/20/11 and discontinued on 1/11/12), Vancomycin HCl 1250 to 1700 mg (milligrams) IV every 48 hours (started 12/29/11 and discontinued 1/11/12), Doxycyline Hyclate 100 mg by mouth twice daily for 30 days (started 1/11/12) and Levaquin 750 mg by mouth daily for 30 days (started 1/11/12). The Clinical Pharmacist Medication Regimen Review Summary form dated 10/12/11 through 1/5/12 indicated the consulting pharmacist made no recommendations regarding the ongoing use of Trimethoprim. At 9:03 a.m. on 1/26/12, the facility's consulting pharmacist was contacted via phone. The pharmacist stated neurogenic bladder is not an indication for the use of Trimethoprim. The pharmacist stated, the resident "has multiple practitioners and perhaps we need to try a little more coordination of care." She added, the resident has been on multiple antibiotics since her admission and the use of the antibiotics increases the resident's risk for developing C. difficile (a bacterial infection in the GI tract that causes severe diarrhea). The pharmacist stated she had not addressed the use of the Trimethoprim with the director of nursing or the resident's physician and this is worth following up on.	21530		

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21530	Continued From page 29 SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.	21535		

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21535	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 1 resident (R18) in the sample who received ongoing antibiotics for neurogenic bladder. Findings include: R18 received Trimethoprim (an antibiotic) and lacked indications for continued use. The resident was admitted on 9/21/11 with diagnoses of a stage IV sacral ulcer, osteomyelitis, neurogenic bladder and multiple sclerosis (MS). The physician's orders printed 1/3/12 and signed by the MD (no date), indicated the resident had an indwelling catheter and received Trimethoprim 100 mg by mouth daily at bedtime for neurogenic bladder. A hospital Discharge Summary dated 8/15/11 indicated the resident had been on long term Trimethoprim and has had no issues with urinary tract infections. A physician's progress note dated 12/30/11 and a urology consult note dated 1/2/12 failed to address the continued use of Trimethoprim. The medical record lacked evidence of a physician documented clinical rationale for the ongoing use for Trimethoprim. During the month of January 2012, in addition to Trimethoprim, the resident received multiple antibiotics for the treatment of poliomyelitis	21535		

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21535	Continued From page 31 including: Meropenm one gram IV three times a day (started 12/20/11 and discontinued on 1/11/12), Vancomycin HCl 1250 to 1700 mg (milligrams) IV every 48 hours (started 12/29/11 and discontinued 1/11/12), Doxycycline Hyclate 100 mg by mouth twice daily for 30 days (started 1/11/12) and Levaquin 750 mg by mouth daily for 30 days (started 1/11/12). In the afternoon on 1/25/12, the clinical manager (CM-A) was interviewed regarding the history of and rationale for the continued use of Trimethoprim. CM-A requested an opportunity to review the medical record prior to responding to the questions asked. At 8:31 a.m. on 1/26/12, CM-A verified the medical record lacked a physician documented clinical rationale for the ongoing use of Trimethoprim and it's concurrent use with IV and oral antibiotics that were prescribed for the treatment of osteomyelitis. CM-A stated the resident has had no urinary tract infections since admission. CM-A stated the medication was ordered by the urologist and she contacted the physician's office on 1/25/12 regarding this medication. The physician put the Trimethoprim on hold while the resident was receiving Doxycyline Hyclate and Levaquin. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one	21535		

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21535	Continued From page 32 (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility did not ensure the accuracy of 1 of 2 insulin vial labels observed during medication administration. Findings include: The insulin vial label for R89 did not accurately reflect the current physician orders. Observation of medication administration for resident (R89) on 1/24/12 at 11:55 a.m. included Novolog insulin. Registered nurse (RN)-A administered 9 units of the insulin subcutaneously to R89. The resident had also been observed to receive 9 units of Novolog insulin at 8 a.m.1/24/12. The label on the vial of insulin indicated 9 units to be administered daily. RN-A stated the physician's order had changed to include 9 units of insulin every a.m. and every noon. RN-A placed a change of direction sticker on the vial of insulin and stated "that should have been done." Record review for R89 revealed a physician's order dated 9/27/11 indicating the change of insulin orders to 9 units every a.m. and every noon. Review of the facility policy for medication labels indicated "medication labels are not altered,	21620		

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21620	Continued From page 33 modified, or marked in any way by nursing personnel." The policy directed "the nurse may place a direction change label on the medication container." The policy further directed "if directions for use change, the provider pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are labeled appropriately. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Thirty (30) days	21620		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not ensure that 9 of 21 residents observed had access to their overhead bed light. Findings include: During stage one resident interview at 7:00 p.m. on 1/23/12, two of ten residents expressed	21665		

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21665	Continued From page 34 concern that they had to call a staff member to turn on the bed overhead light because they were unable to reach the cord to turn on the light. On the environmental tour at 8:00 a.m. on 1/25/12, with the administrator and director of maintenance, 9 out of 21 overhead bed light cords were not accessible to the resident to use independently because the cords were either broken off or not long enough for the residents to reach. The administrator and director of maintenance confirmed that the facility did not have a policy to address overhead light cords. They went on to explain that the facility system is for staff discovering a problem in a resident room to complete a maintenance slip for repair. The maintenance director stated he would go through all resident rooms and make sure all residents had access to the overhead bed light cords. SUGGESTED METHOD FOR CORRECTION: The administrator could monitor the status of physical plant conditions periodically to insure that a routine maintenance plan in place is being effectively instituted. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21695	Continued From page 35 and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not maintain a sanitary resident bathroom for four residents sharing a bathroom in rooms 229 and 231. Findings include: During observation on 1/23/12, the bathroom between rooms 229 and 231 had a strong urine odor, the floor was stained yellow near the toilet, and the baseboard behind the toilet contained yellow stains. Four residents shared this bathroom. On environmental tour at 8:00 a.m. on 1/25/12, the administrator and director of maintenance verified the bathroom shared by rooms 229 and 231 had a strong urine odor and stated the baseboard behind the toilet may be the source. Both acknowledged the room needed to be deep cleaned because of the odor. The administrator and director of maintenance also confirmed that the facility did not have a policy to address cleaning of resident bathrooms. They went on to explain that the facility system is for staff discovering a problem in a resident room to complete a maintenance request slip. The maintenance director stated he would ensure the bathroom odor for rooms 229 and 231 would be eliminated. SUGGESTED METHOD FOR CORRECTION:	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21695	Continued From page 36 The Director of Nursing, Housekeeping and/or designee could monitor to assure the facility is clean, sanitary and well maintanined. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		